

**How is a 'Trauma-Informed' approach experienced
and perceived by staff and survivors in a
Domestic Abuse service?**

by

Rachel Taparjan

A thesis submitted in partial fulfilment for the requirements for the degree of
Doctor of Philosophy at the University of Central Lancashire

January 2025

RESEARCH STUDENT DECLARATION FORM

Type of Award: PhD

School: School of Health, Social Work and Sport

Sections marked * delete as appropriate

1. Concurrent registration for two or more academic awards

Either *I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution

2. Material submitted for another award

Either *I declare that no material contained in the thesis has been used in any other submission for an academic award and is solely my own work

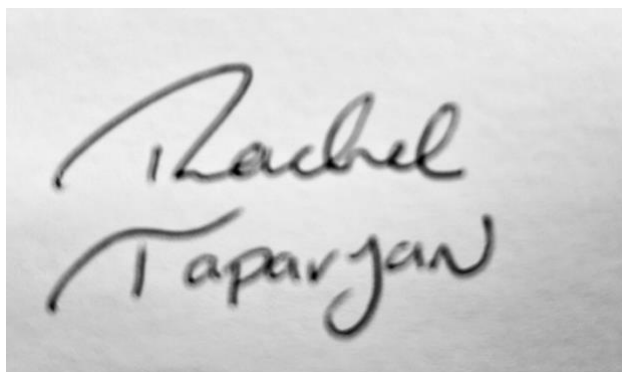
3. Collaboration

Where a candidate's research programme is part of a collaborative project, the thesis must indicate in addition clearly the candidate's individual contribution and the extent of the collaboration. Please state below: NA

4. Use of a Proof-reader

*No proof-reading service was used in the compilation of this thesis.

Signature of Candidate

A photograph of a handwritten signature in black ink on a light-colored surface. The signature is written in a cursive style and reads "Rachel Taparjan".

Print name: RACHEL TAPARJAN

Abstract

Trauma-informed approaches (TIAs) have evolved from an individualised clinical intervention model to address the symptoms of post-traumatic stress disorder (PTSD) to a psycho-social educational empowerment approach into a new holistic paradigm for service delivery. TIAs are increasingly being adopted by UK domestic violence service provision. Much of the existing literature on the implementation of trauma informed approaches in domestic abuse service provision does not include survivor perspectives, and very few studies include survivor and practitioner perspectives. Consequently, much of the existing research offers little understanding of how practitioners and survivors conceptualise and utilise a trauma-informed approach or provide insight into operational and contextual barriers for the domestic abuse sector in harnessing a trauma-informed approach. This study aims to redress this balance by adopting an ecological case study approach focusing on two domestic abuse service provisions in the Northeast of England.

This study is influenced by elements of feminist theory, ecological and systemic theory as well as neurobiological research on psychological trauma and distress, acknowledging the socially constructed conceptualisation of trauma as well as the physiological and psychological experiences of trauma survivors. Data collection took place in two domestic abuse services in the north of England, each offering a range of service provision including refuge provision, advocacy, and counselling. It involved semi structured interviews with 15 domestic abuse practitioners and six domestic abuse survivors.

Originality resides in the ecological adapted case study approach and the inclusion of UK based domestic abuse survivors as well as practitioners. The domestic abuse survivor's Meso-system includes any interaction between professionals that she is engaged with (interactions not involving the survivor directly), which has previously been overlooked in any other study using the ecological framework to examine domestic abuse in the UK. Recommendations include a revised ecological framework that can be used by other domestic abuse researchers who are focussing on service delivery.

Two distinct trauma-informed service delivery models were being harnessed by domestic abuse practitioners across the two services included within the study.

Trauma-informed practice was cited as instrumental in bolstering the legitimacy and credibility of domestic abuse survivors and domestic abuse services. Practitioners also spoke about psychologically distancing themselves by situating challenging behaviours exhibited by survivors in the context of trauma responses.

While the experience level of the practitioner seems to correspond with more nuanced and reflective approach to trauma-informed practice, all practitioners said that a trauma-informed approach helps them to better understand domestic abuse survivors. Practitioners also offer caution about some of the potential barriers to harnessing trauma informed practice in the context of the domestic abuse service provision.

Survivors in this study highlighted the re-traumatising effects of being stigmatised or disbelieved by statutory services and the transformational impact of trauma. While survivors' views on best practice align with some of the principles of trauma-informed practice, they placed the greatest emphasis on being believed and cared for by professionals they work with emphasising the value of the relational component of domestic abuse interventions.

Contents

ACKNOWLEDGEMENTS	7
LIST OF TABLES AND FIGURES	8
GLOSSARY OF TERMS, ABBREVIATIONS, LIST OF SYMBOLS	10
Abbreviations	10
Key Terms	11
CHAPTER 1: INTRODUCTION	14
Background to PhD Study	16
Background to the Research	17
Key Questions and Methodological Approach	18
Thesis Outline	19
CHAPTER 2: LITERATURE ON TRAUMA	21
Introduction	21
Trauma Is a Contested Term	23
The Evolution of Trauma	24
Contemporary Institutional Definitions of Trauma	38
Critique of Bio-medical Conceptualisation of Trauma	40
Impact of Trauma	41
Summary	54
CHAPTER 3: LITERATURE ON DOMESTIC ABUSE	56
Introduction	56
Theoretical Models for Understanding Domestic Abuse	59
Evolution of Professional Discourse and Response to Domestic Abuse	81
Training and Professionalisation of the Domestic Abuse Sector	90
Summary	93
CHAPTER 4: LITERATURE ON TRAUMA-INFORMED SUPPORT FOR WOMEN	95
Introduction	95
Women's Aid and Trauma	95
Historical Context	97
Trauma-Informed Service Provision	106
Summary	136
CHAPTER 5: METHODOLOGICAL APPROACH	138
Introduction	138
Research Questions	138
Epistemological Base	139
Research Design	145
Selection of Participating Organisations	151
Designing The Research Tools	159

Ethical Framework.....	170
Conducting the Research	179
Approach to Analysis	181
Limitations of the Study	182
Summary	183
CHAPTER 6: PRACTITIONER FINDINGS	185
Summary	216
CHAPTER 7: SURVIVOR FINDINGS	218
Summary	245
CHAPTER 8: DISCUSSION	247
Introduction.....	247
Language: Naming Harm in the Context of Domestic Abuse	248
Micro Level: How Trauma Theory and Trauma-Informed Practice Were Manifested in Staff-Survivor Interactions.....	256
Meso-Level: How Trauma Theory and Trauma-informed Practice Were Manifested in Professional Interactions.....	267
Exo Level: Indirect Influence of Organisation and Community Networks	270
Macro Level: Society And Culture	275
Summary	280
CHAPTER 9: CONCLUSION	283
Revisiting the Research Questions.....	283
Summary of Key Research Findings	284
Contribution to Knowledge	294
Recommendations for Domestic Abuse Practice and Research	295
The Shifting Policy Landscape of Domestic Abuse Services.....	303
Concluding Comment.....	305
REFERENCES	308
APPENDICES	391
Appendix A Practitioner Interview Schedule.....	391
Appendix B Practitioner Information Sheet.....	398
Appendix C Practitioner Consent Form	403
Appendix D Survivor Interview Schedule	405
Appendix E Survivor Information Sheet.....	412
Appendix F Survivor Consent Form.....	422
Appendix G Survivor Ethical Approval.....	424

ACKNOWLEDGEMENTS

I would like to thank the two Women's Aid Domestic Abuse Federation services who agreed to participate in this study. I would also like to thank all the survivors who gave up their time to participate in this study.

I would like to thank all past and present members of my Connect Centre supervisory team, particularly Ruth Parkes, Nicky Stanley and Helen Richardson Foster for providing me with the opportunity to undertake this study and for their continued support, guidance and understanding throughout.

LIST OF TABLES AND FIGURES

Number	Title	Chapter Location
Figure 1	Bronfenbrenner's ecological framework model (Bronfenbrenner, 1979)	Chapter 3: theoretical models for understanding domestic abuse
Figure 2	Factors related to violence against women at different levels of the social ecology (Heise, 1998 p 265 & 284)	Chapter 3: theoretical models for understanding domestic abuse
Figure 3	World health organisation - Violence Prevention Alliance Ecological Model, (adapted from Heise 1998)	Chapter 3: theoretical models for understanding domestic abuse
Table 1	Strategic responses to intimate partner violence (IPV) (Collated from Goodman et al., 2003, table 2, page 178)	Chapter 3: theoretical models for understanding domestic abuse
Figure 4	Ecological model for explaining women's strategic responses to IPV (Bliss, Cook & Kaslow, 2014, page 101 & 107).	Chapter 3: theoretical models for understanding domestic abuse
Table 2	Finding from Bliss et al 2014 mapped out using Goodman et al (2003) strategic responses to IPV	Chapter 3: theoretical models for understanding domestic abuse
Figure 5	Theoretical Model: A Trauma-informed, Intersectional Theoretical Model for IPV (Baird 2018 p 19)	Chapter 3: theoretical models for understanding domestic abuse
Figure 6	The Power and Control Wheel (Pence & Paymer, 1993 cited in Carr, 2024, p 11)	Chapter 3: theoretical models for understanding domestic abuse
Figure 7	The Multicultural Power and Control Wheel Chavis & Hill (2008, p 139)	Chapter 3: theoretical models for understanding domestic abuse
Figure 8	Figure 10: The cycle of violence (Walker, 2006)	Chapter 3: theoretical models for understanding domestic abuse
Figure 9	Importance, Uniqueness and Extent to which Components of trauma-informed care were implemented (Hanson and Lang, 2016, p 98)	Chapter 3: theoretical models for understanding domestic abuse
Table 3	Principles and Implementation of Trauma-informed Services for Women (Elliot et al, 2005 p 465-469)	Chapter 4: trauma informed services for domestic abuse survivors
Figure 10	The VOICES case recording template	Chapter 5: selection of participating organisations, service A
Figure 11	TIME (Trauma-informed Model of Empowerment)	Chapter 5: selection of participating organisations, service B

Figure 12	Components of trauma-informed care were implemented (Hanson and Lang, 2016, p 98)	Chapter 5: Designing the Research Tools, Practitioner Interviews
Table 4	Practitioner sample demographics	Chapter 6: Introduction
Table 5	Practitioner themes	Chapter 6: Introduction
Table 6	Survivor sample demographics	Chapter 7: Introduction
Table 7	Survivor themes	Chapter 7: Introduction
Figure 13	Bronfenbrenner's Model adapted to show Key findings from this Study	Chapter 8: Ecological Model
Figure 14	Lancashire Violence reduction Network: A Trauma Informed Organisational Development Framework	Chapter 9: Summary of Key Research Findings
Figure 15	Trauma informed care screening tool from Trauma Informed Oregon	Chapter 9: Recommendations for domestic abuse practice
Table 8	Ecological systems framework for mapping service user- service provision interaction	Chapter 9: Recommendations for domestic abuse research

GLOSSARY OF TERMS, ABBREVIATIONS, LIST OF SYMBOLS

Abbreviations

TIA - Trauma-Informed Approach
TIC- Trauma-Informed Care
PTSD - Post Traumatic Stress Disorder
C- PTSD - Complex Post Traumatic Stress Disorder
DVA - Domestic Violence and Abuse
DA – Domestic Abuse
IPV - Intimate Partner Violence
STS- secondary traumatic stress
VT- Vicarious trauma
DASH- Domestic abuse, Stalking, Harassment and Honour Based Violence
MARAC- Multi Agency Risk Assessment Co-ordinator

Key Terms

There is a slight distinction between the terms domestic abuse (DA) and intimate partner violence (IPV) in that domestic abuse encapsulates abusive behaviour between any 'connected' persons over the age of 16, while intimate partner violence describes abuse between any two individuals above the age of 16 who have (or have had) a romantic connection of some kind (CPS, 2022; NICE, 2016; Capaldi et al., 2012). In the UK, the National Institute for Health and Care Excellence (NICE) and the contemporary legislative frameworks (such as the Domestic Abuse Act, 2021) use the terms domestic violence and abuse (DVA) or domestic abuse (DA).

Intimate partner violence (IPV) is defined by the World Health Organisation (WHO) as: 'Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in that relationship' (Krug et al, 2002 p 89). The World Health Organisation also makes reference to 'controlling behaviour' as a component of IPV (WHO, 2024).

An additional term used commonly within the literature is gender-based violence (GBV) which refers to violence and abuse perpetrated by known or unknown men against women and girls (Russo & Pirlott, 2006; Heise et al., 2002).

Coercive control is one of the domains of non-physical abuse while the term psychological IPV can be used to refer more broadly to acts such as verbal aggression or belittling (Lohman et al 2024). Coercive control better describes dimensions relating to monitoring, isolation and dominance as illuminated by psychometric measures such as the Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1989). In Johnson's three typologies of domestic violence, intimate terrorism is the term he coined to describe patterns of violent coercive control (Johnson, 2011).

While domestic violence or intimate partner violence are still frequently used terms within the literature, a broader understanding of abusive behaviour between connected adults is widely promoted in order to prompt policy makers, practitioner, survivors and perpetrators to recognise the other forms of non-physical abuse that can occur alongside or without the presence of physical violence. This thesis will refer to the all-encompassing term of domestic abuse, unless quoting specific research that uses other terminology.

Trauma in the broadest sense is used to describe the bio-psycho-social harm caused by adverse events experienced by an individual or a group. In this thesis, various conceptualisations of the term trauma are examined, including the medicalised and diagnostic classifications of psychological trauma in Medical Definitions (page 31). Given that the focus of this research is practitioners and survivors who are working with two women's aid federation organisations, it is pertinent to note the definition given by Women's Aid (taken from MIND):

'Very stressful, frightening or distressing events. When we talk about emotional or psychological trauma, we might mean situations or events we find traumatic or how we're affected by our experiences' (McCarthy, 2022, p 22).

Trauma-informed approaches (TIA), sometimes written as trauma-informed approaches to care (TIA/C) or trauma-informed care (TIC), are 'a process of organisational change aiming to create environments and relationships that promote recovery and prevent traumatisation' (Sweeney et al., 2018 p 323). Trauma-informed approaches to care, unlike trauma-specific models, provides a framework that increases providers' awareness and understanding of the impact of trauma, thus guiding and monitoring their interventions, actions, and behaviours in working with clients (Hopper et al., 2010).

Meanwhile trauma-specific support or trauma specific services directly address trauma and its effects where an individual with a known trauma history is seeking specific support or intervention to ameliorate trauma related difficulties, with the goal of reducing symptoms and working with clients toward recovery (Hopper, Bassuk, & Olivet, 2010).

While TIAs primarily operate at an organisational or service level, Trauma-informed practices (TIP) can be implemented at the level of individual practitioners (Sweeney & Taggard, 2018). Trauma-informed practice (TIP) is 'a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both [service] providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.' (Hopper et al., 2010, p. 133).

Trauma-informed support has many overlapping descriptions in the academic and grey literature, from the 4 Rs which realise the impact of the trauma, recognise the

symptoms, respond and resist re-traumatisation (SAMHSA, 2018) to the 4 Cs (calm, contain, care and cope) of trauma-informed care (Kimberg and Wheeler, 2019);

Fallot and Harris (2006) developed the first five principles of trauma-informed care: safety, trustworthiness, choice, collaboration and empowerment, which can be operationalised for use in a variety of settings. The Fallot and Harris principles were built upon by SAMHSA to also include peer support and cultural, historical, and gender issues. The Mental Health Co-ordination Council posits eight principles of trauma-informed practice including; understanding trauma and its impact, promoting safety, supporting consumer control, choice and autonomy, ensuring cultural competence, safe and healing relationships, sharing power and governance, recovery is possible and integrating care (MHCC, 2018 p 8).

Secondary Traumatic Stress (STS) was a term first coined by Figley (1983) which he later referred to as Compassion Fatigue (1995), to describe the negative emotional impact experienced by practitioners working with trauma survivors and those close to the traumatised person (hearing about or reading about the traumatic experiences of the survivor). Symptoms of STS are akin to post traumatic stress disorder (PTSD) (such as intrusive thoughts or avoidance).

Vicarious Traumatization (McCann & Pearlman, 1990) describes how exposure to the trauma of others can disrupt and permanently alter practitioners' views of the world and of other people. VT impacts areas of cognition: thoughts and beliefs about the world, the self, and others in the context of trust, safety, self-worth and human capacity for both benevolence and malevolence.

This study will refer to trauma-informed approaches but use the term trauma-informed care when citing other research using this term. The study will use the term trauma-informed practice when referring to implemented at the level of individual practitioners and cite other research using this term. Trauma-specific modalities or support will be discussed in relation to other studies using this terminology. Secondary traumatic stress and vicarious traumatization will also be discussed in accordance with the definitions provided within the literature.

CHAPTER 1: INTRODUCTION

The concept of trauma, especially in the context of violence against women, has many different interpretations (Baird, 2018). While domestic abuse is widely recognised as a potentially traumatic experience, there is no single agreed-upon way to define the trauma it causes. Some experts believe domestic abuse itself constitutes a unique type of trauma (Briere & Scott, 2013), while others categorize the resulting trauma as personal (Evans & Cocomma, 2014) or interpersonal (Kelly, 2015). Much of the research on trauma and domestic abuse has centred around diagnosing PTSD (DeJonghe et al., 2008), often using criteria like those in the DSM (American Psychiatric Association, 2013). However, some argue that focusing solely on PTSD diagnoses overlooks the broader societal factors that contribute to trauma (Burstow, 2003; Tseris, 2013). They emphasize the importance of understanding individual experiences within a larger social and environmental context (Heisse, 1998; Bonnan-White, Hetzel-Riggin, Diamond-Welch, & Tollini, 2015). Ultimately, the varying definitions highlight the need for a deeper, more nuanced understanding of how domestic abuse survivors experience trauma.

There has been considerable focus on encouraging the domestic abuse sector to become more trauma-informed in the ways it meets and responds to the needs of survivors. In its essence, the trauma-informed approach that asks us to consider ‘what happened?’ to someone, instead of ‘what is wrong?’ with someone, should indeed lend itself to domestic abuse service provision in the way it links impact with event. Numerous academic commentaries promote practice guidance and toolkits aimed at enabling practitioners to adopt a trauma-informed approach to domestic abuse service provision as a means of better protecting service users and practitioners (Elliot et al., 2005; Wilson et al., 2015; Hopper et al., 2010; Kulkarni et al., 2019; Purtle, 2020). A literature review by McCarthy et al., (2020) concluded that when women’s traumatic responses and behaviours are explained and normalised by practitioners (so that survivors are understood as having normal reactions to abnormal behaviour enacted upon them) evidence suggests that this makes a significant difference to their recovery by increasing feelings of safety, which is particularly important for people with experience of trauma (Community Connections, 2003; Sullivan et al., 2018).

Definitions of trauma and trauma-informed working remain inconsistent, ‘fuzzy and complex’ (Sweeny & Taggart, 2018, p383) and very few empirical studies have evaluated the implementation of a trauma-informed approach at the organisational

level (i.e. focussing on strengths and barriers to implementing trauma-informed approaches across an organisation). As Goodman et al (2016) point out: 'The extent to which programs have successfully translated TI principles into everyday practice remains unclear. Advocates, researchers, and policymakers are eager to learn whether programs have made this translation successfully,' Goodman et al, 2016, p759). Service providers and commissioners are calling for more concrete examples of what 'trauma-informed care' actually means for service delivery and for evidence on the most effective strategies to implement this approach at the organisational level (Bunting et al, 2019; Wilton et al, 2019).

This introductory chapter explains how my interest in trauma-informed approaches to domestic abuse service provision developed, describes the context for the research and highlights the gap in the existing literature in respect of trauma-informed approaches to domestic abuse service provision: the chapter specifies the key research questions and methodological approach and concludes with an outline of the thesis.

Background to PhD Study

Women's Aid Federation England (WAFE) and SafeLives (SL) collaborated over five years (2016-21) to develop and implement the Roadmap Programme which aimed to promote early intervention and reduce the prevalence, impact and tolerance of domestic violence and abuse. Funded by the Big Lottery's Women and Girls Initiative, WAFE and SL collaborated with domestic abuse survivors and expert partners to develop and implement two contrasting interventions in five different sites in England. The University of Central Lancashire (UCLan) evaluated the programme and together, UCLan and the Roadmap commissioners provided support for additional in-depth PhD study of a particular intervention or aspect of the programme. The topic of this PhD was agreed in collaboration with the student and with WAFE and SL.

While this doctoral research is distinct from the Roadmap study (Stanley et al. 2021) and does not feed into the findings of the Roadmap evaluation, it draws on and is informed by this larger study.

Women's Aid's methodology—Change that Lasts—originates from a needs-oriented framework, positioning the survivor at the core and constructing responses that revolve around her specific needs and the available strengths and resources, thereby recognizing that when services are attuned to the expressed needs of women and leverage their strengths, outcomes tend to be more favourable and enduring. The Roadmap evaluation (Stanley et al. 2021) revealed that the interventions outlined in the Change that Lasts programme led to several significant accomplishments at the individual, community, and systemic levels.

Background to the Research

There are competing and evolving discourses around domestic abuse and how trauma theory can be best understood and utilised in order to intervene in the lives of those affected. Mental health clinicians and researchers call for domestic abuse to be conceptualised within the 'complex post-traumatic stress disorder' model (C-PTSD) (Kozłowska, 2020, WHO, 2018; ICD-11) and advocate for an increase in the provision of trauma specific treatments to address the symptoms of trauma such as Eye Movement Desensitization and Reprocessing (Shapiro, 1989) or Trauma Focussed Cognitive Behavioural Therapy (Cohen et al., 2000).

Meanwhile, feminist researchers such as Judith Herman (1992), argue that it is essential to move beyond the focus on biological and psychological 'symptoms' of trauma located within the individual to an understanding of broader and structural contexts that allow for certain groups to be disproportionately exposed to traumatic experiences. More specifically, feminist researchers argue for women's 'symptoms' of mental illness to be understood in relation to the disproportionate experiences of violence they endure (Humphreys & Thiara, 2003; Tseris, 2013). Kennedy et al (2024) offer a framework for assessing the 'trustworthiness' of domestic violence and abuse (DVA) support services, alluding to the fact that these very services can indeed become part of a (re)traumatising system.

These differing perspectives, one placing emphasis on the 'traumatised individual' and the other focussing on the 'traumatising systems around the individual', influence the direction of energy and the focus of intervention, specifically the way in which trauma is identified and worked with. In this sense, the definition of trauma can be seen as having a political stake. Chatterjee & Park (2024) encapsulate this sentiment when they ask, 'To what types of experiences could trauma be validly yoked and who could legitimately claim trauma?' (2024, p 3).

Key Questions and Methodological Approach

This research addresses the gap identified above by obtaining unique insight into the extent to which domestic abuse service provision can or should harness a trauma-informed approach to service design and delivery. This study focuses on the views of domestic abuse practitioners and the domestic abuse survivors they work with by generating data on their subjective experiences of trauma-informed domestic abuse service provision.

Although a significant number of studies report the efficacy of specific trauma focused modalities with survivors of domestic abuse (Kubany et al., 2004; Koopman et al, 2005; Franzblau et al, 2008; Stover et al, 2009; Iverson et al., 2011; Trabold et al., 2018; Kelly & Garland, 2018), very few studies examine the implementation of a trauma-informed overall approach to domestic abuse service delivery. Qualitative research exploring the experiences of domestic abuse practitioners and survivors accessing domestic abuse services adopting a trauma-informed approach is currently limited. Consequently, this research aims to contribute to the existing body of knowledge by considering the following research questions:

1. How do domestic abuse practitioners and survivors understand the links between trauma and domestic abuse?
2. How is a Trauma-informed Approach (TIA) being harnessed and utilised in the context of two specific domestic abuse service provisions?
3. How do domestic abuse survivors understand and experience a TIA in relation to domestic abuse?
4. What are the key barriers and facilitating factors to implementing a TIA within DVA service provision?

The choice of methods for this study reflects both the aims of the research and the theoretical stance of the research. This study focuses on how the concept of trauma is understood, experienced and addressed within the context of a domestic abuse service by practitioners and by service users. It will harness feminist theories of gender and violence to study this type of trauma, and this demands a social constructionist lens which acknowledges the socially constructed nature of gender and violence.

A key tenet of feminist research is reflexivity, which entails the researcher recognizing and examining how their own 'social backgrounds and assumptions can intervene in the research process' (Hesse-Biber & Leavy, 2010, p 120). From this perspective,

social reality is subjectively interpreted through an exploration of people's own understandings (Holliday, 2007).

An additional theory underpinning this research is ecological theory (Bronfenbrenner, 1979; Dutton, 2006; Bliss et al, 2006) which dictates that any given phenomena is experienced on multiple levels including the intrapsychic, physiological, interpersonal, and societal. Therefore, using this ecological lens to examine trauma offers a multi-dimensional model of trauma that can accommodate and acknowledge the value of knowledge produced through both qualitative and quantitative methods. This ecological approach will be discussed in detail in the chapters reporting the research findings. The methodology and its rationale are described in full in the Methodology Chapter.

Thesis Outline

This thesis includes three chapters of literature review. The first chapter of the literature review focuses on the evolution and conceptualisation of traumatic stress as well as the impact of trauma on the individual. The second chapter focuses on domestic abuse, including the UK legislative framework, theoretical conceptualisations of domestic abuse and the evolution of professional discourse and responses to domestic abuse. The final chapter of the literature review explores trauma-informed support for women, starting with an overview of trauma-informed organisational structures and the conceptualisation of trauma-informed approaches to service provision before focussing specifically on trauma-informed service provision for survivors of domestic abuse. The aim of the chapters is to summarise current knowledge and identify strengths and weaknesses in previous research to develop my own research approach. There are a limited number of studies exploring the implementation of trauma-informed approaches to service provision from within the UK, so research from beyond the UK is introduced and discussed where relevant.

Chapter five is the methodology chapter which explores the process of undertaking the research. It begins with a detailed explanation of the research questions, before describing the epistemological basis of the research, specifically feminist research epistemology. The researcher's own positionality is then discussed, which includes a reflexive discussion of systemic ideas informing the researchers own approach. The

chapter goes on to outline the adapted case approach to research design, the election of participating organisations and the ethical framework. The chapter concludes with a discussion of how the data was analysed and coded using an approach based on reflexive thematic analysis and organised within an ecological systems framework.

Chapters six and seven present the key findings from interviews with domestic abuse practitioners and survivors, under themes which are listed in tables at the beginning of each of these chapters.

Chapter eight is the discussion chapter, in which findings are analysed, contextualised and organised within the ecological systems framework. Analysis of findings from practitioner and survivor interviews are interwoven within this section so that differences and consistencies between the two groups of participants can be identified.

Chapter nine is the conclusion, which starts with revisiting the research objectives and summarising the key findings from the research. The chapter then discusses the originality and potential impacts of the findings and what these findings add to the existing theoretical and research evidence. The implications for future practice are outlined which include recommendations for stakeholders, before the final concluding comment.

CHAPTER 2: LITERATURE ON TRAUMA

Introduction

This chapter focuses on the concept of trauma with an exploration of its contested and evolving nature. Historically, the understanding of trauma has shifted from early notions of hysteria to the recognition of physical wounds and further evolved from being perceived as a character flaw to an acknowledgment of trauma as a reasonable response to adversity. This evolution reflects a growing awareness of the psychological dimensions of trauma, culminating in its medicalization, where distress is often framed within a clinical context.

The chapter also examines the intersection between trauma, abuse, and adversity. It highlights how these factors are interrelated, complicating the understanding of trauma and its effects on individuals. In contemporary discourse, definitions of trauma have expanded to incorporate a broader range of experiences, recognizing that trauma can manifest in various forms and contexts.

A critical analysis of the biomedical model of trauma is presented, scrutinizing its limitations and the potential oversimplification of trauma-related experiences. While the biomedical approach has contributed to understanding trauma through a medical lens, it often overlooks the social, cultural, and psychological factors that play a significant role in the experience and recovery of trauma survivors.

Furthermore, the chapter outlines the profound impacts of trauma on individuals including emotional dysregulation, cognitive impairment anxiety and depression among trauma survivors, as well as feelings of shame that often accompany traumatic experiences.

The chapter concludes with an exploration of Post-Traumatic Stress Disorder (PTSD), particularly in relation to those who have experienced domestic abuse.

Literature Search Strategy

This research began with a review of the literature surrounding trauma, trauma-informed approaches to service delivery and domestic abuse. The search strategy

utilised alternative terms for trauma such as 'psychological trauma', 'post-traumatic stress disorder' and 'traumatic stress'. The literature search around trauma-informed service delivery included terms such as 'trauma-informed approaches', 'trauma-informed care', 'trauma-informed service', 'trauma-informed principles' and 'trauma-informed practice'. The search for literature in relation to domestic abuse included terms such as 'intimate partner violence', 'domestic violence and abuse', 'battery' and 'spousal abuse'. It was not feasible to complete a systematic review due to time and resource constraints.

All relevant UK literature and international publications in English language were included regardless of date. Additional sources were identified from references found in these papers. Evaluation research was also reviewed in addition to peer reviewed academic sources. Online databases included: Google Scholar, Scopus, JSTOR, EBSCOhost EJS, Science direct and Academic Search Complete. Relevant journals included the Journal of Gender-based Violence, British Journal of Social Work, The Journal of Interpersonal Violence and The Journal of Traumatic Stress.

Authors such as Herman (1992), Elliot et al., (2005) and Wilson et al., (2015) were of particular importance in relation to defining and exploring trauma-informed approaches and principles when working with women who have experience domestic abuse. Useful systematic reviews of trauma-informed service delivery implementation included McCarthy et al., (2020) Berring et al., 2024 and Champine et al., (2019)

It was important to source all available and relevant research on trauma and trauma informed approaches to service delivery from a UK context as well as any qualitative research drawing on the experiences of service providers and survivors of domestic abuse. The majority of identified research focusing on the implementation of trauma-informed approaches in service delivery was from the USA as was much of the seminal literature on the development of trauma principles and large-scale studies focussing on the various biological, psychological and social impacts of trauma.

Trauma Is a Contested Term

Although there is growing agreement on the significance of trauma in the lives of survivors and how it is experienced by those working in the helping professions, trauma remains a "contested term" (Tseris, 2013, p. 160). Researchers distinguish between different types of traumas, such as post-traumatic stress disorder (PTSD), complex trauma (Price et al, 2017), and toxic stress (Franke, 2014). They also differentiate between trauma resulting from adverse childhood experiences (ACEs) (Hughes et al., 2017), trauma occurring in adulthood (Sachs-Ericsson et al., 2009; Krause et al., 2004), and historical trauma arising from the legacies of genocide, colonization, and current systemic violence experienced by minoritised racial, ethnic, and other identity groups (Mohatt et al., 2014). Collective complex traumas (e.g., historical trauma, intergenerational trauma) aim to counter pathologization by emphasizing long-term systemic oppression for marginalised groups with shared identities (Evans-Campbell, 2008, cited in Newton, 2019, p. 223).

There are active debates between medicalised and socio-political views of trauma and the corresponding interventions (Burstow, 2003; Tseris, 2013; Herman, 1992). There is also a wealth of literature on secondary traumatic stress (Figley et al., 1983; Figley, 1995) and vicarious trauma (McCann & Pearlman, 1990) in relation to the helping professions, although there is still some confusion or deviation from the original definitions with secondary traumatic stress (STS) and vicarious trauma (VT) often being used interchangeably.

Chatterjee and Park (2024) conclude that trauma remains an 'unmoored concept' (2024, p 5). Burstow (2003) explains that 'trauma' is not a singular concept; but a multi-faceted, politicised and contested term. It has undergone its own evolution, with each iteration being imbued with the aims or interests of those providing the description, and all claiming to expand or progress the understanding of this phenomenon. The question of what qualifies as a traumatic event has been a persistent point of contention in trauma research. Weathers & Keane (2007) note that disagreement is inevitable because "there is a continuum of stressor severity and there are no boundaries demarcating ordinary stressors from traumatic stressors" (207, p 108).

The notion of 'concept creep' (Haslam, 2016; Haslam & McGrath, 2020) is useful in charting the evolution of trauma, from its etymological origins to how it is understood and utilised today. Haslam (2016) coins the term 'concept creep' to describe the vertical (capturing new phenomena) and horizontal (capturing less extreme phenomena) semantic expansion of harm-related terms such as trauma, postulating that 'Trauma need no longer refer only to a discrete attack on the body's physical integrity but can also refer to an enduring state of affairs that upsets us' (2020, p 509).

The Evolution of Trauma

Hysteria to Wound

The evolving understanding of trauma responses began with a crucial shift from viewing "hysterical" symptoms as physiological to understanding them as psychological in origin. Haslam & McGrath (2020) point out that the etymological route of the word trauma can be traced back to in Latin medical terminology, deriving from the Greek word for "wound".

Trauma theory originates at the interface between neurology and psychiatry with the French neurologist Jean-Martin Charcot's (1825-1893) study of traumatic hysteria which 'foreshadowed the more modern concept of post-traumatic stress disorder' (White, 1997, p254). German pathologist Von Rindfleisch, writing in 1884, described trauma as 'any external attack which forcibly alters the physical or chemical composition of a part or the whole of the body' (1884, p187). While Charcot took his inspiration from other work exploring organic etiological explanations of hysteria (such as the Egyptian idea of the wandering uterus), his understanding evolved to conceptualising traumatic hysteria as a disease of the nervous system brought about at least in part by environmental factors (Micale, 1995).

Charcot's students, Sigmund Freud and Pierre Janet, furthered these ideas on hysteria and dissociation to conclude that upsetting events could indeed produce 'pathological reactions' not through physical damage to the body but by 'injuring the psyche in some way' (Haslam & McGrath, 2020b, p 518). Chatterjee and Park (2024) point out that the early understandings of trauma were also deeply rooted in the 'context of industrialisation... embedded in anxieties about the need to manage a new type of industrial labour force emerging in the era' (2024, p 3). This emerged in relation to industrial accidents such as 'railway spine', shown to have 'lasting effects on the nervous system' (Fassin and Rechtman, 2009, p. 30), persisting long after the 'visible and enduring physical injury' had healed (Luckhurst, 2013; Gasquoin, 2020), and was understood by Charcot as a neurological disorder (Goetz, 2016, p. 12).

Charcot, Freud and Janet were instrumental in their contributions to the contemporary definitions of trauma as not only resulting from an event that has threatened our 'body integrity' (Pearlman & Saakvitne, 1995; 60), but as a potential consequence of psychological harm, resulting in affective responses (Haslam & McGrath, 2020b, p 518) that could endure across time (Freud, 1920 cited in Chatterjee & Park, 2024 p 4).

Haslam et al (2020) found that 'trauma as a general concept rose most steeply in frequency during the 1980s but that specifically psychological trauma increased most sharply in the 1990s, and an ensemble of shared forms of trauma (i.e., "collective", "cultural" and "intergenerational" trauma) accelerated upwards in the 2000s' (2020a p 259).

Non-Western Conceptualisations of Trauma

In Caruth's seminal works, *Trauma: Explorations in Memory* (1995) and *Unclaimed Experience: Trauma, Narrative and History* (1996), the phenomenon of cultural trauma is conceptualised through the prevailing Western diagnostic framework, which characterizes trauma as an individual and event-centric occurrence. This framework has undergone a significant reorientation and expansion to encompass a considerably broader array of agents in trauma, prompted by the contributions from non-Western literary studies. This has entailed a departure from Freudian psychoanalytic frameworks and deconstructive methodologies. Balaev (2014) asserts that non-Western literatures have exerted a significant influence, particularly in facilitating 'a view of trauma as multi figured with diverse representations in literature and far-

reaching effects in culture' (pages 2, 10).

Trauma theory has indeed been significantly shaped by the intellectual contributions of non-Western scholars, including Franz Fanon, Alfred Memmi, and Achille Mbembe, whose impact is essential to consider in any comprehensive examination of the evolution of trauma theory within its non-Western framework (Visser, 2018). Franz Fanon is indisputably the pre-eminent figure among theorists originating from non-Western contexts. He asserted what has now become established knowledge in trauma theory: that for trauma theory to achieve genuine effectiveness and productivity, it must consider both material and ideological conditions while integrating a multitude of influences, including political, social, economic, ideological, and historical factors (Visser, 2018). Perhaps the most contentious aspect of trauma theory is his assertion regarding the liberating potential of violence. Within his resistance framework, violence transcends its designation as a criminal act, evolving into a mechanism of emancipation. This radical political perspective must be contextualised within Fanon's personal narrative of active participation in armed struggle and Fannon's writings cannot be extended to include all forms of colonialism (Zahar, 1974; Nikro, 2014; Visser, 2018).

Fannon's contemporary, Alfred Memmi stated that colonial oppression and exploitation adversely affect both coloniser and colonised, positing that both are alienated and dehumanised through the acts of oppression and degradation. These thoughts resonate with present conceptualisations of trauma as affecting both perpetrators and victims (Visser, 2018).

Other prominent non-western influences on the way in which we conceptualise trauma have come from Native American scholarship which has long questioned the usefulness and applicability of Freudian post structuralist psychoanalysis as a means of framing the experiences and histories of Native American people (Allen, 1992; Vizenor & Lee, 1999). Vizenor (2008) emphasises the importance of acknowledging through language the way in which people have survived, seeing language and storytelling tools of resilience and resistance. Vizenor rejects the notion of victimhood and its centrality to western conceptualisation of trauma. Instead, Vizenor coins the term 'survance' and describes it as 'an active sense of presence over absence, deracination, and oblivion; survance is the continuance of stories ...' (2008 p 1).

Kabir (2014) argues that a challenge to academics interested in the 'future of trauma

theory' is to find ways of conceptualising the traumas of the non-Western world that 'acknowledge the myriad modes of consolation, memorializing and reconciliation which are deployed by traumatised subjects who may never have heard of Sigmund Freud, psychoanalysis and, indeed, trauma theory' (2014 p 64).

Kabir's challenge to academics also poses an interesting conundrum for front line practitioners who have been influenced by the prevailing western diagnostic framework but who are working with survivors who may not be familiar with this western framework or with the language of trauma.

Trauma; A Reasonable Response to Unreasonable Stressors

The Centre for Substance Abuse Treatment, (SAMHSA, 2014) provides a comprehensive Chronological account of the history of trauma, highlighting the shift from focussing primarily and exclusively on single incident or Type I trauma - those traumatised by war or natural disaster - towards a focus on interpersonal trauma such as rape and domestic abuse (Olff et al, 2007). The authors note that the greatest recent resurgence of interest in this topic came as a result of war and conflict (Courtois, 2004), giving rise to the diagnosis of 'shell shock' or homesickness experienced by veterans which was originally framed as a 'character flaw' (SAMHSA, 2014) or weaknesses on the part of the individual (Bonanno & Mancini, 2012).

Kardiner's (1941) observations of soldiers advanced the understanding of the impact of combat trauma on veterans, who were observed reenacting their traumatic experiences and trying to resolve them using ineffective methods repeatedly. Classifying soldiers' reactions as 'illnesses,' challenged the prevailing notion that pronounced trauma responses were indicative of personal weakness or that the atrocities of war were inherently tolerable (Gersons & Carlier, 1992).

Instead, traumatic stress symptoms could now be framed as a 'normal' reaction to extreme adversity. The experiences of soldiers in combat played a crucial role in enhancing the knowledge of trauma symptoms and their treatment (Gersons & Carlier, 1992; Linden, Hess & Jones, 2012). The advent of "Psychological First Aid" during World War I marked a significant milestone, as it acknowledged the benefits of psychological interventions for those who had faced repeated trauma exposure.

It is important to note that much of the contemporary psychiatric understanding of trauma does place emphasis on the impact of threats to bodily integrity as well as psychological integrity, and neurobiology has been particularly influential in the understanding of how changes to central nervous system as well as the autonomic nervous system (and the interaction between the two) are manifested as symptomology.

Medicalised Distress

The dominance of the medical model and psychological understandings of trauma cannot be overstated. The medical model focuses on identifying symptoms and corresponding diagnoses, which understands trauma responses as 'resulting from differences in brain structures, genetics, chemical or hormonal balances' (Clarke, 2021, p17). The underlying assumption of such paradigms follows the logic that while trauma symptoms (as responses to traumatic events/situations) may be adaptive in the immediate or short term, the persistence of such symptoms should be viewed as maladaptive and eligible for clinical treatment such as medication or corrective intervention.

Post Traumatic Stress Disorder (PTSD) is now legitimised through its classification as a mental health disorder, classified in both the highly influential Diagnostic and Statistical Manual, fifth edition (DSM-5) produced and revised by the American Psychiatric Association (APA), and the International Classification of Diseases- 11th revision (ICD- 11), produced and revised by the World Health Organisation (WHO). The criterion for diagnosis of PTSD in these two different major classifications are similar but differ slightly, for example there are fewer diagnostic ICD-11 criteria for PTSD compared with the DSM-5 criteria for PTSD.

The next section will discuss the evolution of post-traumatic stress in relation to medical classification.

The American Psychological Association (2019) defines trauma as an emotional response to a serious event, such as assault, accidents, or natural disasters. The British Psychological Society (2019) further highlights the distressing nature of these events, emphasizing the individual's struggle to cope with the psychological stressors they generate. Both the APA and BPS acknowledge symptoms like emotional dysregulation, intrusive thoughts, and physical symptoms as natural, immediate responses to such events. However, in cases of prolonged exposure to threat or hostility, such as domestic abuse or war, the term "complex trauma" is used to describe the more intricate and enduring psychological impact.

When these mental and physical symptoms persist and significantly impair an individual's daily functioning, a diagnosis of PTSD may be warranted. In addition to the subjective interpretation of the adverse or stressful event, the frequency and nature of the stressor must also be specified when discussing trauma and its effect on the individual. Defining trauma and its potential long-term consequences, such as Post-Traumatic Stress Disorder, requires a nuanced understanding of both the subjective experience and the clinical presentation.

Trauma and the Diagnostic Statistical Manual

The birth of trauma theory helped to provide a framework and a language for psychological distress experienced by soldiers and was included in the Diagnostic and Statistical Manual of Mental Disorders, published in 1980 (Courtois, 2004). The earliest medicalised conceptualisation of trauma and its impact on the brain can be found in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I; American Psychiatric Association [APA], 1952), which outlines a classification of 'chronic brain disorders associated with trauma', including disorders caused by 'brain trauma, gross force' and 'electrical brain trauma'. Consequently, the view of trauma at this time was as a 'physical agent causing organic brain pathology' (Haslam 2016, p7). While this understanding is still present within contemporary discourse and classification (i.e. traumatic brain injury), later iterations of the DSM have continued to expand the definition of trauma.

The recognition of 'post-traumatic stress disorder' came with the DSM-III (APA, 1980), which is described by Haslam (2016) as a conceptual 'turning point, recognizing trauma as a mental disorder for the first time' (2016, p7). This formal recognition

underscored the need for ongoing support for those grappling with significant psychological distress, furthering the destigmatization of trauma and shifting the focus from judging character strength to addressing a legitimate medical need. A key distinction between the DSM-I and the DSM-III is the shift and broadening in the understanding of possible causality and manifestation of trauma symptoms, no longer just seen as arising from 'organic injury to the brain...[but] from psychological injury (such as a distressing experience) to the mind' (Haslam 2016, page 7). This paradigm shift encompassed the recognition that individuals often cope with trauma through dissociation, and that the individual's subjective perception of the traumatic event, rather than the event itself, shapes their symptomatic response (Barlow et al., 2017).

This conceptual split between trauma as an event and trauma as the result of harm is still something that causes confusion and significant debate amongst contemporary scholars. While some argue that certain events can be characterised as traumatic, regardless of the effects on those who experience them (Voith et al, 2020;), others insist that the trauma lies in the subjective experiences of those affected, specifically in their emotional and psychological responses (Vila and Pomeroy, 2020; Van Der Kolk, Allen, 2008; Williams, 2006). As Haslam (2016) states, 'trauma can now refer not only to an event that causes a wound (physical or psychic) but also to the psychological symptoms that result' (2016, p7). Haslam's assertion is evidenced in the broadening range of events recognised as potential PTSD triggers within the most recent iterations of the DSM-IV and V.

For example, Criterion A has changed significantly since DSM-III, which initially stipulated that PTSD diagnosis was only warranted where an individual has been exposed to a life-threatening event 'so intense that it was outside the range of normal human experience' (Roberts et al., 2012, p 2). In the next iteration of the DSM (DSM-IV), Criterion A was split into two parts, A1 which referred to the event and an added category, A2, which referred to the impact of the event. Criterion A1, the event itself, now included witnessing or being confronted with events that threatened serious injury and Criterion A2 required events to elicit horror, intense fear, or helplessness (Roberts et al., 2012, p 2).

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5)¹. PTSD is included in a new category in *DSM-5*, Trauma- and Stressor-Related Disorders. It includes Criterion A stressors (exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence) as well as Criterion B, C, D and E (symptoms), F (timeframe) G, functional impairment and H (exclusions) (American Psychiatric Association, 2013).

The DSM-V, while retaining the requirement of exposure to a traumatic event, no longer mandates the presence of intense emotions during the event as a diagnostic criterion, recognizing the subjectivity and unreliability of such self-report. Instead, the DSM-V outlines four symptom clusters: re-experiencing, avoidance, negative cognitions and mood, and hyperarousal. It's crucial to note that these PTSD symptoms can be understood as amplified versions of the natural psychological responses most individuals experience following significant life events. According to the Diagnostic and Statistical Manual of Mental Disorders (5th edition; DSM-5, American Psychiatric Association, 2013), a person must have been exposed to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

Directly experiencing the traumatic event:

- Witnessing in person the event(s) as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or close friend (actual or threatened death of a friend or family member, violent or accidental)
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics).

In addition, the person must report the following experiences related to the traumatic events:

‘One or more of the following intrusion symptoms which relates to re-experiencing of the traumatic event (e.g., flashbacks, unwanted upsetting memories, nightmares); one symptom relating to the avoidance of trauma-related stimuli after the trauma; two symptoms relating to negative thoughts or

feelings that began or worsened after the trauma (e.g., exaggerated blame of self or others for causing the trauma, negative affect, feeling isolated); and two symptoms linked to trauma-related arousal (e.g. irritability, hyper-vigilance, difficulty sleeping). All these symptoms should have lasted more than one month and create distress or functional impairment (social, occupational). Finally, these symptoms cannot be due to medication, substance use or other illnesses.’ (DSM-5 PTSD criterion summarised by Bailey, 2019, p 16).

The next section focuses on the classifications that are not included within the DSM but have wide cultural and professional significance and application in work with those accessing support services.

Classifications Excluded from DSM

Complex and Developmental Trauma

The addition of psychological trauma and PTSD to the DSM-III represented a significant milestone, officially acknowledging these conditions as mental disorders. Herman (1992) further emphasised the importance of recognizing the effects of chronic trauma exposure, introducing the term "Complex PTSD" to address the specific needs of individuals such as abuse survivors, combat veterans, and emergency responders. SAMHSA (2014) attribute this shift to a widening of the definition of what constitutes a traumatic event, and the rise of the women’s movement which called for more attention to diverse and disenfranchised groups (Figley, 2002).

There has been some contention surrounding the classification of ‘complex post-traumatic stress disorder’ (C-PTSD) as well as ‘developmental trauma disorder’ (DTD) which is often used to define the impact of early complex traumatic stressors ensured by children.

C-PTSD was originally conceptualised as the ‘sequelae of complex trauma’ (Resick, et al, 2012, p 242), or trauma that is prolonged, repetitive and interpersonal in nature, and sometimes of early life onset (Herman, 1992) such as childhood sexual abuse or childhood neglect. The diagnosis was not added to the DSM-4 or DSM-5 (see more in medical definition section below) but there have been other diagnoses proposed to capture cluster of symptoms that Herman identified as C-PTSD, such as the ICD-10 diagnosis of personality change following catastrophic experience.

Post-traumatic stress disorder (PTSD) in the 11th edition of the International Classification of Diseases (ICD-11) is divided into related but distinct disorders: Post traumatic stress disorder and complex- post traumatic stress disorder (C-PTSD), which is not listed in the DSM-5.

The diagnosis of complex PTSD which was added to the ICD-11 (11th ed.; [ICD-11], WHO, 2019) is made when the criteria for PTSD (re-experiencing, avoidance, hyper arousal and reactivity) are met plus three further set of symptoms which are called 'disturbances in self-organisation' or 'DSO'. Disturbances in self-organisation are identified as:

- Difficulty regulating emotions (affective dysregulation) which could manifest as heightened emotional reactivity, dissociative experiences, or emotional numbing.
- Negative self-concept including feeling of guilt, shame and loneliness
- Disturbances in relationship, such as difficulties building and maintaining relationships or feeling close to others.

An essential criterion for an ICD-11 C-PTSD diagnosis is the “exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible” (WHO, 2019). Whilst there is no formal diagnosis of C-PTSD (not yet listed in the DSM), Bailey (2019) points out that the symptom clusters are sometimes referred to as Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Resick et al (2012) highlight that the proposal to add complex PTSD to the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV; American Psychiatric Association, 1994) prompted a field trial, the findings of which indicated that almost all who met criteria for DESNOS met criteria for PTSD (Roth et al 1997) and the committee concluded that DESNOS would not be listed as an independent diagnosis, but as associated features of PTSD in the DSM-IV. Subsequently, other diagnoses have been proposed to capture the phenomena that Herman (1992) called C-PTSD, including personality change after a catastrophic event (ICD-10; World Health Organization [WHO], 1992), developmental trauma disorder (Van der Kolk, 2005), and posttraumatic personality disorder (Classen, Pain, Field & Woods, 2006). Resick et al (2012) points out that although DESNOS and C-PTSD are often used interchangeably, they are not entirely

synonymous: 'DESNOS represents symptoms not included in the criteria for PTSD (i.e., some of the associated features described in the DSM-IV), while definitions of C-PTSD generally include PTSD symptoms and associated features' (2012, p 243).

Courtois (2004) points out that while the 'prototype trauma' (2004, p 86) that prompted the call for an additional classification trauma (C-PTSD) was child abuse, this classification can also be used to conceptualise the cluster of symptoms experienced by adults who experience 'other types of catastrophic, deleterious, and entrapping traumatisation' including 'all forms of domestic violence' (2004 p. 86). Conversely, others seem to use the term complex trauma to refer more specifically to events that occur in self-development, which occurs during a critical window of development in childhood, when self-definition and self-regulation are being formed' (Resick, et al, 2012, p 242).

In contemporary discourse, the most common term used to describe the 'sequelae of complex trauma' that occurs during childhood is developmental trauma disorder (DTD). Bessel Van Der Kolk and others heavily campaigned for the inclusion of DTD within the DSM-5: their campaign was ultimately unsuccessful in its fight for official classification, but extremely far reaching in popular discourse, and was taken up by many researchers and mental health professionals.

This new conceptualisation of trauma as not just something related to acute stressors such as assault or natural disaster to include developmental stressors could be described as a 'horizontal expansion' of the term trauma, extending the concept to a 'qualitatively new class of phenomena or new context' (Haslam, 2016, p 2). Some may also see this a 'relaxing' or 'lowering of the threshold' of what constitutes traumatic experience, which Haslam would characterise as 'vertical expansion' of a concept (2016, p 2). Cascardi and Brown (2016) offer a tentative critique of Haslam's notion of concept creep, stating that while the term is useful in articulating 'justified concern about sloppy overuse of a concept', it is sometimes used to dismiss 'meaningful concept expansion, which improves and advances the understanding of problematic human behavior' (2016, p 24).

Bessel Van Der Kolk and his colleagues might well argue that including DTD in the DSM is the latter, an important meaningful expansion to capture the chronic detrimental impact of an unsafe home environment on child development. This distinction between acute and chronic developmental stressors is sometimes referred

to as 'Big T' and 'Little T' trauma. The connective tissue between the two for Van Der Kolk and his colleagues lies in attachment theory (as developed by Bowlby 1951 and Ainsworth 1963) and inter-personal neurobiology (as developed by Seigel, 2015 and Shaw et al., 2023). Widening trauma definitions to include acute and developmental stressors (at least in mainstream discourse) seems pertinent to consider when charting the paradigm shift from binary conceptualisations of trauma toward trauma existing on something more like a spectrum (Carr, 2023).

There is some confusion in wider discourse about the precise events that constitute big T or little T trauma, with some arguing that big T trauma is only that trauma which is life threatening, while little T trauma is any adverse event that is 'ego threatening' (Barbash, 2017). Others such as Gabor Mate (2023) claim that adverse childhood experiences are all examples of big T trauma (including household dysfunction such as having a parent with a mental illness, or an incarcerated parent; Felitti et al, 1998, p248). Mate goes on to say that big T constitutes 'the bad things that happened' while little T trauma is the 'good things that didn't happen, [which includes] a child not getting the attention they need or not having their emotional needs met...' (2023, video). However, Van Der Kolk includes abuse, neglect and household dysfunction in his definition as developmental trauma, therefore incorporating both acute and chronic stressors. In this sense, developmental trauma may be better understood as arising from complex, repetitive stressors, what Herman called 'complex trauma' (1992).

A clearer delineation may be found in Terr's (1991) distinction between single incident and complex trauma, stating that single incident traumas are sudden, short term and shocking. The cause of trauma could be either impersonal (caused by a random event or accident) or interpersonal (caused by another person). Meanwhile, complex or repetitive trauma refers to an ongoing form of maltreatment, oppression, violence or longer-term threat (Courtois & Ford, 2012). Herman (1992) similarly distinguishes between type I and type II trauma. Type I refers to single-incident trauma, while Type II refers to a complex or repeated trauma, the syndrome that follows upon prolonged, repeated trauma.

While Herman (1992) prioritised the need for diagnosis of 'complex PTSD' and Van Der Kolk and colleagues continue to campaign for the inclusion of 'developmental trauma' (1995), other authors have used the terms 'attachment-based trauma' (Boris & Zeanah, 1999) and 'relational trauma' (Shore, 2009; Isobel et al, 2017). Interpersonal trauma is often used as an overarching term to describe any traumatic events that

have occurred between people. Interpersonal trauma was defined by Mauritz et al (2013) as involving any of the following adverse experiences; emotional abuse, emotional neglect, physical abuse, physical neglect and/or sexual abuse in childhood and/or adulthood.

Abuse, Adversity and Trauma

Some researchers prefer to use the term 'adversity' to avoid the medical overtones of 'trauma' (Johnstone and Boyle, 2018). Tseris (2013) echoes the view that trauma theory has become 'preoccupied with medically oriented issues concerning diagnosis and standardised treatment' (2013, p 4). Haslam & Mcgrath (2020b) posit that many experiences that may have previously been described as adverse or difficult are now being referred to in common parlance as traumatic. Erikson (1995) pointed out, "trauma" refers to "wounds" and "reactions to wounds," with the distinction between the two becoming 'blurred' and 'messy' (Burstow, 2003). This concept blurring between adverse events and traumatic events may be further evidence by more expansive definitions of trauma offered by various institutions.

When considering the shifting, evolving and malleable nature of concepts both in academic literature and in popular discourse, it is useful to chart the relationship between the introduction and evolution of other related concepts, such as abuse. Hacking (1991) charts the expanding definition of abuse which Haslam (2016) interprets through the lens of 'concept creep', drawing some interesting parallels between the expansions of the concepts of abuse and trauma.

Hacking (1991) writes specifically about how ideas on what constitutes abuse have shifted over time, shaped by social movements such as feminism and human rights activist groups whose work was influenced by and has influenced cultural trends and legal definitions and processes. Haslam (2016) charts three significant changes to the conceptualisation of abuse within the psychological literature, representing both horizontal expansion (extending outward across a range of behaviours) and vertical expansion (less extreme) of what constitutes abuse.

The first change noted by Hacking (1991) was the introduction of emotional abuse as a new subtype of abuse within much of the psychological literature (i.e. Thompson & Kaplan, 1996) and subsequent changes to legislative frameworks. Haslam (2016)

frames this as a horizontal expansion of the notion of abuse, which previously meant intentionally causing physical or sexual harm but now includes 'verbal aggression and other behaviour that is domineering, intimidating, threatening, rejecting, degrading, possessive, inconsistent, or emotionally unresponsive' (Haslam, 2016, p 3).

Haslam (2016) also points out that this form of abuse was more commonly studied in intimate or domestic relationships between adults, which represents another horizontal expansion of the notion of abuse, which had traditionally been studied and stated in reference to adult-child relationships. Finally, Hacking (1991) notes that the concept of abuse was then expanded to incorporate neglect, which had previously been framed distinct (but related) concept in the child maltreatment literature. Haslam (2016) views the extension of abuse to include 'acts of omission' (neglect) to be another example of horizontal expansion of what constitutes abuse. Haslam (2016) also posits that the inclusion of emotional abuse and neglect could be framed as a vertical expansion of the notion of abuse, as both forms of maltreatment are more diffuse and ambiguous; determining what constitutes either may have a larger element of subjectivity than physical or sexual abuse.

Haslam (2016) warns that if the 'determination of emotional abuse depends on the self-identified victim's perception, what might seem harmless to an external observer could be perceived as abusive' (2016 p 3). This subjectivity is evident in certain self-report measures of abuse such as the Child Abuse and Trauma Scale (CATS) (Sanders & Becker-Laussen, 1995) which asks, 'As a child, did you feel unwanted or emotionally neglected?'

Meanwhile, as Haslam, (2016, p. 6) points out there is a growing body of evidence that validates the claim that certain adverse experiences can precipitate the development of PTSD (see Carlson, Smith, & Dalenberg, 2013).

Adverse Experiences Precipitating PTSD

The Adverse Childhood Experiences (ACEs) study (Felitti et al, 1998) highlighted the threat posed to physiological and psychological health in adult life by exposure to early traumatic experiences. Anda et al (2007) concluded that more than six in ten people have experienced at least one Adverse Childhood Experience. The ACES study has been replicated many times and has consistently found strong links between adverse experiences in childhood and negative health and social outcomes in adulthood,

including chronic physical health issues, mental ill health, substance abuse issues, homelessness and violence (Knight, 2019; Banaj & Pellicano, 2020; Dolezal & Gibson, 2022).

The precise causal mechanisms rendering those children experiencing ACEs more likely to experience physical, psychological and social problems in adulthood are very difficult to identify. Many scholars have concluded that the way high levels of adversity impact the body's regulatory and stress response systems is likely to be the most significant variable (Buss et al., 2017; McEwan 1998). Chronic stress during childhood has been strongly correlated with elevated allostatic load (wear and tear on the body) (McEwan 1998), insecure attachment relationships which can lead to emotional regulation issues (Van der Kolk, 2010; Dvir et al, 2014), relational difficulties (Shipman et al., 2000; Bell and Higgins, 2015; Messman-Moore and Coates, 2007) and problems with hyperarousal relating to impulse control and aggression (Sheilds & Cicchetti, 1998; Van der Kolk, Perry and Herman, 1991; Wilson, Calhoun and Bernat, 1999)

Contemporary Institutional Definitions of Trauma

Thirkle et al (2022) point out that a well-informed conceptualisation of trauma should be 'threefold' (2022 p 3) as it must acknowledge the trauma *event*, how the event is *experienced* and the *effects* of the event (Sweeney et al., 2018; Thirkle et al., 2022). Most contemporary institutional (UK-based) definitions of psychological trauma allude to this variable and mysterious connection between event, experience and exposure.

The National Health Service in the United Kingdom describes trauma as an 'overwhelmingly distressing, negative or intense event that overwhelms a person's capacity to cope' (Oxford Health NHS Foundation Trust, n.d.)

The working definition used by the government's Office for Health Improvement and Disparities (OHID) reflects the original internationally recognised definition developed by the United States Substance Abuse and Mental Health Services Administration (SAMHSA). The OHID states that:

'Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the

individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being' (OHID, 2022).

The British Psychological Society seems to largely adhere to this definition in most of its publications. Its recommendations for education and training of psychologists when working with psychological trauma (British Psychological Society, 2016) states that trauma-informed professionals should know about the impact of 'traumatic stress' arising from 'psychological, neurological and physical health sequelae of potentially traumatic events, risk and protective factors for traumatic exposure across the lifespan' (BPS, 2016 p 6).

The Royal College of Psychiatrists (RCPsych, 2021) defines post-traumatic stress disorder (PTSD) as a 'mental health condition that can be caused when someone is exposed to a traumatic event'. It describes a traumatic event as experiencing, witnessing, learning about or having repeated exposure to actual or threats of death, serious injury or sexual violence' (RCPsych, 2021).

The leading mental health charity in England, MIND, defines trauma as 'when we experience very stressful, frightening or distressing events that are difficult to cope with or out of our control. It could be one incident, or an ongoing event that happens over a long period of time' (MIND, 2023). MIND frames trauma as something that 'most of us will experience... in our lives [events] that could be considered traumatic' (MIND, 2023).

Women's Aid conducted a review of mental health and domestic abuse literature (2021) in which they asserted that Women's Aid use a feminist understanding of trauma, which recognises that 'women as a group are disproportionately impacted by violence and abuse, taking into account the socio-political context of sexism, racism and other forms of structural oppression, and emphasises individual women's strengths and resilience' (2021, p 8). This Women's Aid (2021) report refers specifically to the feminist approach described by Tseris (2013);

'Trauma theory, guided by feminist values, challenges the conventions of traditional mental health interventions with women by questioning the assertion that the assessment and diagnosis of clients are the cornerstones of effective work. As such, the focus of counselling is extended beyond the Micro level of the "client in treatment," instead emphasizing the sociopolitical context of

women's lives, especially high levels of trauma experienced by women, such as child abuse and sexual violence, and the impact of these experiences on women's mental health." (2013 p 153).

The definition of trauma offered in this report (2021) adheres to an intersectional feminist lens by acknowledging intersecting forms of discrimination and other adverse experiences faced by women, extending beyond the 'Micro-level of "client in treatment"' as highlighted by Tseris.

Critique of Bio-medical Conceptualisation of Trauma

While many trauma researchers utilize the diagnostic criteria to frame trauma as 'a syndrome of intrusive re-experiencing, avoidance and emotional numbing, and hyperarousal symptoms that occurs in some individuals in the aftermath of a traumatic event' (DeJonghe et al. 2008, p. 294), it is important to highlight that trauma responses and coping mechanisms can be understood outside the medical paradigm. Taylor and Shrive (2023) point out in the first edition of their indicative trauma impact manual (ITIM), that once a person's mental or emotional life has been 'recast as disordered and abnormal' then their responses and reactions will be viewed through the lens of disorder, which is defined as a 'state of confusion' or as an indication of 'lack of normal functioning...' (2023, p 16).

There is an ever-increasing consensus that adverse experiences and toxic or traumatic stress brought about by such experiences can have short term and longer-term impacts on brain and body, particularly specific brain regions associated with cognition, emotion and memory as well as the autonomic nervous system and the endocrine system. Others have been more critical about the idea that trauma is a state of the body that can be mapped or coded in the way that non-psychiatric diseases can. In a recent interview with Bessel Van Der Kolk, neuroscience historian Danielle Carr warns against the dangers of traumatic literalism, the idea that trauma is a literal state of the body that can be made visible through fMRI, PET, brain imagery scans or biomarkers, preferring instead to describe trauma as a historical and political concept (Dandridge, 2023).

Carr echoes some of the criticism directed towards the antipsychiatry movement when

she says that the biological should not be understood as the opposite of the political, but rather than 'a site where politics happens'. Instead, she advocates for a 'dialectical materialist' approach that 'takes biology seriously but understands that the biological body transforms in relation to an environment that far exceeds the medical interventions possible in a clinic' (Dandridge, 2023, no page number).

Another challenge presented by the biological and medicalised paradigm lies in the issue of causality: How can we determine which events lead to which effects in which people? This is exemplified by the 'downstream' vs 'upstream' pathologies debate (Sherin and Numeroff, 2011). It was originally thought that symptoms of post-traumatic stress disorder were actually indicative of a normative response to particularly severe stressors; the severity of response was related to the severity of the stressor intensity (downstream). However, the question persisted around variability: Why do only a minority of people who have endured the same severity, type or duration of stressors develop PTSD? While some researchers turned their focus to biological factors or 'upstream' neurological biomarkers that modulate outcome variation, such as hormones levels (Mu et al, 2022), genetic susceptibility or traumatic brain injury (Sherin and Numeroff, 2011), others posit that the underlying mechanisms of susceptibility or resilience to trauma lie in the complex interplay between biology, environment and mind (Al Jowf et al, 2023; McKeever and Huff, 2003; Yehouda and LeDoux, 2007).

Impact of Trauma

Trauma impact: Conceptual understandings

Many of the foundational definitions of trauma in the literature allude to the ambiguous but profound relationship between external stressors and individualised response:

'Intense fear, helplessness, loss of control and threat of annihilation...'
(*Comprehensive textbook of psychiatry; Andreasen 1985*, cited in Herman 1992, p 33)

'An event ends in a 'trauma if and when the individual is in an emotional state of discomfort resulting from memories of the event' (Gersons and Carlier, 1992, p. 743)

‘The individual’s ability to integrate their own emotional experience is overwhelmed (i.e. it affects the ability to stay present, understand what is happening, integrate the feelings and make sense of the event/experience) or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity.’ (Pearlman & Saakvitne, 1995; 60)

‘Any experience that presents a perceived or actual threat to the physical or psychological integrity of the self, or others, which causes a person to respond with fear, terror or helplessness.’ (Rothschild, 2000; 6)

‘An event, or series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening’ (Substance Abuse and Mental Health Services Administration (SAMHSA) 2014, p7).

Most of these definitions refer to a ‘threat’ which ‘overwhelms’ an individual’s ability to cope. The term ‘overwhelm’ can be understood at a biological level (i.e. hinders the autonomic nervous system’s ability to self-regulate) (Van der Kolk, 2000) as well as at a psychological level (i.e. feelings of fear, confusion and helplessness) or it could be understood at a system level, a social phenomenon so toxic and corrosive that its detrimental effects stem beyond the individual layer to perpetuate structural dysfunction.

LeVine argues that the ‘threat’ or the ‘determination or source of the trauma is based on the individual’s perception of the event’ (2008;11), in other words, trauma is in the ‘eye of the beholder’ (Allen 2008; 21). Allen goes on to specify that the ‘subjective experience of the objective events constitute trauma’ (Allen 2008; 21). LeVine (2008) and Allen (2008) echo the cognitive model of PTSD (Beck, 1964; Ehler & Clark, 2000) in their emphasis on the individual’s perception of the distressing event as a key factor in exacerbating or ameliorating trauma symptoms following the event. Similarly, emotional processing theory (Foa & Kozak, 1986; Foa et al., 1989) focuses on how an individual’s beliefs are shaped before, during, and after experiencing trauma and suggest that those who hold rigid views about themselves and the world, those who interpret their trauma in an excessively negative manner, and those who fear experiencing anxiety are more inclined to use maladaptive coping strategies.

Other psychological causal models of understanding trauma include the psychodynamic model (Freud, Crittenden, 2000), and the dissociation model (Holmes et al., 2005 and Dalenberg et al., 2012 cited in Clarke, 2021, p 13-15). These causal models would best fit within a psychological framework as they all posit that trauma is caused by psychological changes or differences. Two alternative conceptual frameworks that allow practitioners to move away from or to be less reliant on the medicalised paradigm in relation psychological trauma are offered by the power threat meaning framework and trauma-informed approach.

The power threat meaning framework (PMFT) (Johnstone et al., 2018) was introduced as an alternative to diagnosis and re-characterises symptoms as adaptive survival strategies in the face of adversities brought about by 'power structures and threats caused by coercive power operations' (Clarke, 2021, p17).

The Trauma-informed approach falls somewhere between the aforementioned frameworks. While this approach is not considered as an alternative to diagnosis, it does provide a 'framework for identifying and working with trauma that is not reliant on diagnostic manuals' (Clarke, 2021, p17) focussing on event, experience and effect (SAMSHA, 2014). This understanding of trauma incorporates structural forms of oppression and adversity and impacts of trauma across generations and community groups.

While more systemic conceptualisations of trauma such as PMFT and TIA have grown in popularity at a service delivery level, most of the empirical research on the impact of trauma or traumatic stress on various populations adopts a medical lens with an emphasis on biological, neurological and physiological symptoms and diagnostic criteria to identify PTSD symptoms.

The following sections provide a brief overview of some of the neurological and psychological impacts of trauma commonly cited in the literature, with the final section focussing solely on studies that have explored the impacts of trauma on domestic abuse survivors.

Dysregulation of the Fight/Flight Response

Sensory input such as sights, smells or sounds are routed into the brain via the hypothalamus before being sent to the limbic brain which recognizes or identifies threat (Le Doux, 1996). If a threat is present, the hypothalamus triggers the release of stress hormones which enable the body to defend itself through increased blood flow, hyper vigilance and shutting down of the higher or executive functions of the cortex (Howe, 2008). If a person is repeatedly switching into survival mode, their stress response system could become over sensitised or numb (Perry, 2006). Terror or great fear overwhelms executive brain functioning because as Cozolino explains ‘the focus on immediate survival supersedes all long-term goals’ (2002 p 252).

Sherin and Numeroff (2011) highlight the way in which the usually adaptive fight-or-flight response to perceived threat can become dysregulated in the process following exposure to perceived threat. Chronic dysregulation of these systems can lead to functional impairment in certain individuals who become “psychologically traumatised” and suffer from post-traumatic stress disorder (PTSD).

While the stress hormones released by the body in the face of threat may allow people to operate in ‘fight’ or ‘flight’ mode, to protect or escape potential threat, it has also been posited that they can shut down prefrontal cortex functioning (Perry, 2006; 48). This is judged helpful if an individual needs to act quickly, as the full thought process would slow someone down and may increase the risk of harm. The problem occurs when an individual has frequent or overwhelming exposure to stress, their stress response system could become overactive, and the prefrontal cortex is constantly underactive while the brain is in fight or flight mode (Milad et al., 2009; Rougemont-Bücking et al., 2011; Aupperle et al., 2012; Hayes et al., 2012; Garfinkel et al., 2014), sometimes known as amygdala hijack.

The amygdala (centre of survival brain) has been described as a ‘smoke detector’ (Van der Kolk, 2014 p 60) that sounds an alarm in response to threat or danger (Hayes et al., 2012; Patel et al., 2012). In traumatised people, the smoke detector can become over-sensitised or under sensitised. An over sensitised amygdala can hinder a person's ability to make relationships as they struggle to be psychologically present and are constantly distracted (Van der Kolk, 2014). Siegel (2014) and others refer to the neurological ‘dysregulation’ that traumatic experiences can cause, making it

difficult for traumatised people to regulate emotional reactions or behaviours. Certain sights, sounds, smells or situations can trigger reactions or behaviours that may appear to come 'out of nowhere' (Allen, 2005 p 232).

This smoke detector metaphor utilised by Bessel van der Kolk (2014) draws on ideas introduced by the fear network theory (Foa, Steketee and Rothbaum, 1989) and the 'Cognitive-Action Theory' of PTSD (Chemtob et al, 1988). The fear network theory of traumatic memories is highly complex, with a large number of potential stimuli, such as trauma related objects (objects encountered pre- or peri-trauma) which can result in high levels of disruption to everyday life, where the fear responses can be frequently activated. The Cognitive-Action Theory proposes that increased psychological and physiological arousal is adaptive in combat settings, allowing individuals to remain alert to threats and act quickly upon them but this 'survival mode' becomes maladaptive in civilian contexts (Chemtob et al, 1988). While the Cognitive-Action Theory was developed in relation to veterans and armed combat, it is easily applicable to individuals living in ongoing, chronic abusive or frightening circumstances.

The presentation of trauma in an individual can range from hyperarousal and hypervigilance (an over-reliance on the sympathetic nervous system which can causes a person to be anxious, alert and 'always on the look-out' for threat or danger) to hypo-activity or a dissociative response to perceived threat (Hopper et al., 2007; Lanius et al., 2010; Harnett et al, 2020). Perry describes the psychological effect of dissociation as 'dream like consciousness,' which creates a sense of disconnection or 'unreality' (2006 p 182).

It has been argued by some researchers that trauma impacts the development of the Nucleus Accumbens, which is the part of the brain responsible for pleasure, reward and motivation (Sherin and Numeroff, 2011). Traumatic stress may lead to the depression of synaptic excitability in the medial pre-frontal cortex which could cause long-lasting affective changes in vulnerable individuals (Herry & Garcia, 2002, Yehuda, McFarlane, & Shalev, 1998). Failure of medial prefrontal networks to regulate amygdala activity may thus result in hyper-reactivity to threatening stimuli (Bremner, 2007; Grossman, Buchsbaum, & Yehuda, 2002; McNally, 2006; Nutt & Malizia, 2004), or a more general inability to dealing with emotional conflict (Etkin, Egner, Peraza, Kandel, & Hirsch, 2006).

Cognitive impairment

The impacts of trauma on the brain-body systems of various population groups have been well documented. Campbell et al. (2019) describe the way in which trauma affects multiple brain–body systems, causing ‘neuroendocrine and limbic system dysregulation [that] can make it challenging for trauma survivors to process complex information (2019 p 4771). Campbell et al.’s research addressed women's experiences of sexual violence but there is a wealth of literature exploring how these impairments to information processing can negatively impact various populations who have experienced trauma, including impairment of cognitive processes such as decision making (Southwick et al, 2005; Halonen, & Zoladz, 2007; Arnsten, 2009; Baldwin, 2013; Diamond et al, 2015; Cuevas et al., 2018), reasoning (Eliades et al., 2012; Blanchette et al., 2014; Caparos et al., 2018), working memory (Goller et al., 2020; Scott et al., 2015) and attentional focus (Polak et al., 2012; Aupperle et al., 2012).

Neurological connections between the limbic (survival) regions of the brain and the prefrontal lobes (thinking brain), that are essential for learning could be compromised in a person who has suffered adversity which has been stressful or traumatic (Bremner et al., 2007; Tischler et al., 2006; Milad et al., 2009; Carrión et al., 2010; Hayes et al., 2011; Rabinak et al., 2017). Clinical studies have found that trauma can impair decision-making in a range of individuals, including women with PTSD (Sailer et al, 2008), combat veterans (Bloggs et al, 2010) and victims of sexual assault (Bloggs et al, 2014).

Shame

An expanding body of literature examines the significant role of shame in individuals who have experienced trauma (Budden, 2009; Cunningham, 2020; DeYoung, 2015; Goldblatt, 2013; Herman, 2011; Lee et al., 2001; Plante et al., 2022; Saraiya and Lopez-Castro, 2016; Sieff, 2015; Taylor, 2015; Theisen-Womersley, 2021; Wilson et al., 2006). Recent research has highlighted that shame and trauma are intrinsically connected (Theisen-Womersley, 2021, p. 211). Some scholars assert that "post-traumatic shame" is a central aspect of post-trauma states (Theisen-Womersley, 2021), while others describe PTSD as a "shame disorder" (Herman, 2011; Salter and Hall, 2020), indicating that chronic shame exacerbates PTSD symptoms (Cunningham, 2020; Lee et al., 2001). This body of work collectively suggests that

shame is a pervasive effect that shapes the maladaptive behaviours associated with trauma, PTSD, and other post-trauma conditions.

The emergence of shame in post-trauma states is complex, stemming from numerous overlapping factors that make it a dominant emotional experience after trauma. Research indicates that shame can arise from the traumatic event itself (Budden, 2009; Lloyd and Sieff, 2015); from misplaced blame or responsibility for the trauma (e.g., "It was my fault...", "If only I had...") (Bhuptani and Messman, 2021; Kalsched and Sieff, 2015; Wilson et al., 2006); feelings of defilement and unworthiness resulting from neglect or abuse, especially during childhood (Pattison, 2000); rumination about one's behaviour during the trauma (Lee et al., 2001); and a sense of being damaged or defiled due to the trauma or a diagnosis like PTSD (Herman, 2011).

Avoidance behaviours resulting from chronic shame can manifest as 'isolation, detachment, withdrawal, hiding, self-imposed exile, cancellation of appointments, surrender of responsibilities, emotional constriction, psychic numbing, emotional flatness, and non-confrontation with others' (Wilson et al., 2006, p. 138). These behaviours protect individuals from shame by avoiding it or placing it outside conscious awareness (Sanderson, 2015). Consequently, shame manifests externally through other reactions and behaviours that "mask the shame" (Ng, 2020, p. 30). Donald Nathanson's "compass of shame" theory outlines four common patterns of shame-avoidance: withdrawal, avoidance, attacking others, and attacking oneself (Nathanson, 1992, pp. 305–377). These defensive behaviours can damage oneself and social bonds and are consistent with many PTSD symptoms, such as anger, violence, addiction, isolation, feelings of hopelessness, and helplessness, which can progress to depression and suicidal ideation (Taylor, 2015).

The next section will look specifically at some of the literature on post-traumatic stress responses in relation to domestic abuse survivors.

Post-traumatic Stress and Domestic Abuse Survivors

There are numerous and diverse definitions of trauma, especially in relation to understanding women's experiences of violence. Domestic abuse is often viewed as a potentially traumatic event that can lead to additional experiences of trauma. While some theorists categorize domestic abuse as its own distinct type of trauma (Briere &

Scott, 2013), others refer to the trauma stemming from domestic abuse as personal trauma (Evans & Coccoma, 2014) or interpersonal trauma (Kelly, 2015).

Much of the trauma-focused domestic abuse research has concentrated specifically on PTSD (Birkley et al., 2016; Dutton, 2009; Trevillion et al., 2012) which some have argued is overly centred on individual deficits and symptoms, failing to adequately account for broader societal factors contributing to trauma (Burstow, 2003; Tseris, 2013; Bonnan-White, Hetzel-Riggin, Diamond-Welch, & Tollini, 2015) (see discussion above in critique of bio-medical conceptual understanding sections).

Given that this current study is a qualitative exploration of trauma-informed approaches to domestic abuse service provision, it adopts a more experiential perspective rather than focusing on statistical acts or diagnostic prevalence. It acknowledges the need for a deeper understanding of women's experiences of trauma following partner abuse, particularly from their own perspectives. However, it is important to note that much of the contemporary framing, education and training on trauma and domestic abuse derives from readily accessible empirical research, and its influence on service provision and front-line practice should not be overlooked or underestimated.

In addition to domestic abuse, which is now widely acknowledged as a potentially traumatic event(s) (Dutton et al., 2006), other adverse experiences associated with a victim's attempts to resist, escape and survive abuse, including financial hardship and the navigation of statutory processes (Kennedy et al, 2024) could now also be identified as potential triggers for PTSD. domestic abuse survivors may experience symptoms that mental health clinicians associate with Type II or complex, repetitive, interpersonal traumatic experiences and may even be diagnosed with PTSD or complex PTSD (see discussion above).

Butler et al (2020) conclude that the 'burden of intimate partner violence (including sexual violence) is disproportionately experienced by small numbers of adult women who experience high frequencies of victimisation' (2020, p 9). When considering the significant associations found between poly-victimisation in childhood and high frequency victimisation levels in adult victims of domestic violence and abuse, it is not surprising to learn that individuals who have experienced this compounding or cumulative adversity are at increased risk of trauma-associated health issues including mental health problems (Oram et al., 2013; Ferrari et al., 2018; Cloitre et al 1997;

Messmen-Moore et al 2000; Arata, 2002), such as higher levels of PTSD (Wilson et al 2012; Golding, 1999; Jones et al., 2001; Stith et al., 2004; Pico-Alfonso et al., 2006; Khadra et al, 2015; Spencer et al., 2019).), depression (Barrett, 2010; Fogarty et al, 2008; Koopman et al., 2007), and low self-esteem (Reyome, 2010).

There are some variations in the prevalence of PTSD reported by domestic abuse survivors across the literature. Jones et al. (2001) reported a range from 31% to 84% depending on sample characteristics, IPV severity, IPV chronicity, and history of interpersonal violence, among other factors. In contrast, an earlier meta-analysis of 11 studies (Golding, 1999) found a mean prevalence of 64%. More recent single studies have quoted a much higher prevalence, such as Khandra et al (2015) who reported that 97% of women who had experienced physical IPV reported experiencing PTSD symptoms.

Some researchers have examined the relationship between abuse type and the prevalence of PTSD symptoms, such as Dokkedahl et al (2021) who aimed to establish the prevalence of both PTSD and C-PTSD among female victims of partner violence (IPV) and whether the different forms of IPV (psychological, physical, sexual) correlated with specific types of trauma response. The study focussed on 147 Danish women living across four different women's shelter provisions in Denmark. The study concluded that PTSD was most commonly experienced in their sample (56.6%), followed by C-PTSD (21.1%). They found that psychological abuse was the strongest risk factor for negative mental health outcomes, correlating with PTSD and C-PTSD, with victims showing statistically significant levels of negative affect and somatization.

However, Ruark et al (2022) found 'no differences between abuse types on either emotion dysregulation or post-traumatic stress symptom severity' (2022, p 1164) in their sample of 89 women in the USA who were seeking treatment for IPV related distress. They conducted semi-structured clinical interviews to determine abuse type and administered two psychometric scales to identify the psychological impacts of IPV relating to emotional regulation (The Difficulties in Emotion Regulation Scale; Gratz & Roemer, 2004) and post-traumatic stress (The PTSD Checklist–Civilian Version; Weathers et al., 1993).

Ruark et al (2022) suggest that emotional dysregulation may be a better predictor for developing PTSD in survivors of IPV than abuse type. The finding of a strong link between difficulties in emotion regulation and post-traumatic stress (PTS) symptom

severity is consistent with some other studies. For example, Muñoz-Rivas et al (2021) carried out a cross-sectional survey of 150 women with different IPV experiences to 'determine the variability of emotional dysregulation among women with different types of IPV revictimization and post-traumatic stress' (abstract 2021). They generated three profiles of emotional regulation: emotionally regulated, avoidance and overwhelmed. They found that the emotionally overwhelmed group exhibited greater levels of dysregulation as well as more intense/severe post-traumatic stress symptoms.

While the assertion that emotional regulation may be a more important factor than abuse type when predicting severity of mental health outcomes for IPV survivors is supported in multiple studies, Ruark et al (2022) are careful to point out the limitations of drawing this conclusion based on their study. An important limitation of their research design was that interview questions included in the intake process were not standardised and definitions or examples of abuse type were not fully standardised. A major limitation of the research is that abuse types may not have been consistently defined in research interviews and subsequently coded within analysis.

Fernández-Fillol et al (2021) compared the presence of PTSD and C-PTSD symptoms (according to ICD-11 criteria; 2) in 162 female IPV survivors and found that the prevalence of C-PTSD (39.50%) was twice that of PTSD (17.90%), with high levels of fear associated with re-experiencing, avoidance, sense of current threat and disturbances in relationships. The researchers utilised a socio-demographic and violence related interview and questionnaires and found that victims experienced high levels of fear (related to re-experiencing), avoidance, perceived threat and relationship disturbance. They concluded that the key difference between meeting the criteria for C-PTSD and PTSD seemed to be differences in emotional regulation strategies, with IPV victims showing more 'maladaptive' coping strategies such as expressive suppression (efforts to conceal, inhibit or reduce emotional expression).

Karatzias et al., (2018) also found that expressive suppression was one of the most important factors in the diagnosis of C-PTSD as well as negative trauma-related cognitions about the self and attachment anxiety. Karatzias et al., (2018) examined the role of negative cognitions, emotion regulation strategies, and attachment style in complex post-traumatic stress disorder (C-PTSD) to help inform the adaptation or the development of effective interventions for C-PTSD. They carried out a cross-sectional study with clinical sample of 171 men and women in the UK who had been exposed to trauma, 86 with PTSD and 85 with C-PTSD. One of the psychometric scales used was

the Emotion Regulation Questionnaire (ERQ; Gross & John, 2003) which is a 10-item measure evaluating perceptions of the use of cognitive reappraisal (six items) and expressive suppression (four items) to regulate emotions. The expressive suppression associated with C-PTSD, conveyed by efforts to hide, inhibit or reduce emotional expression, could inhibit a practitioner's ability to track the client's emotion or provide adequate emotional support.

The over overutilization of expressive suppression and underutilised emotion regulation strategies such as cognitive reappraisal associated with C-PTSD population samples (Boden et al., 2013) could also inhibit a person's ability to process traumatic memories (Jackson, Nissenson, & Cloitre, 2009). Karatzias et al., (2018) conclude that 'promoting skills acquisition in emotional regulation' (2018, p 178) could be an important part of the treatment of C-PTSD but further research is required on the development of appropriate models to treat C-PTSD that tackle skills deficit in this specific area.

Butler et al., (2020) seems to echo the Cognitive-Action Theory' of PTSD (Chemtob, Roitblat, Hamada, Carlson & Twentyman, 1988) in postulating that these changes in developmental processes could serve to help or hinder an IPV victim in their survival and everyday coping, serving as adaptive or further endangering them. For example, a hyper-aroused state could increase vigilance (hypervigilance) to danger cues in the environment so better enabling them to identify or even anticipate danger, where as it could also have the opposite effect, rendering an individual less able to distinguish between dangerous and neutral situations (Risser et al., 2006, Van der Kolk, 2014; Perry 2017).

Baird et al (2021) carried out a small qualitative grounded theory study to explore the perspectives of 15 women in Canada on trauma related to their experiences of IPV. One of the research questions was 'What do women who have experienced IPV indicate are experiences of trauma?'. Five of the women quoted within the study interpreted trauma as a kind of emotional pain or negative feeling such as fear, anxiety or isolation. Many participants identified psychological symptoms such as panic attacks, flashbacks, nightmares, trouble sleeping, or being easily startled.

In relation to non-violent domestic abuse, such as coercive control, a recent systematic review (68 studies) and meta-analysis (45 studies) by Lohman et al. (2024) indicated moderate associations involving coercive control and PTSD which were comparable

to those involving psychological IPV and PTSD. Other findings on the relationship between coercive control and PTSD are more mixed; Taft et al. (2005) found large associations ($r=.56$) for coercive control and post-traumatic stress while Beck et al. (2011) found small associations ($r=.18$), Lohman et al (2024) emphasise that coercive control is both 'highly prevalent, occurring in up to 58% of IPV relationships, and a particularly insidious form of IPV' (2024, p 632). Crossman et al (2016) and others (Kennedy et al., 2018; Stark, 2007) assert that the chronic nature of coercive control leads to more severe mental health implications than situational psychological or physical IPV that is not embedded in the context of coercive control.

Ferrari et al (2016) set out to 'characterise the demography and mental health' of female domestic abuse survivors who were seeking support from specialist domestic abuse services within the UK. They were also interested in establishing the relationship between the severity of abuse (as measured by the Composite Abuse Scale (CAS) and mental health problems, as recorded by popularly used psychometrics including; Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM), Patient Health Questionnaire, Generalised Anxiety Disorder Assessment, and the Posttraumatic Diagnostic Scale to measure posttraumatic stress disorder (PTSD). They analysed the data from a baseline data set on 260 women who enrolled in a randomised controlled trial of a psychological intervention for domestic abuse survivors. The study found that symptoms of mental illness increased in tandem with increasing severity of domestic abuse. Female domestic abuse survivors seeking support from domestic abuse services had recently experienced high levels of abuse, depression, anxiety, and especially PTSD.

Ferrari et al., (2016) note that professionals, particularly medical clinicians, need to be aware that patients presenting with mental health conditions or symptoms of depression or anxiety may be experiencing or have experienced domestic abuse. They also conclude that trauma-informed psychological support is needed for survivors who seek support from domestic abuse services, suggesting that advocacy and non-specialist support workers should be equipped with psychological skills to support survivors. This recommendation is consistent with findings from Prosman et al (2014) who found a 'low threshold home-visiting intervention' for female survivors of domestic abuse provided by 'trained mentor mothers' was effective in reducing exposure to domestic abuse as well as symptoms of depression and improved social support. The 'mother mentors' were recruited from welfare, healthcare and educational institutes in Rotterdam and were all educated for social or healthcare, such as doctor assistants

and social workers.

In addition to decreased exposure to domestic abuse, reduced depression symptoms and increased social involvement (education, employment etc) the women who participated in this intervention study showed a greater acceptance of mental health care after taking part (Prosman et al., 2014 p 74). The authors argue that the effectiveness of this intervention was in part due to the fact that the mentoring programme was a 'low threshold, 'friendly' supportive relationship in combination with low-grade cognitive behavioural therapy interventions, which seems to fit with the needs of 'abused women' as well as the careful matching process for mothers and mentors (2014 p 74-75). Ferrari et al. (2016) highlight the potential benefits of up-skilling nonspecialist and non-medical personnel to deliver psychosocial support to women survivors of domestic abuse, particularly in resource-poor settings, as it may help 'engage hard-to-reach populations in a sustainable service framework' (2016, p 8).

Depression and suicidality in domestic abuse survivors

Violence against women has been strongly correlated to an elevated risk of clinical depression, as highlighted by several studies (Chandan et al., 2020; Anderson et al., 2003; Arboleda-Florez and Wade, 2001). Depression can disrupt sleep patterns and cause problematic changes in appetite, energy levels, and overall functionality (Karakurt, 2014), potentially leading to suicidal thoughts or attempts.

Research by McManus et al. (2022) examined the relationship between lifetime and past-year intimate partner violence (IPV) experiences and suicidal thoughts, suicide attempts, and self-harm within the past year. Their analysis of data from 7,058 adults in England, including face-to-face interviews about experiences of domestic abuse, revealed strong associations between various indicators of IPV and increased incidences of self-harm, suicidal thoughts, and attempts. The study found that women are more frequently victims of IPV than men, though strong associations were noted across all genders and ages. The greatest risks were observed among those with recent IPV experiences, particularly involving sexual and emotional abuse, physical injury, or multiple forms of IPV, suggesting a dose-response relationship. These findings align with high suicidality rates reported by individuals using domestic violence support services (Munro et al., 2020). McManus et al. (2022) concluded that one-third of women who attempted suicide in the previous year were recent victims of IPV, in

contrast to one in twenty among the broader population.

Attempted suicide and self-harming behaviours are crucial indicators for potential future suicide, important for prevention (Mars et al., 2020). Suicide usually results from a combination of multiple factors rather than a single cause (Sinyor et al., 2022). (McManus et al 2022) highlight that IPV victims often live in precarious situations, such as rented accommodation in deprived neighbourhoods. Socioeconomic instability exacerbates the risk of suicidality and prolongs domestic violence episodes (Guillén et al., 2015). Those who have experienced IPV are twice as likely as those who have not to encounter five or more significant life adversities, such as financial crises, loss, unemployment, and illness (McManus et al 2022). Both poverty and IPV contribute to entrapment, a mechanism in the progression from suicidal thoughts to acts.

Numerous studies underscore the connection between violence and clinical depression. For instance, Kernic et al. (2003) found that battered women with multiple abusive relationships suffered from much higher rates and severities of psychopathology, including PTSD (36%) and depression (17%), compared to women with a single abusive relationship or no history of abuse.

Summary

This chapter began by exploring the way in which the concept of trauma shifted from physiological to psychodynamic origins towards its contemporary definitions within the medical and psycho-social paradigm. The chapter explains in detail the developments in trauma diagnosis in accordance with the diagnostic statistical manual and exclusion of developmental and complex trauma. Haslam's (2016) notion of 'concept creep' provided a useful framework in charting increasingly diffuse distinction between trauma, harm, adversity, and abuse. The chapter went on to outline the role of adverse childhood experiences as a precipitating factor to the development of post-traumatic stress disorder before providing some contemporary institutional definitions of psychological trauma.

.

The chapter provided a short critique of bio-medical conceptualisation and highlighted the importance of the acknowledging the complex interplay between biology, psychology and environment when discussing trauma. Impacts of psychological trauma on emotional regulation, cognition and emotional state before finally reviewing

some of the literature base on post-traumatic stress and domestic abuse survivors.

The literature base reviewed within this chapter informed this current study through highlighting the ever changing and malleable conceptualisation of trauma and how the concept itself evolves in relation to environmental pressures and phenomena. Within this study, trauma is acknowledged as both a socially constructed phenomena as well as physiological and psychological subjective experience. The socially constructed and ever shifting classification of psychological trauma is relevant when exploring and why any given sector or discipline is adopting and using this knowledge base, and how the pre-existing knowledge base is influencing the way it is being utilised. In the domestic abuse sector service providers will have to decipher which iterations and manifestations of trauma-informed work align with their over-arching mission as well as how it may bolster or hamper the day to day demands of frontline service delivery.

The next chapter focuses specifically on domestic abuse and provides an overview of the theoretical frameworks often used to understand and conceptualise domestic abuse as well as the evolution of professional discourses in relation to domestic abuse service provision.

CHAPTER 3: LITERATURE ON DOMESTIC ABUSE

Introduction

While the previous chapter focused on theories of trauma, this chapter focuses on domestic abuse theories, especially those that have informed this study. The chapter also explores a range of theoretical models that provide insights into the dynamics of domestic abuse. It includes an examination of feminist theory, which contextualizes domestic abuse within broader societal structures of power and inequality. Social learning theory is discussed to illustrate how behaviours are acquired and perpetuated within familial and social contexts. Additionally, the chapter addresses the impact of adverse childhood experiences (ACEs) on both victims and perpetrators, highlighting the long-term psychological and emotional effects of such trauma. Ecological theory is also presented, emphasizing the interplay between individual, relational, community, and societal factors that contribute to the prevalence and perpetuation of domestic abuse.

This chapter also provides the latest working statutory definition of domestic abuse in the UK and outlines its prevalence. In addition to defining domestic abuse, the chapter briefly describes the legislative framework for domestic abuse and looks at how CP legislation impacts on domestic abuse victims in the UK. The focus on child protection legislation is relevant to this study as most of the survivors interviewed in this research were mothers, and many spoke in detail about their involvement with child protection social workers who work in adherence to the principles of embedded within child protection legislation, which presented some significant barriers for survivors who were mothers. There is an intricate relationship between domestic abuse legislation and child protection laws, emphasizing the complexities and challenges that mothers—who are often the primary caregivers—face when navigating these legal systems as victims of domestic abuse. The discussion reveals how statutory provisions, while designed to protect children, can inadvertently place additional burdens on mothers, complicating their ability to seek help and support.

Furthermore, the chapter traces the evolution of professional discourse surrounding domestic abuse, noting shifts in understanding and approach over time. It critically examines concepts such as risk and responsibility, shedding light on how these notions

influence the treatment of victims and the expectations placed upon them. The phenomenon of "mother blame" is scrutinised, revealing how societal attitudes can unjustly stigmatize mothers for their circumstances, often overlooking the systemic issues at play. Finally, the chapter evaluates the landscape of statutory and voluntary service provision in the UK, assessing the effectiveness and accessibility of resources available to victims of domestic abuse, as well as the ongoing challenges that remain in adequately addressing the issue.

Definition

In England and Wales, the Domestic Abuse Act (2021) defines domestic abuse as abusive behaviour between persons aged over 16 and who are personally connected to each other. The definition of abusive includes 'physical, sexual, violent or threatening behaviour, controlling or coercive behaviour, economic abuse and psychological or emotional abuse', enacted once or multiple times (sections 1 [2] and 1 [3], Domestic Abuse Act, 2021)

Domestic Abuse is defined by the Women's Aid Federation 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...'
(Women's Aid Website, 2024)

While neither of the definitions above mention trauma, both refer to behaviour that is repeated or continuous.

Prevalence

In 2020, The World Health Organisation (WHO) confirmed that domestic abuse had become the most common form of all gender-based violence. It is estimated that 1.4 million women in England and Wales (5.7%) experienced domestic violence and abuse (DVA) in the year ending March 2023, representing 75.3 % of all reported domestic abuse related crimes (ONS, 2023). Women's Aid Federation, the leading UK charity supporting female survivors of domestic abuse in the UK, reported that 77% of

domestic abuse survivors were female, and 96% of the perpetrators were male (ONS data collected between 2017-19) (Women's Aid, 2020). They identified that where there were male survivors of domestic abuse (83 male survivors identified), the abuse was perpetrated by females in less than half (46%) of these cases. They emphasised the scale of the issue in explaining that 222 women were killed by their abuser between 2016 and 2019, which equates to three women in the UK being killed every fortnight by domestic abuse perpetrator, who in 98% of cases was male (ONS, 2020; domestic homicide statistics).

Legislative Framework

The most recent legislation concerning domestic abuse in the UK is the Domestic Abuse Act 2021 which attempted to unify some of the other existing legislation. This act does not establish a separate criminal offence specifically for domestic abuse, which makes it vital for frontline responders to continue to rely on the extensive array of existing laws and protective safeguarding measures. Offences relevant to consider include grievous bodily harm or wounding with intent to endanger life

In 2015 England and Wales criminalised coercive control, which is included within the criteria of abusive acts within the Domestic abuse act 2021. The serious crime act 2015 was amended to better align with the Domestic Abuse act 2021 in removing the co-habitation requirement to ensure that post separation to include coercive abusive behaviour that is enacted when the perpetrator and victim do not live together. The Women's Aid federation defines coercive control as 'an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim' (Women's Aid Website, 2024).

The Domestic Violence, Crime and Victims (DVCV) Act 2004 outlines that individual living in the same household as a child or vulnerable adult, as well as those who have regular contact with them, have a responsibility to safeguard them from harm. This obligation extends to situations where these individuals may be the targets of the violence and abuse themselves. As a result, women with children who are facing domestic abuse may find themselves in a challenging predicament. While they may not directly contribute to the harm of the child or vulnerable adult, the DVCV Act (2004) can hold them accountable under specific circumstances.

Section 120 of the Adoption and Children Act 2002 revised the definition of harm in the Children Act 1989 to clarify that a child may be at risk of suffering any impairment to their health or development as a result of witnessing the mistreatment of another individual, such as in cases of domestic violence. The term "ill-treatment" is already defined in section 31(9) of the Children Act 1989, and its definition extends beyond physical violence to include sexual abuse and other non-physical forms of mistreatment. Furthermore, any harm a child experiences due to a parent's harassment or intimidation falls under the definition of "harm." This amendment is applicable in all legal proceedings where the court utilizes the 'welfare checklist' outlined in section 1(3) of the Children Act 1989, including cases involving contact or residence orders.

Theoretical Models for Understanding Domestic Abuse

There are various theoretical frameworks that are used to understand why domestic abuse occurs and persists. This section of the literature review outlines feminist theory, social learning theory, adverse childhood experiences literature and ecological theory. Given the importance of the ecological framework in this current research, the evolution of ecological theory in relation to harm and abuse is explored as well as how nested ecological models have been applied to domestic abuse specifically.

Feminist Theory & Domestic Abuse

A number of schools of thought within the broad school of feminist scholarship, which Longino (2017) describes as a 'family of positions and inquiries characterised by some common sociopolitical interests centring on the abolition of sexual and gender inequality' (2017, abstract). This family of positions includes radical feminism, post-modern feminism and more recently intersectional feminism, which each offer their own nuanced and distinct understanding of the causes and characteristics of domestic abuse and recommendations for how society should conceptualise and address it.

Radical feminism posits that women are fundamentally oppressed by a patriarchal societal order in which men 'dominate, oppress and exploit women' (Walby, 1989, p 2014). Domestic and sexual violence enacted upon women in society are understood as tools of oppression (Millett, 1969; Bryson, 1999; Bograd, 1988; Walby, 1990; Kelly

& Lovett, 2004) and one dimension of 'a collective problem that reflects the unequal gender power relations in patriarchal societies' (Damant et al, 2008 p 124).

Radical feminists not only illuminated the issue of domestic abuse (Fuller, 2023, p 21) but they were largely responsible for bringing about many of material and structural protections for women in society that are relied upon on today, including women's refuges/shelters (Dobash & Dobash, 1992; Radford, 1994) and legislative reform (i.e. criminalising domestic abuse) (Ali & Naylor, 2013). Through this lens, domestic abuse is not seen a problem rooted within the private or family context but as a social issue and consequently must be addressed at a systemic and structural level.

Through a structural lens, domestic abuse as an expression of patriarchal oppression (Ali & Naylor, 2013) has been linked with 'weak governance; poor rule of law; cultural, social and gender norms; unemployment; income and gender inequality' (WHO, 2014). Oram et al (2022) conclude that addressing structural factors such as education, poverty, legislative and policy frameworks are vital in preventing domestic abuse but also in bringing about changes in norms, attitudes and societal beliefs that normalise or sanction gender-based violence and perpetuate gender inequality (2022, p 3).

In contrast, postmodern feminism was heavily influenced by poststructuralist and psychoanalytic theory and postulates that social problems, including domestic abuse, are discursive constructions that vary across time and culture (Damant et al, 2008 p 125). Postmodern feminists point out how definitions and conceptualisations of domestic abuse change and evolve and that the 'recognition and naming' of this phenomenon is 'by no means constant or consistent' (Featherstone and Trinder, 1997 p 148). Postmodern feminism rejects the notion that 'all women' are oppressed, or that 'women' or 'men' are fixed and coherent in their subjective expression or experiences, preferring to conceptualise all individuals as varied and even contradictory in their experience, expression and performance of subjectivity (Davies & Krane, 2003; Fawcett & Featherstone, 2000). Meanwhile it also recognises that the range of subjectivities any individual can express or perform and are heavily influenced by 'dominant or oppositional discourses' (Damant et al, 2008 p 125).

In relation to domestic abuse, postmodern feminists point out that an individual could hold more than one position, for example a woman may be a victim of domestic abuse from her husband while at the same time they may hold a position of power in relation to other people in their eco-system, such as their children or even professionals trying

to engage with them. As Featherstone (1996) points out, 'they can therefore be both victim and victimizer and these positions themselves shift; for indeed children grow up, workers move on, agency policy changes' (1996 p. 183). Due to the epistemological differences between radical feminism (material reality exists independent of discourse) and postmodern feminism, which conceptualises the personal testimony of survivors as a part of discursive construction that cannot be separated from reality, postmodern feminist scholarship is primarily concerned with identifying various discourses across cultural and historical contexts and examining the ways in which they 'shape power relations and construct subjectivities' (Damant et al, 2008 p 126). Through this interpretivist lens, the value of the survivor's personal account of the abuse in her life and its meaning 'must become central to the helping process' (Davies and Krane, 2003 p 69).

The debate around whether to think of intimate partner violence or domestic abuse more broadly as a gendered crime continues to be contested. Female aggression is also a nuanced and complex issue in relation to domestic violence and abuse. Hester (2013) tracked and analysed patterns of domestic violence perpetration through examining incident narratives and progression of cases recorded by the police in England over a six-year period. This study concluded that while the level of intensity and violence perpetrated by men created a context of fear and control, women were three times more likely to be arrested per domestic abuse incident than men (2013, p 630).

Miller and Blecker (2021) offer an interesting finding about the correlation between acts of resistance (such as violent acts) by women who have experienced IPV and their perceived risk of being killed by their partners or ex-partners. Their study looked at the experiences of two groups of women who have been victims of IPV, one group were women in the community who were engaging in survivor related support work and the other group were women who had been arrested on an IPV/abuse related charge. Their study concluded that ACE scores and post traumatic distress symptoms were much higher (at similar levels) in both cohorts than in the general female population. The authors go on to conclude that irrespective of a women's level of active resistance, women from both cohorts experienced high levels of post-traumatic distress, concluding that resistance does not (at least solely) ameliorate or buffer the risk or severity of post traumatic distress. In some way, the women in this study who retaliated or physically resisted felt that they had decreased the level of risk posed to them by their abuser, something that the women accessing specialist/community-based

support services did not feel or report. This correlation between acts of aggression in response to IPV and an increased sense empowerment by way of feeling less 'at risk' of further harm could indicate that physical resistance can actually leave women victims of abuse feeling more empowered than traditionally encouraged formal help seeking strategies (see discussion of Goodman et al 2003 on page 50) such as reporting abuse to services.

The application of both of these feminist epistemological positions can be identified in much contemporary domestic violence service provision (statutory and voluntary) which endorses the importance of educating women about domestic abuse and promoting access to material resources (i.e. housing, legislative orders) as well as the need to deliver needs-led bespoke support for survivors and engage them relationally and therapeutically, paying attention to their subjective experience and not just prescribed ideas about their experience as a domestic abuse victim or survivor.

The radical feminist women's movement has been criticised for the way it 'did not address the multiple, interacting effects of social inequalities' (Baird, 2018), often retrospectively characterised as a white feminist movement. Conversely, Intersectional feminism (Crenshaw, 1991; Hill Collins, 1991) identifies the environmental and societal context in which domestic abuse occurs, and the way in which inequality based on race, gender, class, sexuality, and other identities interweave (Weber & Parra-Medina, 2003). Intersectional feminism offers a lens to examine the interrelation between aspects of personal and social identity and exploring the ways in which privilege or oppression based on those identities can intersect and affect the lived experience of gender-based inequality (Damant et al, 2008; Smith, 2016; Fuller, 2023).

While Crenshaw is credited with creating the term intersectionality, her work rests on a wealth of black feminist scholarship (see bell hooks, 1982, 1984, Audre Lorde 1984, 1995) who advocated for a shift away from thinking about patriarchal oppression as the sole precipitating factor to domestic abuse, offering instead a new 'avenue of enquiry where no category of oppression is automatically considered as the most damaging and where some differences are not continuously highlighted to the exclusion of others' (Hankivsky. 2012 p. 1713). Kelly (2011) contends that an intersectional lens is vital to ensure that services recognise how multiple forms of disadvantage and oppression can affect a women's experiences of domestic abuse, as well as her experiences with service providers (Kelly, 2011; Nixon & Humphreys, 2010). Specifically, intersectional feminism offers an alternative explanation for the

presence of violence in a woman's life, through highlighting 'multiple and intersecting forms of oppression... [and acknowledging how] these will be connected to particular historical, cultural, and social factors' (Mosher, 1998 p. 147).

In relation to power, intersectional feminism sees power as operating at the individual, systemic and structural levels and see identity categories as reflections of existing power relations at each level of the system (Oxman-Martinez et al., 2002; Damant et al., 2008). In this sense, an intersectional approach to domestic abuse service provision would encourage service providers pay attention to the structural factors that both create and maintain domestic abuse societally and move away from 'an overly simplistic rather than multidimensional understanding and approach to the problem' (Kelly, 2011 p. 44). Meanwhile, the intersectional framework has been criticised for being 'overly relativistic' and offers no 'unifying claim against oppression' which could make it 'difficult to operationalize' (Oxman-Martinez et al., 2002, p 24).

While feminist theoretical perspectives on domestic abuse focus on the role of patriarchal and gendered issues relating to power and control over women in society (Oram et al., 2022; Ali & Naylor, 2013; McPhail et al., 2007), social and developmental theories such as social learning theory and family life cycles theory conceptualise domestic abuse as originating from difficulties or norms within relationships or family networks (Ali & Naylor, 2013). These are considered next.

Social Learning Theory & Domestic Abuse

The central tenet of social learning theory is that people learn through observing and imitating the behaviour of others (Bandura & Walters, 1977), an idea which has gained intuitive and empirical gravitas, particularly the idea that children typically model the aggressive behaviours of same-gender role models (Bandura, 1973). There is a substantial body of research that supports the idea that boys who witness their father/father figure abusing their mother are more likely to perpetrate domestic abuse in adulthood (Whitfield et al., 2003; Roberts et al., 2010, Forke et al, 2018). Some similar findings have been reported in relation to girls who witness domestic abuse going on to become victims of domestic abuse in adulthood (Whitfield et al., 2003; Thompson et al., 2006; Ernst et al., 2006; Gover et al., 2008; Milletich et al, 2010).

Research by Whitfield et al., (2003) found a 'positive graded relationship between the number of violent experiences and the risks of victimization among women and

perpetration by men' (Whitfield et al., 2003, p 176). The researchers analysed data from 4,674 women and 3,955 men who completed Health Appraisal Centre standardised health evaluations, which included questions adapted from the Conflict Tactics Scale (CTS) (Straus & Gelles, 1990); '(a) Has your partner ever threatened, pushed, or shoved you?' and '(b) Have you ever threatened, pushed, or shoved your partner?' (Whitfield et al., 2003, p 171). Two weeks later the participants were then mailed an Adverse Childhood Experience (ACE) survey (Felitti et al., 1998) which included questions pertaining to witnessing domestic abuse during childhood. The study found that the risk of domestic abuse victimization for women was increased if they had witnessed either of the two forms most commonly experienced forms of domestic abuse identified in the study; 'mother was pushed, grabbed, slapped or shoved' and 'mother was threatened with a weapon' (Whitfield et al., 2003, p 174). The study concluded that there is a dose dependent relationship between frequency of this kind of adversity in childhood occurring in childhood and domestic abuse victimisation in adulthood.

Ames et al (2013) conducted a survey study of 502 married or co-habiting male construction workers and their female spouses, asking them about 'drinking patterns, past-year partner violence, normative beliefs about partner violence, work-related stressors, impulsivity, and childhood exposure to violence and other adverse events' (2013, abstract). The researchers then conducted semi-structured qualitative interviews with 81 workers about work stress, partner violence, and drinking. The study found a significant correlation between ACE exposure, normative beliefs about domestic abuse and 'involvement' in IPV. The study looked at both perpetration and victimisation and interestingly it found that the normative beliefs of women in relation to domestic abuse had a 'significant and direct' (2013, p 202) association with both female perpetration and female victimisation. Meanwhile, the association between male normative beliefs around domestic abuse were only significant in relation to male perpetration of IPV.

The questions that related to normative beliefs around domestic abuse perpetration or victimisation were all centred around perceived approval or disapproval of other people in their social network (colleagues, friends, family, neighbours), i.e. 'Suppose you slapped or hit/ were slapped or hit by - your spouse or partner during an argument. How much do you think the following people would approve or disapprove of your/his/her behaviour?' (2013, p 198). The fact that women estimated lower rates of disapproval around both perpetration and victimisation of IPV, while men only seemed

to estimate lower rates of disapproval from their social network in relation to perpetration of domestic abuse could be due to the patriarchal cultural norms and expectations in relation to men as the perpetrators of aggression, not the victim. Higher rates of social acceptance of male aggression in society more broadly and the way such acceptance contributes towards the perpetuation of male aggression is something that feminist scholars have long argued.

However, some authors have noted that social learning theory, particularly identification with same gender role models, does not completely explain their findings. For example, Forke et al (2018) who found that witnessing bi-directional violence was a more statistically significant indicator for girls becoming victims of domestic abuse in their adult life, which echoes findings from Jankowski et al., (1989). Additionally, Whitfield et al., (2003) point out that the current understanding about the intergenerational transmission of aggression or more broadly how 'violence begets violence' remains 'incomplete' (2003 p 180). Other variables which could impact the likelihood of becoming a perpetrator or a victim of domestic abuse in adulthood after witnessing it during childhood include the severity and frequency of domestic abuse witnessed, identification with parent/caretaker (perpetrator or victim) including gender identification, enabling behaviour by others, attachment history, other adverse experiences in childhood, the dynamics of a person's current adult relationships (Whitfield et al. 2003 p 180).

Another key criticism of social learning theory is that not all adults involved in abusive relationships witnessed domestic abuse in childhood and of those who witness domestic abuse in childhood, not all go on to become perpetrators or victims of domestic abuse in adulthood (Ali & Naylor, 2013). Many of the studies cited above do not explore the role of gendered oppression within social learning theory. Feminist scholars emphasise that social learning exists within familial contexts that are organised by age-gender hierarchies (Collins, 1998) which could seek to maintain and normalise gender-based subordination or oppression (Yount & Krause, 2017).

The next section explores the literature on how adverse experiences during childhood have been linked with further victimisation in adulthood, specifically domestic abuse.

Adverse Childhood Experiences & Domestic Abuse

The correlation between Adverse Childhood Experiences and adult victimisation has been well researched, particularly the relationship between ACEs and adult experiences of domestic abuse (Miller & Becker, 2021; Zhu, 2014; Butler, Quigg & Bellis, 2020). Academics have offered different rationales or theoretical frameworks to explain the possible relationship between ACEs and exposure to interpersonal violence or domestic abuse more specifically. Commonly cited in the explanation of the association between ACEs and domestic abuse is the life course perspective, which suggests that 'an individual's health and well-being is shaped by social and temporal contexts of the individual's history' (Elder, 1998, cited in Zhu et al., 2024, p 930).

There is a substantial body of evidence that broadly supports this theory, with women who report a history of sexual abuse, physical abuse or witnessing abuse consistently being found to experience higher levels of domestic abuse in adulthood, (Barrett, 2010; Whitefield, Anda, Dube, & Felitti, 2003; Salber & Taliaferro, 2006) and therefore at an elevated risk for stressors related to violence in intimate relationships (Roberts, McLaughlin, Conron, & Koenen, 2011). While this finding also corresponds with findings from Whitfield et al., (2003) who found a 'positive graded relationship between the number of violent experiences and the risks of victimization among women and perpetration by men' (Whitfield et al., 2003, p 176), it is important to consider other possible variables. Whitfield et al., (2003) note that the likelihood of becoming a perpetrator or a victim of domestic abuse in adulthood after witnessing it during childhood include the severity and frequency of domestic abuse witnessed, identification with parent/caretaker (perpetrator or victim), attachment history, other adverse experiences in childhood, the dynamics of a person's current adult relationships (Whitfield et al. 2003 p 180).

In the trauma literature, the concept of poly-victimization is used to describe the effects of childhood or youth victimization on becoming victims of further abuse and trauma (Miller and Becker, 2021 p 6955). Finkelhor et al (2005) introduced the term 'poly-victimization' based on research showing that youth exposed to multiple types of victimization are more likely to experience repeated exposure to the same type of victimization (Finkelhor et al., 2007 cited in Ogle et al, 2024, p 2)

When seen from a life course perspective, the correlation between ACEs and

increased risk of domestic abuse exposure in adulthood hinges upon the idea that cycles of violence are likely to be transmitted intergenerationally. Zhu et al (2024) discuss related concepts of homotypic and heterotypic continuity (Berzenski et al., 2014) to contextualise the findings from their meta-analysis on the relationship between ACEs and IPV. Homotypic continuity describes the transmission of the same or similar forms of abuse between parents and their children, while heterotypic refers to the 'parents who experience a different form of maltreatment compared to their own children' (Zhu et al., 2024, p 935). In relation to IPV, Islam et al., (2014) used data from over 10,000 women in Bangladesh who took part in the 2007 demographic and health survey and concluded that domestic abuse was found intergenerationally. Women who witnessed IPV were 2.4 times more likely to experience any kind of IPV, 2.5 times more likely to experience moderate physical IPV, 2.3 times more likely to experience severe physical IPV, and 1.8 times more likely to experience sexual IPV. However, the authors note that the data was cross-sectional, and causality cannot be inferred from their findings. The findings have been partially supported by other studies done on the intergenerational transmission of domestic abuse (Frankin and Kercher, 2012; Renner and Slack 2006; Fergusson et al., 2006; Ehrensaft et al., 2004; Rosen et al., 2001).

Butler et al., (2020) point out that earlier research largely focussed on the impacts of individual types of abuse in isolation, with only a minority of papers including more than one form of abuse (Higgins and McCabe, 2001). Consequently, earlier studies 'tended to focus on a specific type of child abuse and its relationship with a particular, often similar, form of victimisation in adulthood' (Butler et al., 2020, p 13). Butler et al. (2020) warn that focussing on one specific form of abuse when examining risk of revictimization could be misleading. While there is evidence that concludes that the occurrence of a specific form of abuse renders an individual more likely to experience it again in adulthood (Fergusson et al, 1997; Arata, 2002; Coker et al., 2000), they note that child abuse and other types of adversity, typically co-occur (Bellis et al, 2014; Felitti et al, 1998) making it more difficult to establish a clear cause and effect between a certain type of adversity in childhood reoccurring in adulthood.

Consequently, attributing risk of domestic abuse in adulthood to any single form of abuse is likely to be an oversimplification. In addition to co-occurrence, there has been found to be cumulative impact, a dose dependent relationship between the amount of adversity a person experiences in childhood, and the likelihood of negative outcomes in adulthood. Studies have found a graded relationship between ACE scores and physical and mental health issues in adulthood (Felitti et al., 1998, Gilbert et al., 2015),

as well as an increased risk of violent victimisation. One English study concluded that a person is seven times more likely to be victimised in adulthood if they have an ACE score of four or more (Bellis et al, 2014), a finding supported by a more recent systematic review and meta-analysis by Hughes et al. (2017).

Butler et al (2020) used national survey data from the 2015/ 2016 Crime Survey for England and Wales (CSEW), from 21,845 household residents aged 16 to 59 years. Their study found that those who had experienced one form of childhood abuse were three times more likely to have experienced domestic abuse or sexual violence since the age of 16 (adulthood). Furthermore, those who reported experiencing multiple forms of child abuse were six times more likely to have experienced domestic abuse and seven times more likely to experience sexual violence. The authors aimed to create a clearer picture of which forms of abuse were associated with different forms of adult victimisation and controlled for social demographics as well as multi-type childhood victimisation. They found that 'child psychological and physical abuse were particularly significant in the association with IPV' (2020 p 6).

There is a growing body of research that is critical of the deterministic and narrow framework of adversity offered by the ACE scale, and which questions the validity of the ACE framework as the strongest predictor of negative outcomes in later life. Dolezal & Gibson (2022) insist that ACEs and trauma are not synonymous, pointing out that some of the experiences included within the ACE scale could be protective as opposed to traumatic, citing the example of 'parental separation'. White et al (2019) discuss the importance of mediating factors or other more structural forms of adversity such as poverty, which have been largely overlooked in the ACE's research. The risk of experiencing domestic violence and abuse in adulthood has been associated with other forms of adversity through the life course that are not accounted for within the ACEs scale, such as poverty and deprivation (Fahmy et al., 2016), mental health issues and discrimination (Maldonado et al., 2022).

The next section will discuss the utilization of ecological theory models that have been used in various ways to explain the experience and response to domestic abuse.

Ecological Theory

This section provides an overview of how ecological frameworks have been used historically to conceptualise domestic abuse. The ecological framework is important to this current study, which utilises Bronfenbrenner's ecological model (see Figure 1 below) to map out victim-practitioner experience of a trauma-informed approach to domestic abuse support

Bronfenbrenner (1979) framed every individual as sitting within their own ecological system, nested layers of context which influence the individual's development across the life course and layers of context that interact bi-directionally with one another.

The Micro-system is the pattern of 'activities, social roles and interpersonal relations experienced by the person' (Bronfenbrenner, 1994, p 40). Regarding survivor-practitioner interaction, a survivor's Micro-system includes those professionals who they have direct contact with.

The Meso-system comprises a 'system of Micro-systems' (Bronfenbrenner, 1994, p 40). The Meso-system includes any interaction between two parts of a person's Micro-system but does not directly involve them, for example, interactions between two or more professionals working with a survivor.

The Exo-system describes the 'linkages and processes taking place between two or more settings, at least one of which does not contain the person in question' (Bronfenbrenner, 1994, p 40). While the domestic abuse survivor has direct interaction with their advocate/practitioner, there are events that occur that indirectly influence this interaction, such as the organisational ethos, policies and training initiatives influencing that advocate and consequently that survivor.

The Macro-system describes overarching 'characteristics of the culture, belief systems, bodies of knowledge, customs, opportunities and structures' in the societal context within which the other nested systems exist (Bronfenbrenner, 1994, p 40).

The Chrono-system 'encompasses change or consistency over time not only in the characteristics of the person but also in the environment in which the person lives' (Bronfenbrenner, 1994, p 40).

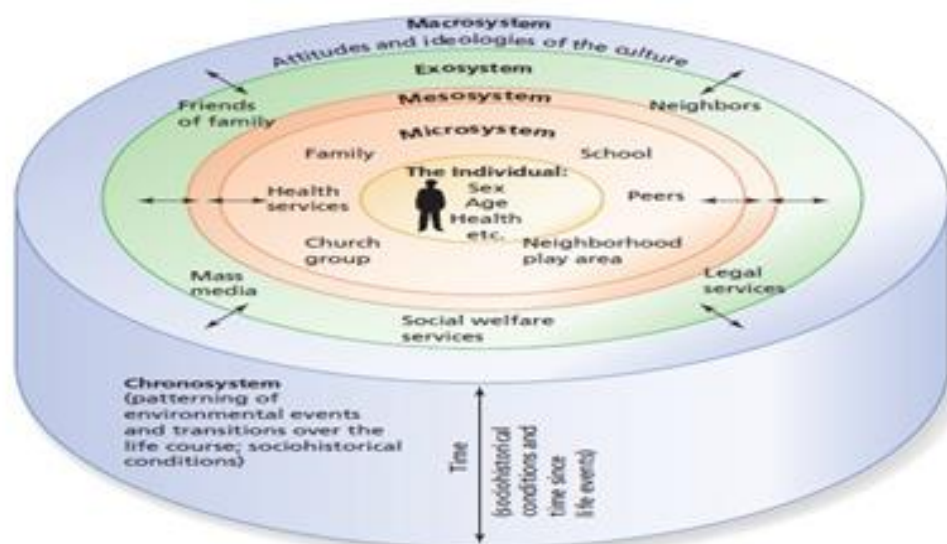


Figure 1: Bronfenbrenner's ecological framework model (Bronfenbrenner, 1979)

Building on Straus's 1973 general systems theory of family violence, Bronfenbrenner's initial conception of the ecological model (1977, 1979) and subsequent nested ecological models (Belsky, 1980; Dutton, 1995), many others have adapted this theoretical framework to explain the aetiology and risk factors associated with domestic abuse. Most notably, Heise (1998) (and later Baily, 2019) used an ecological framework to explore both perpetration of and victimisation by domestic abuse. The ecological systems approach has also been utilised to explain women's responses to domestic abuse (Bliss et al., 2014), to conceptualise women's experiences of coercive control (Carr, 2024), to examine factors involved in disclosure of domestic abuse (Alaggia et al., 2012), and to explore the intersection between domestic abuse and trauma (Baird, 2018). Corbally et al., (2016) suggest that an ecological paradigm offers a more inclusive epistemological framework for domestic abuse researchers as it is not based on 'an overreliance on quantitative methodologies' and is not wedded to one particular theoretical standpoint (Corbally et al., 2016, p1010).

The ecological model lends itself to an intersectional approach, as it provides a framework to examine the way in which wider environmental factors such as poverty, dominant norms, policy and legislative frameworks and constructions of gender interact with individual characteristics to explain risk of (re)victimisation in relation to domestic abuse (Etherington & Baker, 2017; Grauerholz, 2000; Heise, 1998). Belsky (1980) offered an ecological framework for understanding child abuse by merging Tinbergen's (1951, later adapted by Burges 1978) scheme for behavioural development which included ontogenic factors (childhood histories of abusive parents)

with Bronfenbrenner's (1977, 1979) model of ecological development, from which Belsky includes the Micro, Exo and Macro system (excluding Meso and Chrono systems).

Heise (1998) draws on the same four levels of analysis (Ontogenic/personal history, Micro, Exo and Macro layers) to conceptualise 'embedded levels of causality' for gender-based abuse (1998, p 264). Heise uses her adapted ecological framework to integrate findings from various academic disciplines that all offer empirical findings relating to differential rates of violence against women including psychology, sociology, anthropology and cross-cultural comparative studies. Heise emphasises that the real utility of an ecological framework is in enabling exploration of the interplay between different factors operating at multiple levels (See Figure 2). Through considering the varying aetiologies of abuse within an ecological framework, Heise is able to pose questions for further research, such as 'Which factors must appear together for violence to exist? Are factors from each level necessary for violence to occur? What factors are missing?' (Heise, 1998, p 283).

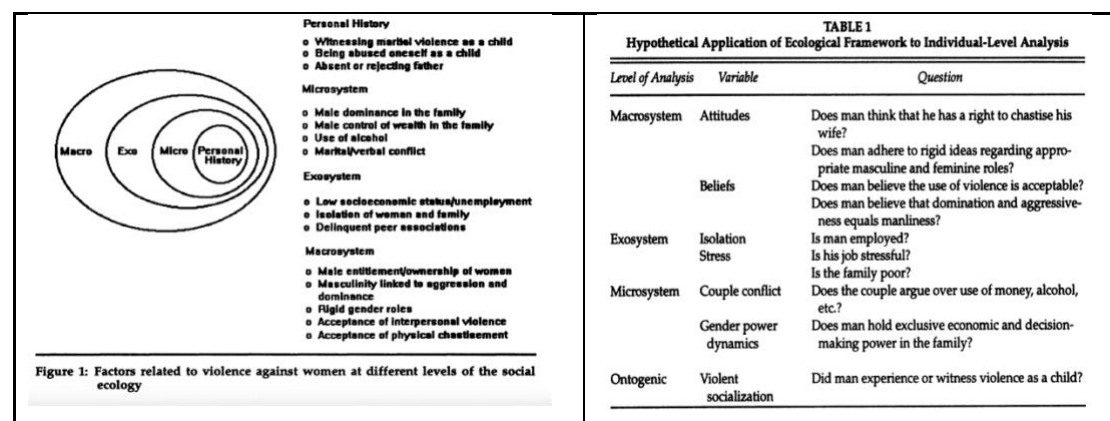


Figure 2: Factors related to violence against women at different levels of the social ecology (Heise, 1998 p 265 & 284)

Heise used the ecological model to organize pre-existing research on all forms of gender-based abuse. She described the ecological model as the best way to fully conceptualise gender-based abuse as a multi-faceted phenomenon that accommodates consideration of the interplay between 'personal, situational and socio-cultural factors whilst also allowing scholars to map out predictive/risk factors of abuse at each layer of the persons ecological system. It is important to note that Heise was primarily concerned about the ecological factors that render the occurrence of abuse more likely to occur, whilst the use of the ecological model is being used within this research to focus on the victim-practitioner experience of a trauma-informed approach

to domestic abuse support.

The Violence Prevention Alliance of the World Health Organisation (Figure 3 below) promotes the use of an ecological model within the public health approach to frame domestic abuse as an 'as the outcome of interactions among many factors and structures at individual, relationship, community, and societal levels, which create both the conditions' for domestic abuse and 'potential intervention sites across the prevention spectrum' (Wathen & Mantler, 2022, p 234).

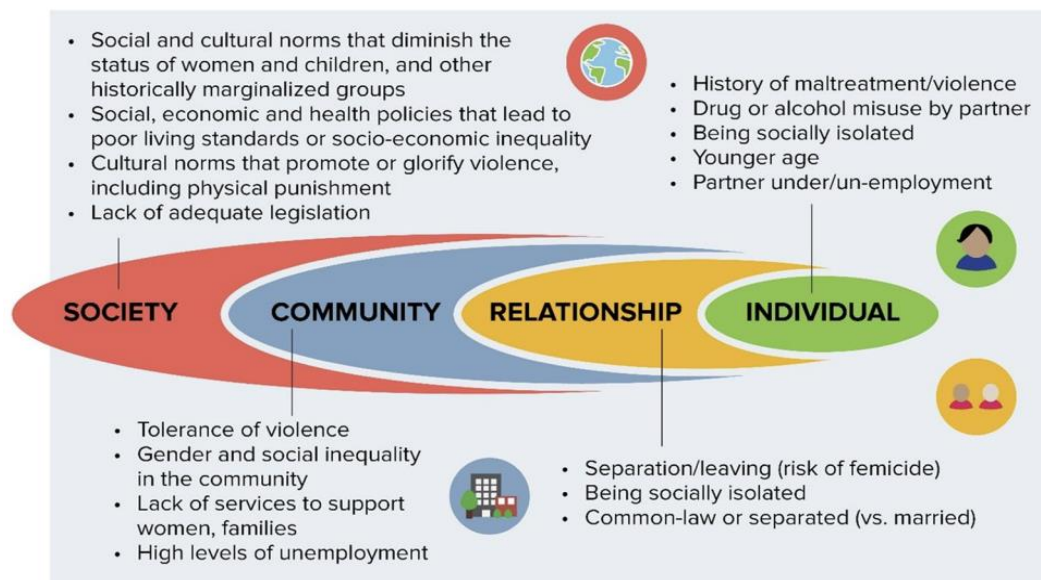


Figure 3: World health organisation - Violence Prevention Alliance Ecological Model, (adapted from Heise 1998)

Johnson highlights that research focussing more on the abuse typologies of 'intimate terrorism' and 'violent resistance' (Johnson, 2011) while also attending to the social and environmental context in which these forms of domestic abuse occurs avoids the conceptual 'de-gendering' (Johnson, 2015) of domestic abuse that can occur when only focussing on 'situational couple violence' (Johnson, 2011). Wathen & Mantler (2022) also emphasise the importance of domestic abuse measures recognising gendered patterns and adopting a structural approach that views domestic abuse as 'arising from, and rooted in, the values, attitudes, and beliefs that we, collectively, have internalised, and that are embedded in our organizations and communities and reflected and reinforced by society' (2022, p 234).

An ecological framework has also been utilised to explore women's responses to

domestic abuse (Dutton, 1996; Rothery et al., 1999; Bliss et al., 2014). Dutton (1996) offered an ecological model to understand and conceptualise a women's strategic response to domestic abuse, consisting of five overlapping systems: (1) the domestic abuse victim (ontogenetic/personal history and meaning making); (2) her personal networks (network history, and meaning making) (Microsystem); (3) links or interactions between these personal networks (Meso-system); (4) indirect influence of community networks (Exosystem); and (5) society and cultural influences (Macrosystem).

Bliss et al. (2014) build on Dutton's work to look specifically at how incarcerated women responded to domestic abuse and used an ecological framework which included four layers - childhood, individual, relationship and community- to establish if any of these contexts relate to the variability in strategic responses (placating, resisting, safety planning, legal, formal, and informal strategies, (Goodman et al., 2003). The various strategic responses used by domestic abuse survivors as categorised by Goodman et al (2003) are listed in Table 1 (below).

Strategy/Category	Example of action
PLACATING	Tried to keep things quiet for him, tried not to cry, did whatever he wanted, tried to avoid him, tried to avoid arguments
RESISTING	Ended the relationship, refused to do what he said, fought back physically or verbally, slept separately, left home to get away from him, used weapon
SAFETY PLANNING	Hide money/valuables, kept important phone numbers, kept the house/car keys close by, hid important papers, kept a weapon accessible, worked out an escape plan, developed a danger code, kept a supply of basics accessible, removed or hid weapons, changed locks
LEGAL	Called police, filed for protection order, file criminal charges, tried to get legal assistance
FORMAL	Talked to a DV program, tried to get him counselling, talked to a doctor or nurse, stayed at a shelter, called a mental health counsellor, tried to get help from clergy, Tried to get help from employer, Tried to get help for alcohol/ substance abuse,
INFORMAL	Talked to family members, stayed with family or friends, sent kids to family/friends, made sure other people are around

Table 1: Strategic responses to intimate partner violence (IPV) (Collated from Goodman et al., 2003, table 2, page 178)

FIGURE 1. Ecological Model of Factors Explaining Women's Strategic Responses to IPV

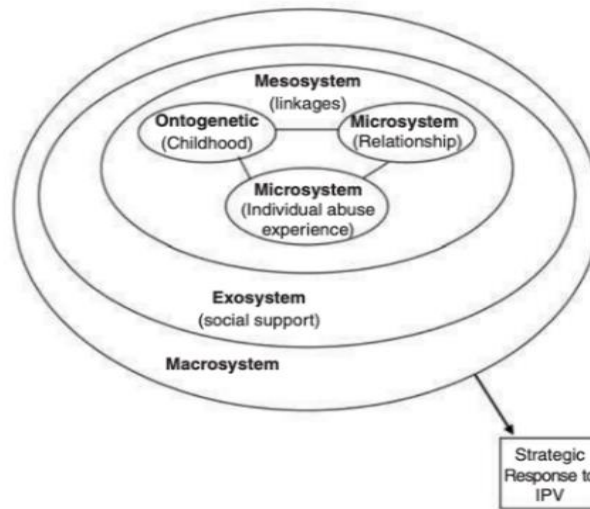


Figure 4: Ecological model for explaining women's strategic responses to IPV (Bliss, Cook & Kaslow, 2014, page 101 & 107).

Bliss et al (2014) developed an ecological model explaining women's strategic responses to IPV (figure 4 above). Their study found that two relationship factors (relating to children and severity of abuse) had the largest effects on strategic responses taken by the 85 incarcerated women included within this US study who had reported domestic abuse from their most recent male partner. Specifically, they found that the more children they had, 'the more types of resisting, legal, and formal strategies' they employed in response to domestic abuse (Bliss et al, 2014, p 108). They also found the more severe the level of domestic abuse, the more likely the women were to rely on placating strategies. Conversely, researchers found no significant relationship between abuse severity and other strategies (resisting, safety, legal, formal, and informal strategies) which they supposed could be due to the mediating effect of other abuse related factors such as 'PTSD, injury or acknowledgement of abuse' (Bliss et al, 2014, 109). While abuse severity alone was not a predictor for other strategic response (aside from placating), when looked at together with presence of children in the household these two factors conjointly had 'largest effect on all strategical responses' (2014, p 108). Bliss et al (2014) postulate that this could be due to abusers making threats to children or disputes over child custody arrangements.

They found that the most statistically significant predictor of strategic response to

domestic abuse was the geographic environment the woman was raised in. Women who were raised in rural settings were much more likely to use the placating strategy. Given that the study sample were women in a maximum-security prison in the Southeastern United States of America, which includes some of the most rural states (Mississippi, Alabama Arkansas) alongside one of the least (Florida), the findings yield important implications for the geographical context of the research. Possible reasons that women living in rural areas are more likely to utilise placating strategies over other possible strategies include; less availability of formal or public resources in rural areas such as refuges (Barnett, 2001; Krishnan, Hilbert, & VanLeeuwen, 2001), more patriarchal family structures, stronger adherence to religion and worries about maintaining privacy due to community dynamics which could render them the source of gossip, or lead to them being stigmatised (Staton et al., 2001). Women from rural communities may also be deterred from employing legal strategies due to their own or their partners' level of familiarity with local police officers (Barnett, 2001). Resistance and safety strategies were more likely to be used by women who acknowledged the relationship as abusive and injury was a significant predictor for safety, legal and informal strategies, but surprisingly not formal strategies such as speaking to a medical professional (Bliss et al, 2014, 109). The author of this current study designed Table 2 (below) to clearly map out the findings from Bliss et al (2014) using the categories strategic responses offered by Goodman et al (2003).

SINGLE VARIABLE	PLACATE	RESIST	SAFETY PLAN	FORMAL	INFORMAL	LEGAL
MOTHERHOOD		X		X		X
ABUSE SEVERITY	X					
RURAL	X					
ACKNOWLEDGING ABUSE		X	X			
INJURY			X		X	X
PTSD	X			X	X	

Table 2: Findings from Bliss et al 2014 mapped out by the researcher using Goodman et al.'s (2003) strategic responses to IPV

The table clearly shows that women who reported PTSD were more likely to use placating, formal and informal resources. The findings from Bliss et al., (2014) relating to reported levels of PTSD and response strategies of domestic abuse victims are further illuminated when considered alongside other research findings on this topic.

For example, the employment of placating strategies such as avoidance of conflict could be due to fear as a motivation for avoiding perceived danger (Dunmore, Clark, & Ehlers, 1999) or disengagement (Kemp & Green, 1995). The use for formal strategies by domestic abuse victims who report PTSD could be due to the increased likelihood of accessing mental health support to mitigate 'psychiatric symptoms' (Bliss et al., 2014, p 110).

Another application of ecological theory to domestic abuse which is particularly pertinent to this research is Baird's (2018) 'Theoretical Model: A Trauma-informed, Intersectional Theoretical Model for IPV and Trauma' (see Figure 5 below) which incorporates intersectionality, ecological theory, trauma theory, and trauma-informed practice to offer a more complex understanding of the perspectives of women who have experienced domestic abuse. The model comprises of four nested circles or interacting layers (like Bronfenbrenner's model) to examine the intersection between the individual, their experiences of domestic abuse as well as other traumatic life experiences and wider societal conditions and oppression (Burstow, 2003 and Timothy, 2012).

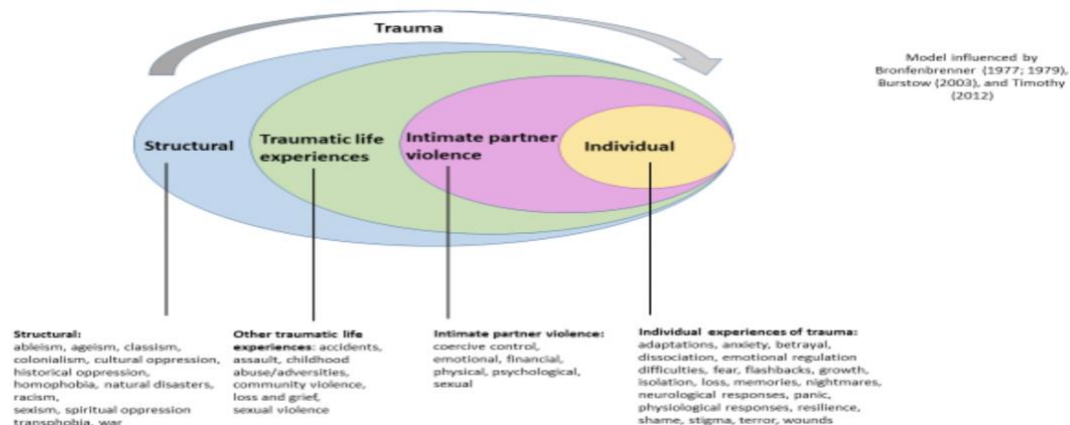


Figure 5: Theoretical Model: A Trauma-informed, Intersectional Theoretical Model for IPV (Baird 2018 p 19)

As with Heise's (1998) model and subsequent applications of the ecological model to domestic abuse, the consideration of the Macro system or the structural layer (Baird, 2018) is essential to understand the social context in which violence against women occurs. Baird's ecological model also sheds a new light on the way in which trauma 'symptoms' are conceptualised in relation to domestic abuse. Baird's model was influenced by Burstow (2003) who points out that when considering the wider social context in which violence against women occurs, women's trauma responses could be seen as an 'attunement to a basic social reality' (i.e. a sexist society) and trauma

'symptoms' could be reframed as 'heightened awarenesses that arise by virtue of experience' (Burstow, 2003, p 1305). This perspective differs from that of other feminist scholars such as Herman (1992) who largely accept the psychiatric underpinnings of trauma theory whilst acknowledging its limitations, and perpetuate the notion that trauma survivors must recover or return to a 'normal orientation' to a world 'in which they can 'trust the goodness of others' (Burstow, 2003, p 1298).

Baird (2018) found that an intersectional lens helped to provide some insight into the psychological and sociological factors that make a sense of safety or trust particularly difficult for many women in part due to the pervasiveness of adverse, abusive and traumatic experiences in their lives and the way this was conceptualised by others within their nested context (2018, 55). Baird carried out in-depth individual interviews with fifteen female domestic abuse survivors who were accessing counselling support from social services and/or counselling settings in southern Ontario in Canada. The author notes that 'theoretical sampling ensured a diverse sample (range of IPV experiences, geographic/service locations, social locations, identities)' (2018, p 22).

Women in Baird's study discussed feeling blamed and shamed for having had multiple experiences of domestic abuse and other adverse experiences such as 'childhood abuse, cultural and spiritual abuse, racism, loss, and assault' (2018, p 56). The implication that if a woman has had multiple or compounding experiences of adversity must have an 'active role' (2018 p 53) in bringing about these experiences adheres with Garland's concept of 'responsibilisation' (1996, 2001) which has serious implications for service design and delivery (see Chapter 3: Risk and Responsibility section). While this small qualitative study (interviews with 15 women) cannot be generalised to other populations, when viewed within the wider context of domestic abuse literature, the findings correspond with larger studies looking at the intersection between domestic abuse, victim blaming and trauma (Beck et al., 2011, Alaggia et al., 2012; Bonnan-White et al., 2015). Women in Baird's (2018) study cited the blame as coming from both informal (family and friends), formal (service providers) and legal (police) systems of support. This is particularly interesting when viewed alongside findings from Bliss et al.'s (2014) study in which women who reported PTSD were more likely to use formal (service providers) and informal (family and friends) strategic responses to domestic abuse.

Another model that integrates an ecological paradigm in its conceptualisation of

domestic abuse is The Power and Control Wheel (Pence & Paymer, 1993), which was developed and based on the experiences of more than 200 domestic abuse survivors at a Duluth battered women's shelter (See Figure 6 below). Carr (2024) points out that the Power and Control wheel 'expanded the research from the Microsystem to both the Meso-system and the Macro level' in its acknowledgement that coercive control impacted various aspects of women's lives 'within their local communities' (2024, p 12).

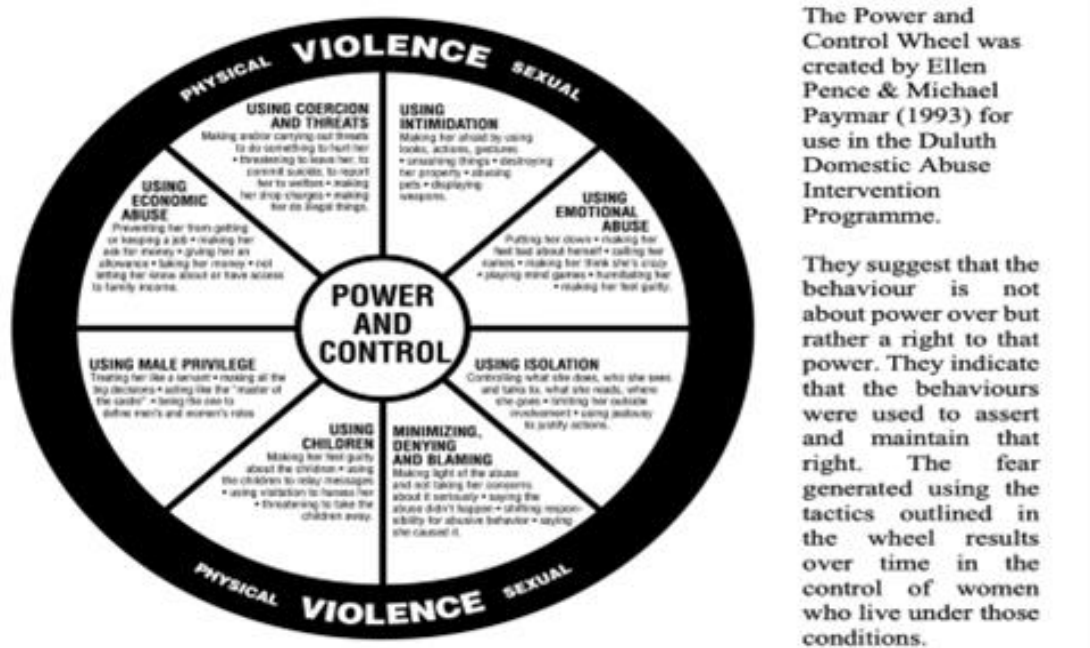


Figure 6: The Power and Control Wheel (Pence & Paymer, 1993 cited in Carr, 2024, p 11)

The constant looming threat of physical or sexual violence (as illustrated by the outermost ring of Figure 6) is seen as strengthening the power of the other tactics on the wheel. Specifically, it is the 'inability to predict these behaviours inevitably drives victims to be hypervigilant about meeting the abuser's needs, wants, whims, and expectations' (Pence & Paymer, 1993 cited in Chavis & Hill, 2008, p 134).

While Pence & Paymer (1993) acknowledge that the tactics used by domestic abuse perpetrators are often the 'tactics employed to sustain racism, ageism, classism, heterosexism, anti-Semitism, and many other forms of group domination' (1993, p. 3), the model has been criticised in the light of intersectionality for not fully acknowledging or integrating the range of diverse and multiple identities and relationship contexts in which domestic abuse can occur. The cultural context model (Almeida et al, 1992, Almeida et al, 1998) was an attempt to address multiple identities through the

consideration of 'racism, colonization, imperialism and heterosexism' but it does not consider 'disability, class, or age' (Chavis & Hill, 2008, p 137).

Chavis & Hill (2008) offer The Multicultural Power and Control Wheel (see Figure 7 below) which builds on Pence and Paymer's (1993) original but adds seven distinct rings, with each ring representing one of the following forms of oppression: racism, ethnocentrism, ageism, classism, sexism, ableism, religious or spiritual oppression, and heterosexism.

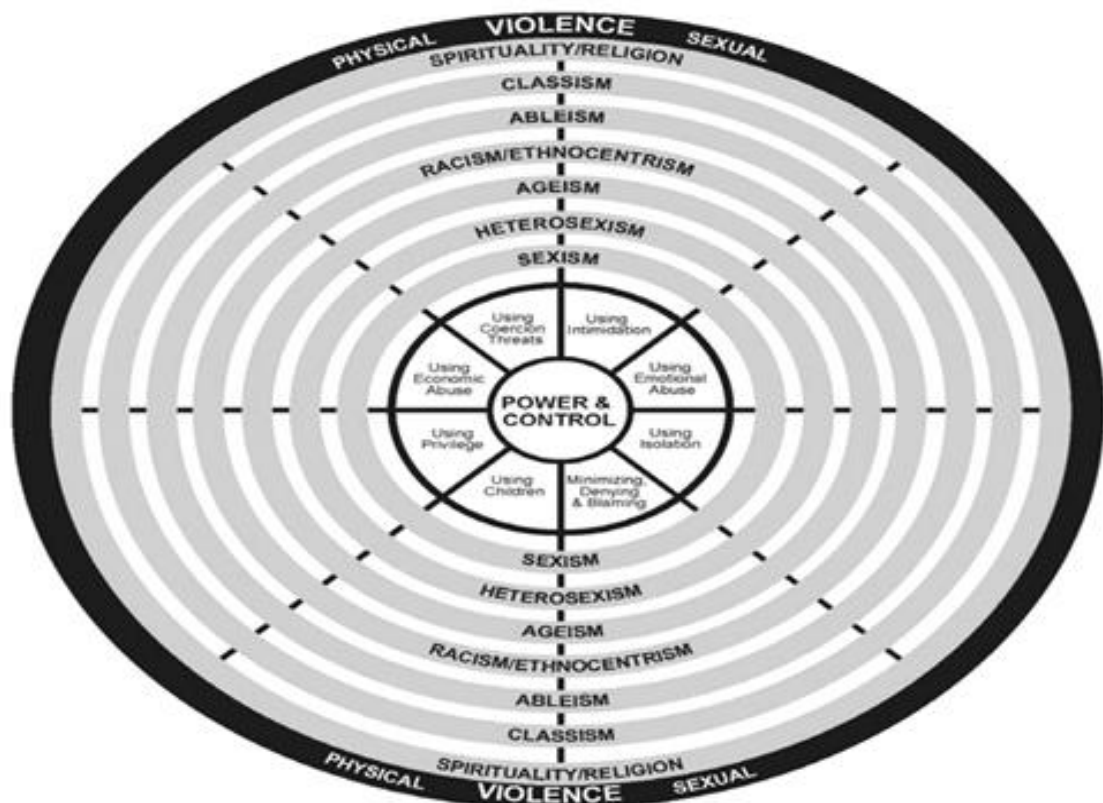


Figure 7: The Multicultural Power and Control Wheel Chavis & Hill (2008, p 139)

'The original eight tactics and the outermost ring (physical and sexual violence) were maintained in keeping with Pence and Paymer's conceptualization of IPV...Unlike the original Power and Control Wheel, where sexism is built into the eight tactics, we made sexism a ring 'to highlight its importance as being equal to that of the other identities' Chavis & Hill, 2008, p 138-139.

Cycle of Violence

While ecological models are helpful in identifying the multitude of behaviours that abusive partners use to gain and maintain power and control over the survivor, they

do not illuminate the interpersonal mechanisms of abusive relationships or cyclical occurrence of domestic abuse. The cycle of violence (Figure 8) is a traditional model for understanding domestic abuse, originating from Lenore Walker's initial conception of 'battered women's syndrome' (1979, 1984) in which Walker posited that women develop battered women syndrome due to 'learned helplessness' (Seligman, 1972) and the 'cycle of violence'. While Pence & Paymer (1993) saw the unpredictable nature of the abuser's behaviour as leading to hypervigilance in the survivor, Walker (1979) postulated that the victim's inability to control or predict abuse leads to kind of psychological paralysis. Walker (1979) asserts that this paralysis derives from a belief that she is unable to influence or control what is happening to her, rendering her passive, helpless and unable to leave the abusive relationship.

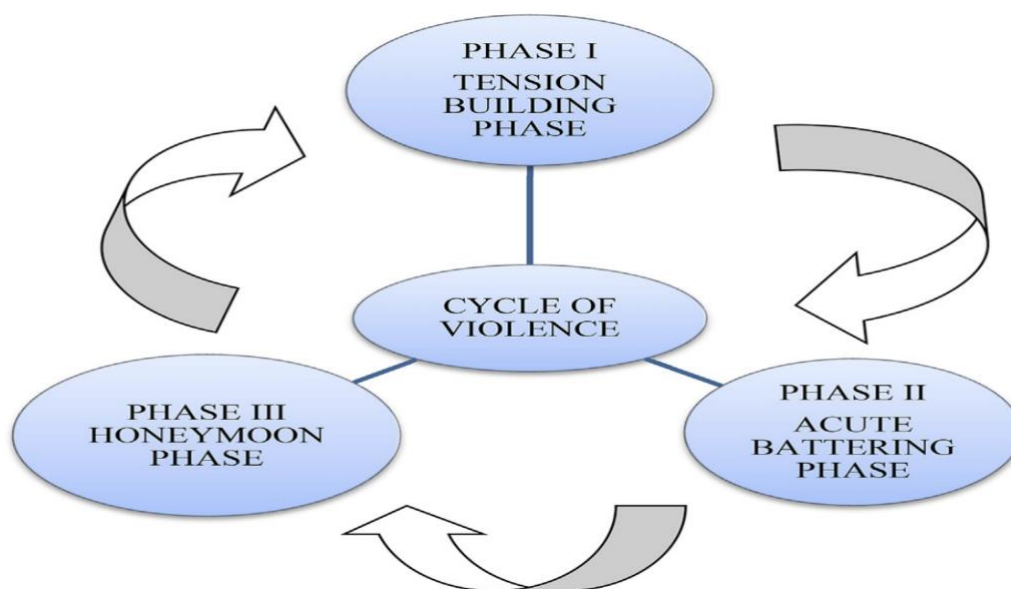


Figure 8: The cycle of violence (Sangeetha et al 2022 p 5)

This theory is still as pervasive as it is controversial. According to Sangeetha et al., (2022), Walker's 1979 text 'The Battered Woman' is still one of the most cited sources in domestic violence literature, according to the Social Science Citation Index and still holds prominence in the criminal justice system as a legal defence (Ferraro, 2017). Ali and Naylor (2013) point out that this theory has been heavily criticised for failing to acknowledge wider environmental and structural factors rendering it difficult for a woman to leave an abusive relationship and does not acknowledge the conscious efforts of women actively trying to minimise, resist, escape or survive abuse (2013, p 613). Kelly's (2003) revision of Lungren's (1998) concept of 'space for action' is a useful framework for considering the actions taken by domestic abuse survivors within

contexts that are increasingly constrained by oppression, control, material and structural forces. Lungren argues that gender violence decreases women's space for action, whilst simultaneously increasing men's (Kelly, 2003, p 143).

Sharp-Jeffs et al (2018) presented statistical evidence from 100 women who had engaged with domestic abuse services and completed two scales measuring coercive control and over a period of three years. Their findings show a significant correlation between coercive control and space for action. However, dealing with violence is not a linear process, and support needs to extend beyond being enabled to separate. Sharp-Jeffs et al (2018) highlight the importance of services recognising how post separation abuse continues to endanger women and limit their space for action. They caution against the choices made by commissioners that prioritize "short-term risk reduction and time-limited interventions," which results in a decrease in resources allocated to addressing the long-term support needs identified in this study. They argue that ongoing support is essential for women to both "feel" and "be" safe. The scales enhance the measurement of women's experiences of coercive control and, through the space for action scale, assess their ability to regain Service And freedom within contexts of relative safety. The authors utilised the nested ecological model of intimate partner violence (IPV) developed by Dutton et al. (2006) to create their Coercive Control Measure. This model outlines several domains through which power can be exercised, including individual, social, economic, and community levels.

The next section of the literature review explores how ideas around the professional response to domestic abuse in the UK have evolved and developed, specifically pertaining to ideas around risk and responsibility, mother blame in the context of child protection contexts as well as statutory and voluntary service provisions.

Evolution of Professional Discourse and Response to Domestic Abuse

Risk and Responsibility

Coy and Kelly (2019) chart the evolution of discourse and professional practice in relation to domestic abuse in England and Wales, stating that 'within a decade, risk had overtaken safety in domestic violence discourses in England and Wales with risk assessment becoming a screening filter: entitlement to services is now organised

hierarchically according to level of risk' (2019, p 152). Many of the early tools for risk assessment in relation to domestic abuse (Danger Assessment, Campbell et al. 2009; Spousal Assault Risk Assessment, Kropp et al. 1995; the Domestic Violence Screening Inventory, Williams and Houghton 2004 and the Ontario Domestic Assault Risk Assessment, Hilton et al. 2010) originated for use in clinical and probation settings and were adopted by victim advocates to guide safety planning before being extended to policing practice (Turner et al., 2019).

Within the UK, the standardised tool utilised by police forces and organizations working directly with victims of domestic abuse is the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment. The DASH aims to identify domestic abuse victims at high risk of serious harm (CAA domestic abuse 2012) for referral to Multi-Agency Risk Assessment Conferences (MARACs) - multiagency panels producing coordinated action plans to increase victims' safety and to manage perpetrators' behaviour. Some statutory practices associated with MARAC seem to directly contradict some of the priorities of the voluntary sector, for example, cases deemed to be 'high risk' can be referred to MARAC without the consent of the survivor in the case, which could clearly infringe upon the principle of survivor self-determination.

Humphreys et al. (2005) warned that the risk discourse could serve to delegitimise female survivor perspectives as it moved away from the idea that women could be the experts of and within their own lives. The DASH model (Richards, 2009) was authorised by the Association of Chief Police Officers (ACPO) and is now utilised by the majority of police forces, along with several partner organizations across the UK who are working directly with victims of domestic abuse. This widespread adoption has led to a standardised approach to sharing knowledge about risk both within agencies and among them. The DASH assessment tool includes screening questions designed to help identify and evaluate risk. Richards (2016) notes that the DASH is grounded in established best practices, incorporating evidence-based risk models such as SPECCS+ Risk Identification. The risk factors included in the DASH are informed by comprehensive research on various domestic abuse incidents and multi-agency Domestic Homicide Reviews (DHRs), which were introduced under section 9 of the Domestic Violence, Crime and Victims Act 2004.

Day et al. (2018) note that, despite changes in the definitions and legislation surrounding domestic abuse since 2009, the DASH risk assessment tool has remained mostly unchanged and unchallenged since its inception. However, there is a growing

body of literature questioning the efficacy of DASH. The College of Policing has acknowledged that they "found no research or evaluation to support the adoption of any one particular risk assessment tool over another" (College of Policing, 2015, p 3), allowing the DASH model to persist as a popular choice among practitioners in the field. Turner et al. (2019) report on the largest-scale study conducted in Europe, arguing that the risk assessment tool is not performing as expected. Each component of the DASH questionnaire demonstrates, at best, a weak ability to predict revictimization. The risk assessments made by officers relying on DASH show only marginal improvement over random chance.

Within the domestic abuse sphere, risk has 'become the compass which guides all other routes of intervention: risk assessment' (Coy & Kelly, 2019, p153). One key criticism of the risk discourse and associated risk screening tools such as MARAC or the DASH, is that they place a greater emphasis on incidents of physical and sexual violence than patterns of psychological harm (Myhill & Hohl 2016) or coercive control (Stark, 2007). This criticism has been partially addressed by the recent domestic abuse Act (2021) which includes coercive and controlling behaviour and the amendments made to the Serious Crime Act (2015) which removed the co-habitation requirement in the coercive or controlling behaviour offence, 'ensuring that post-separation abuse and familial domestic abuse is provided for when the victim and perpetrator do not live together' (Home Office, 2024). The Women's Aid Federation have also sought to address this through a focus on needs led intervention as opposed to risk led services (Women's Aid, 2016, p 6).

The notion of 'the responsible women' (Stanko, 1996, p 15) was introduced to describe the way in which the 'choices' of women are evaluated when determining the level of responsibility they hold for the violence inflicted upon them, concluding that 'the imprudent woman who lacks caution can be denied protection' (1997, p. 486). Garland introduced the concept of 'responsibilisation' (1996, 2001) in relation to the criminal justice system, which Goddard (2012) describes as a mechanism of neoliberal policy agenda which allows the state to transfer responsibility for welfare and safety from the state to communities and individuals. Coy and Kelly further illuminate the consequences of 'responsibilisation' or 'privatising responsibility' (2019, p. 153) that render risk management the responsibility of individuals, determined by their own agency, rather than any 'structural and institutional constraints that limit the possibilities for safety and freedom' (p. 153).

If individuals are to bear the burden of risk assessment and management then the role of the state becomes to educate and facilitate rationale and responsible citizens (Kelly, 2001) to make good choices (Kemshall, 2002). In relation to domestic abuse, the survivor is expected to make 'prudent choices' (Stanko, 1996, 1997) to avoid or escape the violence, and feminist scholars have long criticised the way in which the 'decisions' of a women experiencing domestic abuse are at once overly focussed upon and misunderstood. Some research has shown that the prevailing attitudes of professionals seems to echo the sentiments explored by Stanko (see above). Focus group data collected by Coy and Kelly (2019) from two multi-agency workshops found that 'responsibilisation' of female domestic abuse survivors was the strongest theme from both workshop group discussions:

'The extent to which women were responsibilised surprised us...expressed primarily through the twin principles of "providing information" and "choice" within the interlinked practice frames of "risk" and "child protection/safeguarding. Practitioners returned again and again to reflect on how women were making "bad" choices to stay with abusers, drawing their own roles as directing women to understand the risk they (and their children) faced: a risk that women were then expected to manage and minimise.".' (2019, p. 155)

Practitioners in this study saw themselves as able to positively steer women towards making the 'prudent' choice by educating them about abuse, helping them to identify themselves as an abuse survivor and making them aware of the support that is available to them. In this sense, information gathering, and provision is in itself seen as intervention, with little attention being paid to the survivor's material or structural context rendering them more or less able to act upon that information. In sharing the information, the responsibility is then passed to the recipient of that information, be it the survivor (Coy and Kelly, 2019) or indeed other professionals within a multi-agency setting; 'by passing on what they know to others, the others – or the multi-agency forum itself – become responsible for any actions that could, or should, flow from the knowledge' (2019, p. 155).

Meanwhile, some professionals viewed information sharing (particularly with survivors) through the lens of empowerment, increasing their level of understanding and awareness, so that they could make an 'informed decision' (p. 156). The authors (Coy & Kelly) emphasise that very few of the professionals discussed resources or

constraints in relation to a survivor's ability or 'space' to act. The prevailing sentiment seems to be that all a survivor of domestic abuse needs is an awareness of all the options to enable her, and this information will enable her to free herself from the abuse. This finding echoed a previous study by Silverstein & Spark (2007) who carried out a documentary analysis of the programme guide of a statutory service in Canada (Bridges Programme⁴) for women who experienced domestic abuse and concluded that the programme placed a great emphasis on survivors 'choices and responsibility' (2007, p. 331) and 'reinforced individual responsabilisation as the strategy of freedom' (2007, p. 335).

Another key finding from Coy and Kelly's (2019) focus group study was the influence of the child protection paradigm in the professionals' thinking around assessing and intervening in domestic abuse cases; 'It was evident that since child protection trumped woman protection for agencies, so it should for women' (2019, p157). The professionals from across various agencies all seemed to agree that the presence of children legitimises the case for professional intervention, regardless of the woman's consent and any mother who stays with an abusive partner is framed as harmful to children, often phrased as a 'failure to protect' the child/children (Humphreys & Absler, 2011 p 464). Humphreys and Absler (2011 p 470) authors make an interesting point that this 'mother blaming' is often mirrored by 'worker blaming' of child protection workers which the authors point out is equally unhelpful.

Meanwhile, feminist researchers have also criticised statutory services in their re-framing of domestic abuse as a child protection issue (Brandon and Lewis, 1996), with emphasis on 'risk assessment and investigation' (Robbins & Cook, 2018, p 6). Feminist scholars have been a leading voice in the call for improvements in social work practice in relation to domestic abuse (Hamner and Itzen, 2000) and while many welcome and encourage the acknowledgement and consideration of violence towards mothers which previously went unacknowledged (Stanley, 1997; Humphreys, 2000; Maynard, 1985), this reframing of domestic abuse as a child protection issue has led to abused women being seen primarily as mothers who are assessed on their capacity to protect or shield their children from the abuse they experience (Peckover & Featherstone, 2007).

Mother Blame

Arnall & Stewart (2021) carried out a review of international literature on the construction of 'mother blame' (Millet 1969) and child welfare interventions with mothers experiencing domestic abuse. This enabled the authors to examine the operationalisation of mother blame in a social work context, leading to responsibilisation of mothers for violence perpetrated by their male abusers. The concept of responsibilisation was discussed earlier in this chapter (Ecological Theory) models as a mechanism by which welfare responsibilities can be moved from the state to the individual (Goddard, 2012), or to imply that a women who has had multiple adverse experiences must have an 'active role' (Baird, 2018, p 53) in bringing about these experiences. Coy and Kelly (2019) discuss impact of professional discourse on responsibilisation through practitioner's emphasis on providing 'information' and 'choices' to service users, without considering a survivor's ability of 'space' to act. (Coy and Kelly 2019, p. 155). In relation to mothers, researchers warn that the ways in which mothers are held responsible for the 'actions, behaviour, health and well-being of their (even adult) children' (Jackson & Mannix 2004 p 150) have become so insidious that it has achieved common-sense status within social work practice (Davies and Krane, 2006).

Many researchers warn that domestic abuse victims (who are predominantly mothers; ONS, 2019) are being blamed or further victimised by legislation, policy and discourse that may have unintentionally made domestic abuse victims visible and accountable while making perpetrators invisible (Lapierre, 2010; Hale et al., 2024; Arnall & Stewart, 2023; Wild, 2022; Buchanan & Moulding, 2021; Douglas & Walsh, 2010; Failure to Protect Working Group, 2000).). This concern is underpinned by the fact that domestic abuse perpetrators are usually less likely to engage with professionals (Heron & Eisma, 2021), meaning that the focus of safeguarding intervention is the non-abusive parent, who is held responsible for protecting her children from exposure to domestic abuse or other forms of harm (Hale et al., 2024; Cattagni Kleiner & Romain-Glassey, 2023).

Douglas and Walsh's (2010) research mapped out concerns highlighted within the literature about the social implications for mothers who have been held accountable for 'failing to protect' their children in the context of domestic abuse. Their review concluded that mothers in the UK often feel unjustly held accountable for domestic abuse, bearing the burden of responsibility for the behaviour of the perpetrators, while

receiving minimal support to aid their families. It argues that when Children's Services evaluate families in the context of domestic abuse concerns, mothers—who are victims themselves—are typically not recognised as such. Instead, they are viewed solely as caregivers responsible for the protection of their children.

The observation that a mother's contribution to maintaining the child's welfare and safety is prioritised with little consideration given to the father's efforts in this regard is not new (Phares and Compas, 1992; Davies and Krane 2006). At the widest layer of the ecological system (Macro), religious and cultural beliefs about ideal motherhood have been attributed to the persistence of some of the ideas around mothering in a context of domestic abuse, such as 'good mothers' being selfless and sacrificial (Ladd-Taylor, 2004).

In some instances, it was noted that fathers or perpetrators were not included in the assessment process. This leads to a situation where all blame, responsibility, and guilt are placed on the mother, who is often powerless to influence the behaviour of the perpetrator. Douglas and Walsh's (2010) review also examines additional literature on engaging with perpetrators and discusses the reluctance of social workers to work with aggressive men.

Through an ecological lens, the shifting idealised societal views (Chrono system and Macro system) of mothering could be seen as 'moving target, rendering it forever out of reach, 'elusive and unobtainable' (Arnull & Stewart, 2021), leaving an open invitation for mothers blame themselves, 'which can in turn make them vulnerable to the blame that is part and parcel of domestic violence' (Moulding et al., 2015, p 255). Indeed, most mothers who participated in recent UK based studies (Stewart & Arnull, 2023; Neale, 2018, Witt and Diaz, 2018; Keeling and Van Wormer, 2012) reported feeling blamed by professionals in relation to providing inadequate care for their children in the context of domestic abuse. The interaction between the Exo, Meso and Micro systems is particularly important when examining the role of professionals and service providers in the perpetuation of mother blame.

Moreover, despite evidence indicating that mothers and their children face a higher risk of harm when leaving an abusive relationship (Kelly, 2014; Refuge, 2017), mothers were threatened with the removal of their children if they did not exit the abusive situation (Arnull & Stewart, 2021). This pressure created a climate of fear around

engaging with child protection professionals; mothers were uncertain about what information the local authority might collect, causing them to avoid seeking assistance from other organizations for fear that it could be used against them.

The 'Roadmap for system change' report (Stanley et al., 2021) found that currently one role of independent domestic abuse services is to advocate with children's social care on behalf of mothers who are experiencing or threatened with child protection proceedings and to support mothers in their negotiations with children's social care.

According to Wendt et al. (2021), there is a limited understanding of the challenges, opportunities, and key strategies identified by practitioners involved in collaborative service responses. Macvean et al. (2015) identified several barriers to successful collaboration between child protection social workers and domestic abuse workers including: concerns about the repercussions of mandatory child protection referrals (such as the potential removal of children), variations in organizational philosophies, discrepancies in risk assessments, the exclusion of perpetrators from child protection interventions, an overwhelming focus on mothers evaluated in terms of their perceived "failure to protect," and a lack of appropriate governance and administrative structures.

Changes in safeguarding legislation and policy (Chapter3: Legislative Framework) mean that there are a larger number of families involved with children's social care due to concerns around domestic abuse than ever before, with domestic abuse being identified as the most common factor identified at the end of assessment for children in need (Department for Education, 2021 cited in McAllister, 2022). In conjunction with austerity measures and cuts to services, existing service providers and institutions are overstretched and unable to adequately deal with the volume of domestic abuse cases in their jurisdiction. In an attempt to make their workloads more 'manageable', Neale (2018 p 7) concluded that professionals tend to prioritise work with the domestic abuse victim (usually the mother) who is more visible, available and willing to engage with services than the perpetrator, who is effectively ignored (Neale 2018).

Marianne Hester published an article (2011) in the British Journal of Social Work that explained the frustrations, contradictions, and challenges of working at the intersection of domestic and family violence (DFV) and child protection (Hester, 2011). She has long argued that a unified, coordinated, collaborative approach and an acknowledgement of the processes of gendering within this context is needed to deal more effectively with DFV in child protection settings. Evidence of the prevalence of

domestic abuse in the families who are referred to child protection services has highlighted the urgency of concerted efforts to build collaboration between child protection services and specialist domestic abuse services (Laing et al., 2018). Humphreys and Healey (2017) argue that, for child protection to have a meaningful presence in domestic abuse work, training of practitioners is not enough; major changes in culture and service systems are required. They argue that, given that child protection is a statutory service, any interface with others in the domestic abuse service system will require this foundational change.

Statutory and Third Sector Service Provisions

Women's services within the UK are set up specifically to support women, and often they offer specialist domestic abuse support. As they are often third sector organisations, their approaches and remit differ for both adults' and children's statutory services, adopting a more feminist approach (Stewart & Arnull, 2022). Robbins et al (2016) highlight the contrast between grassroots, community-based responses to domestic abuse 'originally informed by second wave feminist activism' (2016, p5) and domestic abuse within a social care and safeguarding context, more 'informed by case-management and risk assessment' (2016, p5). The authors highlight the way in which these differing approaches are illuminated through differing linguistic descriptions of abusive behaviour:

'Safeguarding uses terms such as financial abuse, sexual abuse or theft, fraud and assault. The emphasis is on the criminal or dishonest behaviours. However, domestic abuse uses terms such as victim, perpetrator and survivor concentrating on coercive and controlling behaviours, with an emphasis on power and intimacy.' (Robbins et al., 2016, p5)

Voluntary services could be seen as offering a discourse more aligned to the welfare and rights of women, while statutory services place their emphasis on 'child protection, risk and investigation' (Robbins & Cook, 2018, p 6). While Hester (2011) and other have argued that the remits of voluntary sector organisations (VSOs) and statutory services are misaligned or conflictual, others have raised concern about VSOs being overly shaped and stifled by their increasing dependency on state funding and thus losing their distinct and independent identities (Williams, 2016, p 212).

In some ways, understanding of the voluntary sector and how it is embraced or even controlled by the state is much more complex. While the statutory understanding and response to domestic abuse can be traced to the influence and evolution of cultural and political contexts through time and space, the way in which voluntary services approach domestic abuse is much less easily defined, or homogenous. In essence, voluntary organisations were founded on the principle of independence from the prevailing policy and political climate. The overarching purpose of any voluntary service organisation is to advocate and prioritise the interests of the community it serves, advocating on behalf of the under-resourced, marginalised or oppressed communities they represent (Williams, 2016).

Others point to the potential benefits of statutory and voluntary services becoming more complementary and unified in their goals, increasing the opportunities for 'smart, joined up and reflective inter-agency cooperation to assist the vulnerable and to support victims' (Punch & James, 2017). Arriving at and establishing cooperation between the two sectors has been a prolonged and even vacillating process. Social Services can be friend or foe, depending upon the focus of the assessment and intervention. Conversely services provided by the voluntary sector are generally well-received from the perspective of survivors (Hanmer & Itzin, 2000; Humphreys & Thiara, 2003), but under-resourced (Bostock et al, 2009).

Training and Professionalisation of the Domestic Abuse Sector

The advocacy model for domestic abuse support was initially developed in North America (Bates & Douglas, 2020) and was later adopted by the UK when the concept of Independent Domestic Violence Advisors (IDVAs) was first introduced by the Labour Government in their 2005 National Action Plan (Home Office, 2005). The IDVA model of intervention was designed to be delivered from the point of crisis over a relatively short period of time (Speed, 2022 p 353) and to provide alternative options for victims of domestic abuse who did not want to leave their home but were still in need of additional support (Howarth & Robinson, 2016).

In conjunction with the establishment of the Independent Domestic Violence Advisor (IDVA) role, two pivotal initiatives emerged: the Multi-Agency Risk Assessment Conferences (MARACs) and the Specialist Domestic Violence Courts (SDVCs)

(Taylor-Dunn & Erol, 2020, p. 2). The Independent Domestic Violence Advocate fulfilled a crucial function in both contexts. In the first instance, their responsibilities included serving as a liaison for victims, ensuring that their perspectives were adequately represented and that the outcomes of the meeting were implemented, whereas in the second instance, they were tasked with offering assistance throughout the judicial process with a primary emphasis on safety.

The IDVA role is grounded in seven fundamental principles: independence from statutory services, professionalism through rigorous training, a focus on safety options, crisis intervention, support for high-risk victims, collaboration with both voluntary and statutory services, and a commitment to measurable outcomes aimed at reducing victim withdrawal rates (Home Office, 2005, p. 10; Taylor-Dunn & Erol, 2020, p. 2). Although IDVAs maintain independence from any single agency, they actively engage in collaborative efforts with a diverse range of domestic abuse services and organizations (Howarth et al., 2009). This independence is considered a vital element in fostering victim engagement and empowering advocates to challenge other agencies when necessary (Taylor-Dunn, 2016).

IDVAs play a crucial role in collaborating with statutory agencies to deliver comprehensive support to victims, focusing on mitigating immediate safety risks and addressing obstacles that hinder access to services (Howarth and Robinson, 2016, p. 44). It is currently recognised within academic discourse that the IDVA role is critically significant in the context of multi-agency collaboration and indeed serves to advocate for the victim during the MARACs SafeLives 2014), as well as facilitating victim support throughout the judicial proceedings (Court IDVA). A significant proportion (approximately 114) of respondents from SafeLives' (2021) study indicated that their experiences were notably enhanced by the presence of a court IDVA (SafeLives, 2021, p.6). Conversely, in the absence of an IDVA, victims articulated feelings of trauma associated with the court procedure, attributing this to 'a lack of comprehension from judges and other court officials; apprehensions regarding their safety and that of their children; inadequate interactions with CAFCASS and the courts, which permit perpetrators to exploit the system for coercive control' (Ibid, p.6).

IDVAs operating within community domestic abuse services typically undergo accredited training that equips them to assist victims in navigating legal proceedings, particularly in the process of applying for protective injunctions. Beyond legal support, these professionals extend their services to encompass various aspects of a victim's

life, including housing and welfare assistance, thereby ensuring a holistic approach to support (Speed, 2023, p. 353). Trained specifically to engage with high-risk victims of Intimate Partner Violence (IPV), particularly those who score 14 or above on the domestic abuse, Stalking and Honour Based Violence (DASH) risk assessment tool (SafeLives, 2015), IDVAs often intervene at critical moments. This includes instances following police interventions or when a victim has sought medical assistance. Their primary objective is to address safety concerns for both the victim and their children, guiding them through the initial stages of service engagement to explore options and develop safety plans (SafeLives, 2014; Bates & Douglas, 2020).

While most IDVAs receive accredited training through organizations such as SafeLives or WAFE, they operate within various organizations that may uphold distinct values and principles (Taylor-Dunn & Erol, 2020, p. 5). This disparity in training can lead to a two-tier system of support for victims, particularly when comparing the qualifications of court IDVAs with those of general IDVAs (Speed, 2022, p. 357). Advocacy support can also be provided by community domestic abuse services, but this assistance may not always come from qualified IDVAs. Instead, it may be delivered by support workers or advocates who have undergone varying levels of legal training (Kelly, 2008). The extent of training and the time allocated to advocacy work are likely to significantly influence the quality of support provided to victims (Speed, 2022, p. 354).

Bates and Douglas (2020) point out that domestic abuse advocacy is a profession 'in need of addition' (p 38) and state that practitioners in this sector could benefit from enhanced training and overall accessibility. Bates and Douglas (2020) go on to recommend that the sector must ensure that all IDVA practitioners are given 'gender-responsive training for staff' (p 39) and properly resourced (Tesch & Bekenan, 2015). Others have highlighted the importance of standardization and consistency in training standards and delivery for domestic abuse advocates (Wilson, 2013). Women's Aid recently advertised a 2024 refresh of the Women's Aid National Quality Standards (NQS) on their website; 'Our Gold Standard of accreditation now offers a robust, independent framework of good practice, informed by our 50 years leading the specialist domestic abuse sector and listening to survivors' (Women's Aid Website, 2024).

Wilson (2013) highlights the need for any intervention delivered by domestic abuse advocates to be underpinned by knowledge (p 45) and an evidence-based understanding of what works well in ensuring women and children's safety (O'Connor

and Wilson 2002). An advocate is expected to be able to use that knowledge in the 'development of skills employed in one-to-one interactions with women, in group work or as advocates for women with third parties' (Wilson, 2013, p 45). Kulkarni (2019) agrees that training is 'useful to help staff intentionally integrate Micro (individual/relationship) and Macro (organizational/societal) perspectives' (2019 p 60) when working with domestic abuse survivors.

Kulkarni (2019) highlights the importance of advocates being prepared with a 'thoughtful understanding of trauma and domestic abuse, as well as survivors' experiences of poverty, racism, and other forms of oppressions' (2019 p 60). Trauma training for domestic abuse advocates should also focus on the effects of trauma into all aspects of service (Kulkarni, 2019 p 59) as well as some knowledge about the neurobiological underpinnings trauma which can help advocates to appropriately normalize survivors' coping behaviours (Wilson et al. 2015). This knowledge could be essential in facilitating a positive working relationship between survivor and advocate which can be instrumental in facilitating survivor empowerment, self-determination and growth (Goodman et al. 2016).

Richardson (2001) posits the need for practitioners to know about concepts such as vicarious trauma (McCann & Pearlman, 1990) and develop appropriate self-care strategies to cope effectively with the various demands of their role and workplace stressors. Kulkarni (2019) goes further in insisting that advocates working for a 'trauma-informed' service provision should be expected to hold each other to account 'for adhering to trauma-informed principles in their work while also normalizing and supporting the real occupational impacts of secondary trauma and burnout' (2019 p 60).

Summary

This chapter begins by defining domestic abuse within a UK context and its prevalence as well as briefly discussing relevant legislative frameworks. The chapter then provides a detailed overview of theoretical frameworks relevant to domestic abuse enquiry including feminist theory, social learning theory, ecological theory, and the cycle of violence, citing other studies employing these ethical frameworks in their domestic abuse research. The chapter concludes with an exploration of the evolution of

professional discourses relating to domestic abuse service provision, specifically risk and responsibilities, mother blame and the relationship between statutory and third sector service provision for domestic abuse survivors.

This literature on how domestic abuse and indeed trauma have been understood by others through an ecological framework was particularly informative for this study. The conceptualisations of women's responses to domestic abuse as forms of support seeking strategies (both formal and informal) and resistance was useful in discerning the possible influence of psychological trauma in women's approach to seeking support for domestic abuse and how that could be perceived by others. While some forms of resistance or support seeking could be seen as inappropriate or unorthodox it will be important to establish how domestic abuse practitioners are conceptualising women's responses to domestic abuse and how trauma knowledge is influencing their thoughts and responses to survivors. It will also be important to learn more about this from the survivor participants, who are all seeking/have sought formal support from one the two domestic abuse services included within the study.

In reviewing the ways in which domestic abuse researchers have utilised the ecological framework, it was striking to find that most omitted any discussion (or even mention) of the Meso-system layer. This will inform this research in ensuring that the Meso-system layer is fully considered in relation to the findings.

The next chapter will discuss how trauma-informed approaches have been utilised by women's services, and other related movements in service provision such as the anti-violence movement and the consumer movement.

CHAPTER 4: LITERATURE ON TRAUMA-INFORMED SUPPORT FOR WOMEN

Introduction

Since the mid-1990s, trauma-informed care models have emerged across various sectors to help professionals work with individuals who have experienced trauma. This movement has often been driven by service providers without consistent government support (Salter et al., 2020). Trauma-informed care is praised for its non-pathologizing and victim-centred approach, shifting professional inquiries from 'What's wrong with you?' to 'What happened to you?' (Bloom, 1994, p. 476). However, Hendrix et al. (2021) argue that, under neoliberal conditions, professional understandings of trauma are reverting to more stigmatizing views, where symptoms are treated as individual and decontextualised issues within a managerial push for diagnosis and treatment. Although key advancements in trauma care were led by the women's movement, McKenzie-Mohr et al. (2012) note that much of the trauma-informed care literature fails to recognize the social contexts that contribute to trauma or advocate for social change. Tseris (2016) contends that individualised trauma-informed responses can undermine feminist perspectives on abuse, which view it as occurring within the context of gender inequality.

In reviewing the current body of literature on the use of trauma-informed approaches within domestic abuse services, the origins of the 'trauma-informed approach' (TIA) will be explored in relation to how it has been understood, defined and utilised in relation to domestic abuse survivors, services and organisational contexts, such as workforce training and wellbeing. This part of the literature review will explore how and why TIAs have been utilised in domestic abuse services and highlight some of the barriers and challenges for implementation.

Women's Aid and Trauma

This study focuses on the use of Trauma-informed Approaches designed as part of the 'Change that lasts' initiative, developed through collaboration between Women's Aid Federation England (WAFE) and SafeLives (SL), two third sector organisations working with victims of domestic abuse. As previously described (Chapter 1:

Background to PhD study) this study specifically focuses the ways in which Women's Aid has adopted and implemented these approaches as part of the 'Change That Lasts' model:

'Our Change That Lasts approach... is placing the survivor and her needs at the heart of the response to domestic abuse . Our approach recognises the strengths of survivors: they are experts in their own lives and know all too well the danger posed by their abuser and what they need to be able to escape the abuse....Expert Voices [VOICES] builds upon the emerging evidence from a pilot delivered by My Sisters Place. This pilot shows that a trauma-informed approach achieved significant positive benefits for the survivors involved' (Women's Aid, 2020).

This opening mission statement from Women's Aid illuminates varying and competing contexts for understanding and intervening in domestic abuse and how best to tackle it. On one hand, it is underpinned by the assumption that domestic abuse is a gendered issue (her needs), which aligns with a feminist social justice perspective that understands domestic abuse as, a problem 'rooted in the unequal power relations between men and women and as a central mechanism in maintaining inequality' (Roggeband, 2012) with an emphasis on escaping abuse. On the other, it champions a strength based, needs-led approach; language once synonymous with the grassroots Women's Movement, now increasingly being used within clinical and therapeutic settings, concerned with alleviating emotional distress at the level of the individual.

The recognition of survivors as 'experts in their own lives' speaks to the rejection of a 'professional as expert' model and the uptake of the 'experiential authority' model (Noorani, 2013) previously championed by the service user and survivor movements, concerned with redressing unequal power relations between professionals and service users (Johnstone & Boyle et al, 2018). However, the VOICES (also known as Expert Voices) intervention framework hinges upon expertise of professionals as trauma-informed domestic abuse 'experts'.

The language of Service And choice once associated with grassroots advocacy groups (antipsychiatry groups, the Women's Movement, survivor groups) has become synonymous with a consumerist model of public services and largely embraced by clinical therapeutic services which place an emphasis on building up internal resources

such as self-esteem and self-efficacy with much less focus on gender inequalities or structural oppression (Humphreys and Joseph, 2004).

Historical Context

In the 1970s, feminist practitioners began using the language of trauma to illustrate the profound effects of male violence on women and children within the socio-political landscape of gender inequality (Herman, 1997; Woodlock et al., 2022). During this time, responses to child abuse, domestic violence, and sexual assault were developed, coinciding with the rise of neoliberal ideologies and structures in the 1970s and 1980s (Bumiller, 2008). Some feminist scholars argue that the focus on mental health symptoms experienced by survivors of abuse provides a legitimate and recognised framework and a language for the psychological distress experienced by survivors (Herman 1992). Arnold and Ake highlight the potential benefits of recognising that 'mental health interventions could also serve the political goals of promoting women's empowerment and agency' (Arnold & Ake, 2013 p 563). Meanwhile, others have highlighted the ambivalent impact of the infusion of trauma theory within the Women's Movement (Burstow, 2003; Tseris, 2013). This critique is often rooted in the fear of pathologizing the survivors of violence rather than the perpetrators of violence. Humphreys and Joseph (2004) note that PTSD has had a particularly 'chequered history' in relation to gender-based and domestic violence (2004, p2).

Chequered History

As feminist ideology, which was previously confined to grassroots advocates, infiltrated the professional spheres of psychology and social work, concern grew about the way in which psychotherapy was being used to keep women from complaining about their situations (Chesler, 1970). This documented misapplication of psychotherapy led to the creation of women's committees in psychiatry, psychology, and social work, and these were largely responsible for blocking male psychiatrists in their efforts to add 'masochistic personality disorder' and 'self-defeating personality disorder' (Walker 2002) to the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM 3). Around the same time, trauma theory underwent a resurgence in interest in the wake of veterans' experiences of the Vietnam war, giving rise to the diagnosis of post-traumatic stress disorder. The diagnosis of post-traumatic stress was quickly

appropriated by the Women's Movement to illuminate the impact of adverse experiences predominantly experienced by women, such as childhood abuse, community violence, sexual harassment, sexual assault and immigration-related trauma (Killeen et al, 2008).

One reading of the evolution of trauma theory since its inception is that it has always been used in a way which places onus on the individual, from Freud's early theory on hysteria as a form of psychic trauma in women, to the notion of shellshock as a character flaw in veterans (Lannamann and McNamee, 2020). Therefore, it seems especially pertinent when considering the application of trauma theory to domestic abuse survivors to query the individualised focus of intervention alongside the risk of further compounding pre-existing victim blaming narratives in relation to abuse survivors. The question of why victims of domestic abuse do not simply leave the abusive relationship, or why they return to it (Anderson et al, 2003; Hayes and Jeffries, 2013) continues to be posed. The allocation of a trauma symptomology located within the individual survivor, in its most reductive interpretation, could place primary focus on the individualised response or perspective, inferring that survivors don't leave because they have a flawed perspective.

Few scholars have explicitly addressed the at times unpopular questions about how best to serve survivors who 'choose' to stay in or return to abusive relationships. Davies (2008) addresses this dilemma in a way which illuminates the impossibility of the 'choice' faced by survivors in her recognition that, for many women, the risks of the abuse itself may be perceived to be less dangerous than homelessness, poverty, the potential loss of child custody or the risk of her abuser murdering her if she leaves. This willingness to acknowledge and destigmatize the psychological complexity of the false choice survivors face could serve to reinforce the value in critically examining and working to change the systems in which the individual and the abusive relationship is situated.

The risk of the alternative is explained by Tseris (2013) who emphasises potentially detrimental impact that an overly simplistic or reductive understanding of trauma when describing a woman's psychological experience and 'choices' could have. Tseris (2013) states the language of trauma can 'carry hidden assumptions that constrain the possibilities for how a woman's identity can be constructed and understood...such as a presumption of lifelong difficulties, which can actually obstruct social justice and discredit the validity of a woman's telling of her own experience' (2013, p 7).

Trauma and the Anti-Violence Movement

Sweet (2018) traces the evolution of anti-violence organizations in North America during the 1970s and 1980s, highlighting the financial challenges they faced amid threats to their funding. While this current study is focused on the UK context, it is important to chart the evolution of the relationship between trauma and the anti-violence movement in North America, as this is where the conceptual integration of the two paradigms was forged and the North American experience foreshadowed the trajectory of trauma-informed approaches to women's services globally. Sweet (2018) asserts that in order to secure funding, leaders in the anti-violence sector had to establish themselves as “experts” in domestic abuse and demonstrate their capacity to coordinate community efforts against this issue. Specific legislation such as the Violence Against Women Act (1994) played a crucial role in galvanising the trend towards the professionalization of the anti-violence sector that started in the 1980s. It encouraged service providers to industrialise (Messner et al., 2015) and emphasise their clinical credentials and professional service delivery models while sidelining more politically oriented forms of activism.

Within the UK context, Ishkanian (2014) notes that the feminist ethos in some domestic abuse provision was somewhat diminished in the 1980s due to increased professionalization and a heavier reliance on statutory funding for service delivery (Lovenduski and Randall, 1993 p 308). However, women's organizations still played a significant role in bringing attention to domestic violence issues while maintaining a focus on the gendered nature of violence (Kelly, 2005).

Scott, Watson, and Williams (2020) assert that long before the term “trauma-informed” became popular, professionals and volunteers in various feminist services were already acting in accordance with trauma-informed principles. The authors make the case for a natural synergy between trauma-informed principles and the core ethos in the Women's Liberation Movement, evident in organizations like rape crisis centres and domestic violence services that emerged in the 1970s within the UK (Burgess and Holmstrom, 1974).

In North America, the utilisation and reliance on terminology and practices of psychological sciences became increasingly common in the effort towards

organizations gaining state recognition (Sweet, 2018). In the 1980s, acknowledging the significant psychological distress experienced by battered women was instrumental in situating domestic violence within the context of legal rights. This transition brought about a significant shift in the relationship between the anti-violence movement and psychological expertise, creating a more porous boundary between feminist activism and the field of psychological sciences. In some ways this legitimised the legal status of 'battered women' through a kind of "psychiatric victimology" (Fassin and Rechtman, 2009 p 114), deepening the bond between domestic violence and the psychological sciences. Expert psychological discourse had become a key instrument for advocacy efforts of victims' rights movements and anti-violence policymakers seeking state endorsement (Sweet, 2018).

By the early 1990s, trauma had evolved into a distinct speciality that attracted professionals from various disciplines outside official psychiatric boundaries, such as psychologists, social workers and victim advocates (Sweet, 2018). Fassin and Rechtman, (2009) chart an important evolution of trauma theory in this context, when newer trauma theories emphasised not only the need for therapeutic attention to the 'persistent psychological wounds' but also the importance of preventing further deterioration of the condition (2009 p. 124). Medicalised trauma theories began to address victims' experiences over extended periods, extending into the future (Sweet, 2014).

Judith Herman (1992) was instrumental in adapting psychiatric victimology to the experiences of abuse, through the introduction and development of 'complex trauma', which considers structural inequalities, oppression, and the continuous nature of trauma beyond singular traumatic events. Herman contended that advancements in psychiatric understanding of trauma could only be achieved through political movements such as feminism and anti-war activism. She described women's trauma as the 'combat neurosis of the sex war' (1992, p. 32), drawing parallels between the experiences of soldiers and the struggles of women within patriarchal systems. Herman situates trauma at the intersection of psychological and political analysis.

Sweet (2018) charts the relationship between the work of Herman and the activist Susan Schechter who began training mental health professionals by framing domestic violence through psychological theories and diagnostic profiles of abused women. Schechter introduced models that depicted "stages of abuse" and shared PTSD diagnostic criteria, though she privately expressed concerns that this approach was

overly 'medicalised' (Schechter cited in Sweet, 2018 p 105), echoing concerns of other leaders in the movement who often felt ambivalent about the advantages that trauma theory could provide. In 1990, the Wisconsin Coalition Against Domestic Violence published an article in their newsletter entitled, "Post-Traumatic Stress Disorder: A label that does not blame?" This highlighted scepticism about whether trauma theory could escape the pitfalls of psychiatric victim-blaming (Saunders cited in Sweet, 2018). Despite using PTSD criteria in her training sessions, Schechter expressed concern over the increasing emphasis on trauma theory within the field. She concluded that movement leaders should follow Herman's frameworks which advocate for a combination of trauma analysis and political context. Importantly, Schechter (cited in Sweet, 2018) stressed that practical strategies, such as safety planning, would be more beneficial for victims than traditional psychotherapy.

While trauma theory was instrumental in establishing legal recognition for battered women in the 1980s in North America, the 1990s witnessed a more pronounced incorporation of trauma concepts into the discourse surrounding domestic violence as it offered a framework that linked domestic abuse with internal psychological responses. The evolution of trauma theory and anti-violence movement as described solidified trauma as a comprehensive narrative that encompasses both political and psychological harm. The integration of trauma theory into the anti-violence movement also helped to strengthen connections with state agencies through available funding opportunities. As demand grew for qualified professionals capable of bridging the mental health treatment goals of mainstream institutions with the feminist-driven objectives of anti-violence organizations, the field of trauma offered a broad and compelling discourse of harm and suffering. This discourse allowed both political and individual psychological analyses to coexist, aiding in the legitimization of the movement's efforts.

Gender Neutrality and Commissioning of Trauma-informed Services

Becoming trauma-informed poses potential challenges and benefits to the domestic abuse sector in relation to funding and commissioning. The challenges faced by domestic abuse services in the UK are multifaceted and deeply intertwined with funding dynamics and systemic changes introduced by government policies. The Roadmap Evaluation Final Report (Stanley et al., 2021) highlights the negative impact of austerity measures, revealing that cuts in government funding since 2010 have led

to limited and short-term financial support for specialist organizations. This situation has increased the thresholds for statutory services, resulting in domestic abuse providers struggling to assist women with complex and entrenched needs due to a lack of resources elsewhere. This theme of inadequate resources continues in the 'Women Working to Support Women: Psychosocial Challenges' report (Burman et al., 2023), which details how frontline workers in community-based organizations face heightened pressure and psychological distress, particularly exacerbated by the COVID-19 pandemic. Both reports underscore that funding shortages not only compromise service delivery but also adversely affect the mental well-being of professionals in the sector, highlighting a dual crisis.

Further emphasizing the inequities in service provision, the report 'A Patchwork of Provision: How to Meet the Needs of Victims and Survivors Across England and Wales' (Jacobs, 2022) reveals significant disparities across regions, suggesting a 'postcode lottery' where access to support hinges on geographic location. This inconsistency is reinforced by Samuel's (2021) finding that over 20% of refuge services in England received no local authority funding in 2019/20, demonstrating the precarious conditions under which these organizations operate. Moreover, 'The Impact of Local Commissioning on Victim Services in England and Wales: An Empirical Study' (Simmonds, 2018) examines the implications of a shift towards local commissioning, which has created a fragmented funding landscape for victim services, particularly for those assisting survivors of domestic abuse. Barter et al. (2018) further discuss the complications arising from this localised strategy, noting that its reliance on short-term grants and competitive tendering exacerbates the instability of funding and undermines the ability to provide consistent, long-term support.

In summary, these reports illustrate how austerity measures have not only impeded the ability of domestic abuse services to meet immediate needs but have also introduced long-term challenges in organizational stability and workforce morale. The intersection of limited funding, high staff turnover, and varying regional access emphasises the significance of systemic support and consistent resource allocation in overcoming the barriers to effective domestic abuse intervention.

Some scholars have warned that the adoption of more neoliberal strategies for addressing gendered violence has resulted in efforts to decontextualize the issue, leading to the development of gender-blind services in response to fundamentally gendered violence (Kail, 2011; Towers and Walby, 2012; Ishkanian, 2014). There is

increasing concern that the current policy environment, characterised by austerity measures and a strong focus on cost-saving, favours more generalised service providers over specialised organizations, which are perceived as delivering better value for money (Ishkanian, 2014). While cost reduction is undoubtedly attractive to policymakers, many leading domestic abuse charities and experts warn that this shift towards generic providers could lead to a "potential loss of specialist knowledge, skills, and experience" essential for effective service delivery (Towers and Walby, 2012, p. 28). Additionally, they caution that opening services for competitive commissioning can lead to a decline in the stability and sustainability of women's organizations (Kail, 2011). This preference for generic providers is further exacerbated by a "gender-neutral" approach to commissioning in areas such as health, welfare, and criminal justice, which undermines the acknowledgment of the gendered nature of domestic violence (Nixon and Humphreys, 2010, p. 142). Walklate (2008) stresses the importance of recognizing that domestic violence is fundamentally a gendered crime.

Gadd (2012) posits that the measure of efficacy (or value for money) has evolved within domestic abuse sector, which has extended its provision beyond merely providing a bed for the night; services also encompass supporting survivors' recovery and empowerment, investing in educational and preventative programmes, and working with perpetrators of violence. Additionally, the interpretation of effectiveness varies depending on whether one is looking at it from the funder's or the service user's perspective.

Ishkanian, 2014 draws on an 'extensive literature review of policy documents, think tank publications' (2014, p 336) and conducted fifteen in-depth, semi-structured interviews with representatives from women's voluntary organizations in London, between September 2012 and February 2013. Some participants in this study expressed concern that the competitive tendering process prioritizes cost over quality in relation to refuge support for domestic abuse victims:

'Contracts are awarded based on the lowest competitive bid rather than on the organization's ethos... officials are more interested in hearing about cost savings than about human rights...this downgrades the skills base because care workers have fewer skills than specialist staff. But refuges aren't only about providing food and care, you need specialised skills to help women recover and rebuild their lives.' (Ishkanian, 2014, P 342)

At the policy level, there has been acknowledgment that trauma is a significant determinant of psychological distress in women and that trauma-informed services should complement, rather than replace, gender-informed services. Unfortunately, this recognition has not yet translated into practical changes, and it remains uncommon for women experiencing mental health issues to receive care that is both gender-sensitive and trauma-informed from statutory mental health services (Scott, Watson, and Williams, 2020). Fundamental aspects, such as systematically inquiring about women's experiences with abuse and trauma, still need to be integrated into routine practices to inform their care and treatment (Howard, 2018). Scott, Watson, and Williams (2020) assert that until this transformation occurs, feminist services will remain essential as models of effective practice and as providers of the mental health support that women seek and require. They also emphasize the vital role that commissioners play in sustaining and developing these services.

A potential limitation of professionalisation and institutionalisation of the domestic abuse sector and specifically of trauma-informed care in the domestic abuse sector is that mainstream recognition and funding streams require evidence-based interventions and clear outcome evaluations (Davies & Lyon, 2013; Goodman & Teintin, 2008). This emphasis does not easily lend itself to community-based prevention efforts or theory-driven frameworks (such as trauma-informed approaches). The focus on frontline services to become increasingly evidence-based and survivor-centred could serve to privilege the response to violence rather than prevention of it, responding to the individual level and neglecting the community level (Arnold & Ake, 2013).

The erosion of feminist politics within domestic violence organizations has been cited within the international literature base, particular research from the USA. Some have posited that a possible reason for domestic abuse organisation moving away from their feminist roots could be due the heightened levels of scrutiny imposed by funding entities, as noted by Wilson (2013). In an effort to secure essential financial resources from state bodies and more conservative funding sources, these organizations may strategically choose to temper or even abandon the language that frames domestic violence as a critical social and political issue. This shift in language is not merely a superficial alteration; it fundamentally transforms the frameworks through which organizations and their personnel interpret and engage with the world around them. As Lehrner and Allen (2008) highlight, such modifications in language can lead to a reconfiguration of meaning perspectives, prompting organizations and their workers to

adopt new understandings of their mission and objectives. Thompson (1997, p. 79) warned of the peril inherent in this kind of compromise, suggesting that in the relentless pursuit of funding and the stability it brings, organizations may inadvertently forget the values and principles that have been sacrificed. This dynamic is particularly concerning in the realm of domestic violence advocacy, where the political agenda aimed at fostering social change may be sidelined in favour of securing "a foothold in the system" (Thompson 1997, p. 79).

Wilson (2013) emphasizes the critical importance of ensuring that training, education, and mentoring are delivered through a radical feminist lens to safeguard against the pressures to conform. By maintaining a commitment to radical feminist principles in all educational and training endeavours, Wilson (2013) argues that organizations can better navigate the complexities of funding pressures while remaining steadfast in their mission to address domestic violence as a deeply rooted social and political issue.

Consumer Movement

SAMHSA (2014) suggest that 'the consumer movement' (Hickey & Kipling, 1998) propelled a wider paradigm shift across health services and offered some promise of moving away from a traditional paternalistic approach to a more inclusive and collaborative way of working that involved the client in the treatment process. This shift from the service providers being seen as the expert towards the view that service users are 'experts in their own lives' could be seen as a nod towards rejection of traditional biomedical psychiatric models of intervention (in which the provider is seen as the expert who determines the best course of treatment) which have been criticised for 'delegitimizing' people's own knowledge (Sweeney et al., 2018, p3) and privileging a 'power over' response to those entering services, positioning the practitioner or therapist as the 'expert' (Johnstone & Boyle, 2018). An alternative view is that a shift in language or terminology, i.e. 'strength based' and 'needs led', (Butler et al., 2011; Sweeney et al., 2016) represents an attempt to transfer accountability from institutions onto individuals or to discourage dependence on these institutions and thus reduce costs (Tomes, 2006).

Survivor led

It is important to highlight efforts made within the domestic abuse sector to push this

debate forward and think about the design and implementation of services that aim to help abuse survivors. Davies' work highlighted the crucial differences between "service-defined advocacy," premised on making women's decisions for them, and "woman-defined advocacy" (Davies, Lyon, & Monti-Catania, 1998) that was premised on individual women's own set of defined needs as the basis for action. The origins of 'woman-defined advocacy' may have been germinated in the women's movement's attempt to bring about a radical paradigm shift, but this idea of service user led service provision has since spread into a variety of other spheres, serving a variety of different political agendas.

Trauma-Informed Service Provision

All trauma-informed practices focus on establishing safety and trust, empowering individuals by providing choices and control, fostering resilience and strengths, and emphasizing personal and collective care and recovery. These approaches also prioritize inclusivity, shared purpose, and the addressing of cultural, racial, historical, and gender inequalities (SAMHSA, 2014; Sweeny, 2016). According to Scott, Watson and Williams (2020), these ten principles form the foundation of all feminist services and are widely recognised as the key attributes of any comprehensive trauma-informed service.

Adopting a trauma-informed approach (TIA) seeks to embed an understanding of how trauma experiences can significantly impact an individual's life course and outcomes, negatively affecting social outcomes, emotional wellbeing, mental and physical health, and health-related behaviour (Poole and Greaves, 2012). Harris and Fallot introduced the term "trauma-informed" in 2001 to incorporate an understanding of trauma and its after-effects into mental health services. The trauma-informed framework offered by Harris and Fallot builds on earlier feminist work on trauma, which shifted the focus from individual symptoms to the broader social context that fosters violence against women (Herman, 1992) and highlights the potential for common psychiatric practices to re-traumatize participants (Frueh et al., 2000). This initiative was driven by evidence showing that a significant number of people accessing mental health services were survivors of domestic abuse.

Advocates of trauma-informed service delivery being adopted across all human

services, such as hospitals and schools, see it as a way of ensuring that all services are welcoming and suitable for trauma survivors (SAMHSA, 2014; Haris and Fallot, 2001; Wilson et al., 2015). A trauma-informed care approach to service provision has been promoted as being particularly vital in helping trauma survivors to create new meanings in relation to their past experiences and restore a sense of control and autonomy in their lives (Goodman et al., 2014; Elliot et al., 2005; Lane et al., 2011). Berring et al. (2024) add that trauma-informed care is a strength-based and holistic framework for human services, which starts from the premise of assuming that individuals are likely to have experienced trauma. This framework acknowledges the impact trauma can have on service users, care providers, and the broader public. Trauma-informed care incorporates six core principles: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice, and choice, and cultural, historical, and gender considerations (SAMHSA, 2014).

TIC is notable for its emphasis on cultural change within helping organizations (Brown et al., 2013), necessitating the reshaping of administrative practices, policies, and services to embody core values such as safety, trust, choice, collaboration, and empowerment (Elliott et al., 2005; Harris & Fallot, 2001). While TIC encourages the adoption of specific evidence-based practices for trauma, its scope is more comprehensive.

Whilst the implementation of TIC has been an increasingly prevalent research focus of service evaluation studies and scoping reviews in the last 15 years, the majority of studies have focussed on the implementation of TIC within health care settings (Blazejewski, 2021; Robey et al., 2021; Kusmaul et al., 2019; Bruce et al., 2018; Isobel & Edwards., 2017; Oral et al, 2020; Wilson et al, 2017; Muskett, 2014; Wilson et al., 2021). Meanwhile, some larger reviews have focussed exclusively on the instruments or measures being used to evaluate TIC implementation in health care settings (Champine et al, 2019; Thirkle et al, 2021). Others focussed specifically on TIC training programmes for care providers (Gundacker et al 2021; Purtle, 2020). The implementation of TIC child and adolescent services is also well explored in the existing literature (Hanson & Lang, 2016; Avery et al., 2021; Bailey et al., 2019; Bendall et al., 2021; Berger, 2019; Bryson et al., 2017; Bunting et al., 2019; Fondren et al., 2020; Lowenthal, 2020; Hickie, 2018, 2019). There is a modest but growing body of literature focussing on the implementation of TIC in women's services (Chung et al., 2009; Hopper et al., 2010; Ward-Lasher et al., 2017; Yoon, 2021). Other aspects of service delivery in the TIC implementation literature include substance misuse support

services (Hales et al., 2019; Hales et al., 2017; Kirst et al., 2016) and disabilities services (Keesler & Isham, 2017; Keesler, 2016). Community wide TIC implementation studies are being undertaken in North America (Matlin et al., 2019; Damien et al., 2017; Hanson, 2021).

The larger scoping or systematic reviews on the implementation of TIC identify gaps or inconsistencies in the literature, such as the lack of unified definition for TIC (Champine et al., 2019), inconsistent methodologies for evaluating TIC, varied implementation procedures and limited involvement of trauma survivors (Berring et al., 2024). Given that evaluation and monitoring are described as an integral part of becoming trauma-informed (Ashby et al, 2019), the fact that only one review (Saunders et al 2023), was carried out in partnership with trauma survivors speaks to the lack of meaningful participation or co-production in research with experts by experience in this field, directly conflicting with the collaboration principle as outlined by SAMHSA (2014).

Trauma can impede an individual's ability to seek and engage with health and social services designed to assist them (Barrett, 2019). TIAs represent a paradigm shift in how services and professionals respond to clients, focusing on addressing root causes rather than surface symptoms. As previously discussed, (Chapter 4: Introduction) this approach reframes the core diagnostic question from "What is wrong with you?" to "What happened to you?" (Kimberly and Wheeler, 2019, p. 42; SAMHSA, 2014). It acknowledges that any person seeking services might be a trauma survivor and that care systems need to understand and mitigate the effects of trauma to facilitate recovery (Goodman et al., 2016, p. 748). The TIA recognizes that typical emotional, psychological, and social after-effects of trauma hinder an individual's ability to seek and engage with services designed to help them (Barrett, 2019). Moreover, when trauma survivors interact with services that do not recognize their trauma, it can result in further disengagement and exacerbation of issues like substance use and mental health problems.

The TIA posits that applying a 'trauma lens' can uncover the root causes of ill health and social difficulties, leading to more effective interventions and treatments. This has led to the redesign and reconceptualization of some health, care, and social services, utilizing the TIA framework to structure care delivery (Gerber, 2019; SAMHSA, 2014; Wilson et al., 2013; Dolezal and Gibson, 2022). The trauma-informed approach also incorporates the four R's framework; Realise, Recognise, Respond and avoid Re-traumatisation (SAMHSA, 2014): (1) realize the widespread impact of trauma and

understand potential paths for recovery; (2) recognize the signs and symptoms of trauma in clients, families, staff, and others within the system; (3) respond by fully integrating knowledge about trauma into policies, procedures, and practices; and (4) actively resist re-traumatization.

Similarities and Differences in How Trauma-informed Approaches Are Understood

A recent rapid evidence review of trauma-informed approaches (Department for Levelling Up, Housing and Communities, 2023) concluded that while there is no one central definition of what constitutes a trauma-informed approach, there are many points of consensus within the existing literature referring to 'trauma-informed approaches, trauma-informed care and trauma-informed systems' (2023, p 5). However, as McCarthy et al. (2020) note, despite the expanding literature on trauma-informed care, there is little clarity or consensus on a precise definition of the concept. Terms such as trauma-informed practice, trauma-informed care, trauma-informed approach, and trauma-informed systems are widely and often interchangeably used to describe programmes, organizations, or systems aimed at supporting individuals who have experienced trauma. However, these terms are often not clearly or consistently defined or operationalised (Hanson et al., 2018).

The difference between trauma-informed service delivery and trauma specific treatment is also broadly understood, with the former focussing on organisational processes and service delivery and the latter focussing on medical or evidence-based models that seek to treat the effects of trauma with specific therapies and other methods (Hopper et al., 2010; SAMHSA, 2014; Sweeney et al., 2016; Addis et al., 2020; McCarthy et al., 2020). As outlined by Berring et al. (2024), TIC is distinct from trauma-specific treatment (TST) such as prolonged exposure therapy or trauma-focused cognitive therapy, which are designed to treat trauma-related symptoms or PTSD. In contrast, Trauma-informed care (TIC) is understood as an organizational framework that encompasses the entire culture and practices of human service organizations, affecting all levels of management and operations, with each level influencing and being influenced by the others. Consequently, TIC necessitates careful prevention and avoidance of institutional processes and individual practices that might re-traumatize those who have previously experienced trauma.

Through organising commonalities around the four R's framework (SAMHSA, 2014), it is clear that much of the literature acknowledges the importance of Realising (R1) the widespread impact of trauma, Recognise (R2) signs of this and Respond (R3) accordingly (Hopper et al., 2010; SAMHSA, 2014; McCarthy et al., 2020). The Department for Levelling Up, Housing and Communities (2023) review found that recognition (R2) assumption was a particularly strong commonality in the literature, often phrased as 'adopting a trauma lens' which includes recognising the impact trauma has on the way people 'think feel and behave' and training staff to identify trauma and utilise trauma screening tools (Department for Levelling Up, Housing and Communities, 2023, p 12). There was less consensus in the literature about exactly how to respond (R3) but the trauma-informed principles of building safety and trust in relationships (Bath, 2008; Sweeney et al., 2017; Sweeney et al., 2016) emerged as common themes in the existing literature. Perhaps the strongest point of agreement was around the preventing Re-traumatisation (R4) principle which prioritises an understanding of how services can replicate power-over or oppressive relationships and trigger distress in trauma survivors (Infield and Boswell, 2020; Wilton & Williams, 2019; Hopper et al., 2010; SAMHSA, 2014; McCarthy et al., 2020).

Addressing disempowerment caused by traumatic situations and providing choice were both common themes in the literature exploring how to avoid replicating 'power-over' relational dynamics between practitioner and survivor (Harris and Fallot, 2001; SAMHSA, 2014; Sweeney et al., 2019; Filson & Mead, 2016). A related concept that was frequently considered within the literature was the importance of adopting a strengths-based approach which recognised the strengths and skills of those accessing a service (Willis & Ward, 2013; Hopper, 2010). Meanwhile Hanson and Lang (2016) point out that a strengths-based approach is in fact one of the least unique components of trauma-informed care but the most extensively implemented.

Table 3. Importance, Uniqueness, and Extent to Which TIC Components Were Implemented.

TIC Component	Importance to TIC, <i>M</i> (<i>SD</i>)	Extent Implemented, <i>M</i> (<i>SD</i>)	Unique to TIC, <i>M</i> (<i>SD</i>)
Required trauma training of all staff	3.74 (.66)	2.68 (1.28)	2.83 (1.27)
Positive, safe physical environment	3.72 (.59)	3.14 (1.17)	2.03 (1.55)
Availability of trained clinical providers of trauma EBP	3.62 (.73)	NA	2.86 (1.25)
Within agency collaboration/service coordination	3.57 (.68)	2.85 (1.14)	2.39 (1.30)
Reduce risk of retraumatization	3.55 (.81)	2.23 (1.32)	2.67
Strengths-based/promote positive development	3.54 (.77)	2.88 (1.17)	1.93 (1.49)
Outside agency collaboration/service coordination	3.50 (.76)	2.62 (1.16)	2.38 (1.31)
Knowledge in how to access trauma EBP	3.50 (.75)	2.70 (1.22)	2.54 (1.27)
Trauma history is always included in case/service plan	3.41 (.87)	2.65 (1.27)	2.58 (1.29)
Written policies that include trauma	3.37 (.90)	2.09 (1.45)	2.77 (1.23)
Use of standardized, trauma screening/assessment measures	3.36 (.94)	2.45 (1.43)	2.74 (1.29)
Address secondary traumatic stress	3.35 (.91)	2.05 (1.33)	2.59
Consumer engagement/input in system planning	3.2 (.94)	2.18 (1.36)	2.24 (1.30)
Measuring staff proficiency in defined criteria	3.16 (.91)	1.91 (1.37)	2.72 (1.24)
Defined leadership position for trauma services	2.96 (1.06)	1.94 (1.53)	2.73 (1.32)

Note. Scale: 0 = not at all; 1 = little; 2 = somewhat; 3 = mostly; 4 = very. TIC = trauma-informed care.

(Hanson and Lang, 2016, p 98)

Hanson and Lang carried out a web-based survey of 414 participants in the USA, all professionals across various systems and job functions, from child welfare (28%) behavioural health services (32%), education, juvenile justice, medical, public health, and other settings (40%). The survey included three questions related to the 15 TIC components: (1) How important was each to TIC, (2) To what extent had each been implemented within the respondent's agency, and (3) How unique was each to TIC, as opposed to reflecting good general standards of practice. Respondents rated each component on a 5-point Likert-type scale from 0 (not at all) to 4 (very). The results (see Table 3 above) indicated that while most of the 15 components were viewed as important to the definition of TIC, not all were considered to be unique. Specifically, the components considered least unique to TIC (strengths-based/promotes positive development, having a positive, safe physical environment, consumer engagement, and collaboration within and across agencies) were the most commonly implemented (Hanson and Lang, 2016 p 96-97).

More broadly, positive relationships between practitioners and clients were seen as central to a trauma-informed approach, with an emphasis placed on connection (Bath, 2008) compassion and respect, empowering relationships and creating hope (Sweeney et al. 2018; DHSC, 2018; Bath, 2008). Additionally, the importance of staff wellbeing and support was frequently highlighted (Hanson and Lang, 2016; HMIP, 2020; Academic Science Health Network, 2021). Elliot et al. (2005) found that the principle of collaboration was the least well represented in the literature however, there has been a growing focus on meaningful co-production (Mahon, 2022; McGeown et al., 2023). Mahon (2022) concludes that more studies are needed that include information about the implementation of the trauma-informed principles of peer support

and cultural practices in relation to both service user and employee outcomes (2022, p 20).

There is a also growing body of literature focussing on the implementation of gender specific trauma-informed service delivery for women with complex needs or multiple disadvantages (Chung et al., 2009; Covington, 2019; Milaney et al., 2020; Monteith et al, 2022; Liu et al, 2024; Jolof et al, 2024; Boyce et al 2025).

Chung et al. (2009) looked at the efficacy of interventions across nine sites within North America targeted to provide trauma-informed integrated services in the treatment of women with co-occurring disorders. The study specifically included women, 'aged 18 or older with histories of interpersonal violence who had experienced mental health and substance use disorders within the last 5 years, at least one of which occurred within the last 30 days' (2009, p 377). Their primary data source was service recipients' self-reported data on service content. The study found strong evidence that the intervention increased the provision of trauma-informed and integrated services as well as services addressing mental health or substance use problems, which authors posit 'may have led to the improved clinical outcomes in both mental health and substance abuse problems' (2009 p 381).

Boyce et al (2025) completed one of the few UK based studies focussing on trauma-informed gender specific care for women with complex needs which includes the perspectives of both practitioners and service recipients. The study focussed on an outreach service working with women involved in street prostitution. The women accessing outreach support were often subject to multiple disadvantages and adversities including mental health issues, substance misuse, homelessness, and experience (past and present) of domestic abuse. Participants included six outreach workers and ten women, exploring the enablers and barriers to delivering trauma-informed and gender sensitive outreach for women involved in street-based prostitution. The outreach workers commented on the ways in which their trauma training had helped them to understand certain behaviours exhibited by the women as a consequence of the trauma they had experienced and emphasised the importance of staying calm. The study also concluded that the low status of outreach work 'presented challenges for securing a consistent and experienced workforce, which affected the sustainable delivery of trauma-informed outreach' (2025 p 206).

The outreach workers also commented on the challenge of working for a trauma informed service in a wider context of other services that were not trauma informed. The women spoke about the importance of their first interaction with outreach workers, stating a preference for workers to appear at ease, relaxed and calm. They also noted the importance of workers following up on their requests in order to build and earn trust and taking things at their own pace, and workers being insightful enough to 'read behind the lines' (2025 p 206). In relation to the aforementioned principles of a trauma informed approach (SAMHSA, 2014) safety, trust and choice emerged as dominant themes in from the testimonies of the workers and the women in terms of what is most important in creating effective working relationships with women with complex needs.

While there is some disagreement about what constitutes the key elements of TIC (Hanson & Lang, 2016), most agree that systems adopt TIC via multiple, intersecting pathways including workforce development; organisational development; leadership development; adoption of TIC policies, procedures, and protocols; restraint and seclusion reduction; use of trauma screening; and implementation of trauma-focused interventions (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011; Bloom & Farragher, 2013; Brown, Baker, & Wilcox, 2012; Harris & Fallot, 2001; Ko et al., 2008; SAMHSA, 2014). Many researchers argue that the implementation of TIC involves a vital cultural shift, where changes must occur across at all levels of an organization (Berring et al, 2024; Elwyn et al, 2017; Keesler, 2016; Kusmaul et al, 2015; Wilson et al, 2017; Hanson and Lang, 2016, Elliot et al, 2005). Relationships, psychological health and emotional literacy are prioritised in service design and delivery (Bloom, 1997, 2013; Kamer, 2016) and social or behavioural issues are reframed from problems to an expression of need for support or even as survival or coping strategies' (Berring, 2024).

TIA is expanding not only geographically but also in scope, being applied to an increasing range of public services, including those for children and youth, education, health services, probation, and policing (Dolezal and Gibson, 2022). In Western countries, the Trauma-informed Approach (TIA) has significantly influenced international policymaking. For example, in the United States, many programmes are designed to integrate TIA at federal, state, and community levels (Melz et al., 2019). In the United Kingdom, both the Scottish and Welsh governments are actively working to implement TIA across various public services (Scottish Government, 2020; Welsh Government, 2021). Similarly, in England, Manchester recently pledged their commitment to becoming ACE-aware, trauma informed and trauma responsive city by 2027 (Trauma-Informed Greater Manchester website, 2024).

The Lancashire Violence Reduction Network (LVRN) was established in 2019 to bring together public, private, third sector, community organisations and individuals in order to prevent and reduce violence, part of this (Youansamouth et al, 2020). One of the primary aims of the strategic partnership is for Lancashire to be a 'Trauma-Informed County' (2019, p 7).

Goldthorpe et al 2022 carried out An Evaluation of the LVRN Trauma Informed Lancashire Communities in four early-adopter sites (Blackburn with Darwen, Fleetwood, Skelmersdale and Southwest Burnley) between February and June 2022. The evaluation found that participants viewed trauma-informed (TI) approaches to community development positively, with the lead organisation influencing the implementation and effectiveness of these approaches. Previous community work and partnerships played significant roles in the success of TI strategies. The Covid-19 pandemic negatively impacted health and education services, hindering the capacity to implement TI approaches and suggestions for adapting TI training included shorter, online sessions for healthcare professionals. Some participants expressed discomfort with the term "trauma" in community contexts. The evaluation highlighted the importance of addressing socio-economic determinants of health;

'Factors associated with poverty and intersecting determinants including ethnicity, gender, housing, employment and disabilities all play a role in determining outcomes for individuals, particularly those living in communities with higher levels of deprivation. Evidence-based TI approaches may be more acceptable to participants, more effective and become better embedded in practice if these factors are acknowledged and included in the narrative and practice of trauma-informed approaches.' (Goldthorpe et al, 2022, p 42).

The quote above indicates a more structural and intersectional lens to trauma and related 'outcome measures', highlighting that it is important resist any attempts to decontextualise the multifaceted social or structural origins of trauma which characterise people's lives.

The study's limitation was the lack of input from service users, but the report recommends that future research focus on enhancing community engagement in evaluations and ensuring the voices of service users and community members.

The LVRN 2023-2024 annual report (2024) chart their progress from developing to implementing a whole system approach to preventing serious violence which includes adopting a trauma informed approach. Over 10,000 professionals from various statutory and third sector organisations have attended Trauma Informed Basic Awareness workshop and seven organisations have been awarded the One Small Thing 'Working with Trauma Quality Mark (2024, p6), with further 10 organisations are on target to receive the same recognition in 2024 (2024, p 19).

Other developments include TIP being included in strategic priority plans for children's services, the creation of NHS Trauma Informed Champions Network, the commissioning of an independent review of Lancashire Constabulary custody suites and collaboration between Lancashire and neighbouring regions to develop a 'Trauma Informed Northern Powerhouse' (LVRN annual report 2024, p 19).

The report notes a smaller reductions in rape (-10%), domestic abuse and violence (-9%), and violence with injury (-3%) from 2022 to 2023 while other violence categories such as aggravated burglary (-39%) and homicide (-38%) have seen significant reductions since the inception of the LVRN in 2019 to 2023.

An interesting finding from the report is that 82.5% of participants agreed/strongly agreed that trauma-informed practice has changed the way they think about their interactions with the people they work with and 72.5% of participants agreed/strongly agreed that trauma-informed practice has changed the way they discuss talk about the people they are working with within in their organisation. While the report does not use the ecological framework, the findings above allude to the possibility that TIAs could have the potential to impact both Micro and Meso-level communication in relation to service users.

Plymouth was one of the first English cities to declare itself as a 'trauma-informed city' (Plymouth City Council, 2021.). In 2019, a joint inspection report was carried out by Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMI Prob) focussing on 'the multi-agency response to 'front door' services, evaluating all forms of abuse, neglect and exploitation, as well as an evaluation of the responses to children's mental health in Plymouth' (JTAI inspection report, 2020 p 1).

The inspection highlighted that a trauma-informed approach has recently been embraced by leaders and members as a model of good practice. While the authors

note that this approach is 'starting to be visible in practice across the partnership' (JTAI inspection report, 2020 p 2), they concluded that it was too soon to evaluate the impact on children and families. They highlighted that quality assurance by the Plymouth and Torbay safeguarding children partnership was underdeveloped hindering the possibility of a 'robust analysis of the impact of statutory training and multi-Service Audits' (2020 p 2). The Plymouth Safeguarding Children Partnership (PSCP) Annual Report 2021-2022 included a summary from an 'Independent scrutineer' who stated that while they have 'seen evidence in how being trauma informed has changed attitudes and behaviours' (p 30) the partnership is not yet in a position to report on we 'how widely these outcomes are being experienced' (p 31). They state that 'Quality assurance measures are being developed within the partnership' in order to understand, fully, across all safeguarding activities the outcomes we are enabling' (p 31).

Berring et al (2024) considers the impact that traumatic experiences can have on organisations and conclude that if unresolved, they can 'create unsafe cultures with constant arousal, untrusting relationships, and the use of coercive measures' impacting practitioners and service users (Berring et al, 2024, p 2). The authors point out that while this could serve to underline the importance of trauma-informed service design in playing a central role in mitigating these negative consequences, there is still a great deal of uncertainty about how TIC should be implemented.

Trauma-Informed Services for Domestic Abuse Survivors

Amidst growing concern that domestic abuse programmes have moved away from a survivor-centred, social change-oriented approach toward a service-driven model (Davies & Lyon, 2013; Goodman & Epstein, 2008) and criticism of the refuge/shelter movement for imposing policies that can replicate coercive patterns of abuse (Glenn and Goodman, 2015), a growing number of domestic abuse researchers, policymakers, and practitioners have called for a renewed focus on developing services that provide adequate support for survivors (Wilson, 2015). Numerous academic commentaries promote the use of adopting a trauma-informed approach to domestic abuse service provision as a means of better protecting service users and practitioners (Elliot et al., 2005; Wilson et al., 2015; Hopper et al., 2010; Kulkarni et al., 2019; Purtle, 2020; Edelman, 2023)

Wilson et al (2015) found six main clusters reflected in their qualitative content analysis

of literature on trauma-informed practice in relation to domestic abuse services: promoting emotional safety, restoring choice and control, facilitating connection, supporting coping, responding to identity and context and building on strengths. Elliot et al.'s (2005) research explored the implementation of trauma-informed (TI) principles within TI services for women specifically (including domestic abuse services) and they identify ten core principles of trauma-informed services shown in Table three (below).

Principles and Implementation of Trauma-informed Services for Women	
Principle 1	Recognize the impact of violence and victimization on development and coping strategies
Principle 2	Identify recovery from trauma as a primary goal
Principle 3	Employ an empowerment model
Principle 4	Strive to maximize woman's choices and control over her recovery
Principle 5	Based in a relational collaboration
Principle 6	Create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance
Principle 7	Emphasize women's strengths, highlighting adaptations over symptoms and resilience over pathology
Principle 8	Aims to minimize the possibilities of re-traumatisation
Principle 9	Strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background
Principle 10	Solicit consumer input and involve consumers in designing and evaluating services

Table 3 Principles and Implementation of Trauma-informed Services for Women (Elliot et al, 2005 PP 465-469)

The Women, Co-Occurring Disorders, and Violence Study (WCDVS) (Mchugo et al., 2005) was a five-year, multi-site project which explored the interrelation between violence, trauma, and co-occurring mental health and substance use disorders among women. All sites employed trauma specific services that were integrated with substance abuse and mental health services. The sites highlighted their trauma group interventions as a major difference between the intervention and comparison conditions. The group-based, trauma-specific treatments included:

- Trauma Recovery and Empowerment Model (TREM; Fallot & Harris, 2002; Harris, 1998);
- Seeking Safety curriculum (Najavits, 2001; Najavits, Weiss, & Leise, 1996);
- Addiction and Trauma Recovery Model (ATRIUM; Miller & Guidry, 2001)
- Triad Group model (Clark & Fearday, 2003)

Crucially, this study provides and examines concrete examples of attempts by various organisations to implement TIC, detailing barriers as well as strategies for facilitating progress when going through organisational change. They highlight the importance of foundational TIC training and 'subsequently the establishment of a TIC workgroup charged with leading the implementation effort' (Yatchmenoff, et al., 2017, p169). Guarino et al., (2009) outline the key roles and responsibilities of a workgroup as: gathering information to identify strengths and challenges, recommending priorities for change, developing solutions or plans for action, monitoring results and changing agency policy to institutionalise trauma-informed practices (SAMHSA, 2014), all of which should 'sustain momentum across the organisation and to model trauma-informed practice' (Yatchmenoff, et al., 2017, p 169). The study found that integrated, trauma-informed models of substance use and mental health treatment for women were more effective than treatment that was not trauma-informed and did not cost more (Veysey & Clark, 2004). Giard et al. (2005) point out that, while this study 'represented a reasonable compromise between the demands of real-world service settings and the need for a scientifically rigorous evaluation' (Giard et al., 2005, p 425), future studies could benefit from focussing on and testing within real-world settings.

Research that fulfils this criterion is Ward-Lasher et al.'s study (2017) which used a case study approach to examine how practitioners and administrators implement trauma-informed care. The participants in this study were seven female employees of the housing agency (3 administrators and 4 practitioners) who worked directly with the Housing First programme. The researchers conducted qualitative semi-structured interviews with all participants as well as observing staff meetings and analysing client survey data collected previously by the agency. The questions for administrators focused on the programme's mission, goals and client outcomes, while practitioners' questions focused on their direct practice with clients.

However, the researchers did not interview service users, but rather analysed data taken from a quarterly survey administered by the agency that included statements related to client knowledge of domestic abuse, client self-esteem, client safety, knowledge of community resources and client perception of the programme, to which clients reported their responses under 'agree' or disagree.

One of the main findings from the staff interviews was the need for emotional safety in relation to clients being housed somewhere where they felt both physically and emotionally safe (Ward-Lasher et al., 2017, p211). Meanwhile, it should be noted that

defining emotional safety can prove to be a stumbling block for research and is subject to highly individual interpretation (Yatchmenoff, et al., 2017). Improving financial literacy to promote self-sufficiency was seen as a priority, as financial assistance during stabilisation could be triggering for those who had experienced financial abuse. Practitioners' risks of secondary trauma and burnout were acknowledged but only briefly explored, with the researchers simply stating that 'practitioners highlighted the positive impact of the agency's supportive culture and prioritisation of self-care for practitioners individually and as a team' (Ward-Lasher et al., 2017, p 211). The most noticeable limitation of this study is the lack of the survivors'/service user's perspective.

Wilson et al. (2015) note that, while a trauma-informed approach is considered best practice for many different service systems (including domestic abuse services), few studies have included service user perceptions of a trauma-informed approach and the impact this had on their experience of the service or intervention. Another limitation of Ward-Lasher et al.'s (2017) study is the lack of nuance or specificity in the description of interventions, for example 'trauma focussed' could encompass anything from 'a brief discussion of a women's traumatic experience' to 'therapy targeted specifically to help her deal with her trauma' (Ward-Lasher, 2017, p208).

Yatchmenoff, et al. (2017) 'consulted and/or facilitated a TIC change process for individual domestic abuse agencies, larger organisations, and inter-agency or cross-system initiatives' (2017, p 168). Their recommendations echo other authors (Elliot et al., 2005; Wilson et al., 2015), in emphasising that staff at all levels of the organisation should receive training in the core trauma knowledge areas: the nature and impact of trauma on brain development and functioning as well as how trauma shows up in service systems (retraumatizing clients, secondary trauma for staff); and the definition and principles of trauma-informed care (2017, p 169). More generally, researchers agree that essential components of TIC include awareness of trauma prevalence and implementing policies, procedures and practice that incorporate an understanding about the impact of TIC on service utilisation and engagement, (Guarino, et al 2009; Hopper et al., 2010; SAMHSA, 2014a). Elliot et al. (2005) highlight the importance of a trauma-informed approach within the wider organisational context of a service to mitigate the risk of retraumatizing clients and removing barriers to service provision, treatment, and recovery for victims (Saakvitne et al., 2000).

Fuller (2023) explored narratives of female survivors of IPV in Essex (UK) to better understand the role of Trauma Informed Care (TIC) through in-depth semi structured

interviews with ten survivors. Narrative analysis of survivor testimonies unearthed some existing gaps in service provision for this population. Fuller's (2023) recommendations for practitioners include; consideration of grief models to address impact of loss for IPV survivors, seek to understand survivor experiences of IPV instead of imposing clinical and traumagenic narratives, caution around setting trauma as a minimum threshold of distress for those accessing services, offering alternative forms of support such as non- talking practical, administrative and psych-education around IPV, intersectional consideration of the various factors that lead to self-stigmatisation, facilitating peer support, survivor-centred care and striking the right balance between empowerment and protection (Fuller, 2023, p 128-144).

Baird (2018) carried out in-depth interviews with 15 IPV survivors from southern Ontario, Canada, who had experienced IPV and attended counselling sessions. One of Baird's research aims was to examine the ways in which counselling service providers can better meet the needs of survivors. Some of the barriers identified by survivors included within her study included service limits, long waitlists, and access issues that women face when seeking counselling services (2018, p 132). Baird (2018) asserts that these barriers often exacerbate the trauma experienced by IPV survivors. The study generated five themes concerning the response of counselling services to IPV-related trauma including: counsellors being validating, connected, and knowledgeable; recognizing individual needs for multiple services; fighting to access services; not fitting into the 'survivor capsule' and creating accepting versus stigmatizing services (2018, p 74). These themes span across various layers of service delivery, from the Micro or interpersonal, to the Macro or societal layers. Baird's study emphasises the need for a broader more intersectional approach to service delivery that understands the complexity of women's experiences beyond domestic abuse and the need for services that address these complexities. In this sense, Baird is recommending that trauma-informed services should prioritize safety and empowerment across all organizational policies and practices, not just in targeted interventions. In a sense Baird is offering a critique of trauma-informed approaches in that they may not fully recognize the broader impacts of marginalization and oppression. The study calls for further research to understand how trauma occurs within cultural contexts and how demographic factors influence the experiences of trauma survivors.

A recent article by Warwick-Booth & Coan, (2024) discusses a qualitative evaluation of one voluntary service programme in the north of England, working to support

females with mental health needs, to provide trauma-informed group-based mental health support for women experiencing DVA. The sample included 34 women accessing the service, who took part in focus groups (N=26) and semi structured interviews (N=8), as well as 10 staff interviews (programme delivery staff and referrers from other agencies) and reflection logs (N=7).

The analysis of data followed a framework approach, based upon trauma-informed principles (Fallot and Harris, 2006), which underpinned the programmes delivery objectives. The evaluation concluded that the principles of trauma-informed support were evident in the service model, which led to positive outcomes for survivors who engaged with the programme. The authors suggest that findings from this evaluation suggests that domestic abuse voluntary sectors services can focus on the mental health needs of survivors through using a trauma-informed approach.

Safety and trust were closely intertwined and established within the support groups by setting and adhering to ground rules around things like confidentiality, keeping the location of the meeting private and avoiding triggering behaviours (such as door slamming or swearing) (2024, p 8). Survivors also highlighted the importance of not feeling pressured or judged and staff emphasised the importance of 'patience, care and soft persistence' (2024, p 8). While some of the women were mandated to attend the group by social services, others engaged on a voluntary basis, but the evaluation findings suggested that choice became particularly pertinent in the women deciding whether or not to continue engaging with the programme, while some survivors reporting feeling 'gutted' when they had to leave the programme in order to 'make space' for new referrals (2024, p 8). Choice was also linked with the removal of barriers in terms of accessing the groups (providing taxi's instead of public transport) and flexibility in terms of the focus and content of each session. Empowerment was linked to women feeling able to assert themselves, learn new things and be part of co-producing the service evaluation feedback events. Survivors accessing the group reported that it decreased their sense of social isolation, gave them something to look forward to and in some cases improved their mental health. One of the most consistent findings among survivors was their increased sense of awareness and knowledge about the signs and impacts of domestic abuse, on themselves and also on children who are exposed to domestic abuse.

Williams, et al. (2021) carried out a qualitative study to explore the impact of the COVID 19 pandemic on delivery of intimate partner violence care in Boston, USA. Specifically,

the study focussed on service provider 'perspectives on the provision of safe, equitable, trauma-informed care for intimate partner violence survivors during the COVID-19 pandemic' (2021 p 2).

Researchers carried out semi-structured interviews with 18 service providers across different disciplines including healthcare workers, social workers, lawyers, advocates, and housing specialists, who continued to work during the COVID19 pandemic. The interview schedule included questions about 'professional experience', 'adaptations and innovations', 'broader implications' and 'lessons learned' (2021, p 3).

Thematic analysis yielded four thematic domains including 'pandemic threat', community and system wide impacts', 'individual impacts' and 'adaptations and innovations' (2021, p4). At the level of service delivery, the professionals referred to widespread uncertainty, confusion and strained resources. They also spoke about societal pressures such as increasing inequity and loss of community. On an individual level, it was felt that the COVID19 lockdown and social distancing increased the risk of IPV for survivors and limited their abilities to access resources, such as limited technology access. For survivors who did not speak English as a first language or who were immigrants it was felt by professionals that their barriers to accessing appropriate care and support for exacerbated by language and cultural barriers. To address these challenges, providers spoke about being 'creative' and flexible' with remote working practices, prioritising emotional support and basic needs and trying to co-ordinate more with other services (2021, p 5).

Unfortunately, this study did not include the voices of survivors themselves which the authors acknowledge as a limitation, stating that survivor experiences and insights 'are essential to the evolution and development of provider practices' (2021 p 9).

One study that included the voices of both service users and service providers is Critelli & Yalim's (2021) exploration of 'service needs and paths to help seeking' for women of immigrant and refugee status experiencing domestic abuse in the USA. The study included 25 in-depth interviews with 10 service providers within organizations that serve domestic violence survivors and 15 programme users. It examined service needs and paths to help-seeking among these women through an intersectional and trauma-informed lens. Recommendations to improve service delivery and policies for this population are discussed. The study found that some of the barriers prohibiting women of immigrant and refugee status from reporting domestic abuse include:

language barriers, social isolation, lack of knowledge about services, amplified fears about reporting domestic abuse due to their immigration status and trauma history, stigma, and fear of community rejection.

Survivors highlighted a need for more culturally relevant forms of outreach through community leaders, ethnic community organisations and cultural brokers instead of telephone helplines, printed literature, or other media outreach (Critelli & Yalim, 2021, p 12). Survivors accessing domestic abuse service found certain aspects of service provision especially useful, such as legal support or assistance through the voluntary lawyers' programme or court based domestic violence advocates.

Practitioners emphasised the need for post-resettlement services that can support immigrant and refugee status women after the initial resettlement period has ended as this is when the cumulative effects of trauma really start to emerge. Service providers also advocated for a more nuanced understanding around the causes of domestic violence perpetration, beyond viewing it as a function of male dominance, to acknowledging additional factors such as acculturation stressors and changes in gender roles. They also highlighted the importance of cultural competence amongst those who provide legal and criminal justice services (Critelli & Yalim, 2021, p 14).

McConnell & Phelan (2022) carried out a pragmatic inquiry to generate a preliminary set of principles and domains of support to guide social service workers supporting women with intellectual disability who had experienced intimate partner violence in Canada. They triangulated 'engagement with relational theory, relevant published research, and original data gathered through interviews with five experienced social service workers' (McConnell & Phelan, 2022 p 5158). They conclude by offering a relational framework for inclusive, trauma-informed services aimed at fostering the relational autonomy of women with intellectual disability.

They emphasise four relational principles; reflexivity, recognition, solidarity and safety in working with IPV survivors who have an intellectual disability. They also highlight the following domains of support; 'safety planning', 'securing basic life needs', 'system navigation and advocacy', 'strengthening social relationships', 'knowledge and skills acquisition' and 'meaning work' (McConnell & Phelan, 2022 p 5161-5163).

In addition to advocating for the more commonly known principles of trauma-informed approaches (in accordance with SAMHSA principles and the four R's; 2014), they

advocate for the importance of a trauma-informed approach in promoting female autonomy through cultivation of self-trust and respect as well as the importance for practitioners to engage in 'meaning work' with the client (as defined by Jirek, 2017). Meaning work is defined as interventions with survivors that help them to rebuild 'a viable assumptive world that can account for their victimization and yet offer a nonthreatening, relatively positive view of the self and the world' (2017, p. 168). This work should involve helping a survivor to integrate their traumatic experiences psychologically, to grieve losses and to reconstruct more hopeful and affirming narratives about their self and the world.

Trauma Specific Interventions with Domestic Abuse Survivors

As research and practice guidance increasingly urge practitioners to move away from generic counselling support (Gray et al., 2015) towards 'evidence-based' interventions focusing on trauma-related distress, which have been shown to best enable posttraumatic symptom reductions (Foa, 2007; Nemeroff et al., 2006), an increasing amount of research specific attention to certain tools and modalities is becoming available. These tools and modalities include: trauma focused cognitive behavioural therapy (Stover et al, 2009); mind-body connection therapies (Franzblau et al, 2008); Expressive Writing (Koopman et al, 2005); Trauma-informed Brief Intervention (TIBI) therapy (Trabold et al., 2018); trauma-informed mindfulness based stress reduction (TI-MBSR) (Kelly & Garland, 2018); group based trauma-informed health intervention (Mchugo et al 2005; Reid et al, 2020; Gatz et al., 2007) and Cognitive processing therapy for PTSD in survivors of domestic abuse (Iverson et al., 2011, Kubany et al., 2004). Eye movement desensitisation and reprocessing (EMDR) is another treatment prevalent within the literature on trauma recovery for female survivors of domestic abuse (Tarquinio et al., 2012; Harris, et al., 2018; Schwarz et al., 2020). Other studies (Serrata et al., 2020; Sullivan et al., 2018) have measured the correlation between the use of trauma-informed practices and positive wellbeing and trauma-informed outcomes from the perspective of survivors using the TIP scale (Goodman et al., 2016).

Sullivan et al. (2017) conducted a small study to examine the effects of a trauma-informed approach on residents of domestic violence shelters in the United States, assessing changes in their thoughts and feelings. The survey, which included 57 participants, found that residents' perceptions of receiving trauma-informed care were

associated with increased self-efficacy and enhanced safety-related empowerment. However, there was no impact on depressive symptoms. It was believed that the support, empathy, and respect from staff members helped survivors recognize their own skills and strengths.

Lewis-O'Connor & Chadwick, (2015) examined health care experiences of survivors of gender-based violence who were referred for follow up care through the patient- and trauma-informed relationship-based framework. Leiberman et al. (2005) and Timmer et al. (2010) evaluated counselling/therapy programmes delivered to mothers and children and concluded that targeted parenting support programmes that specifically address domestic violence and abuse and adopt trauma-informed approaches to support improvements in parental mental health could be further developed.

Interventions aimed at fostering social support have similarly demonstrated effectiveness; for instance, Constantino et al. (2005) reported that their intervention group exhibited significantly lower levels of psychological distress in comparison to a control group. These findings underscore the importance of integrating comprehensive support systems that address both individual and communal needs, ultimately leading to more resilient coping strategies among trauma survivors.

Community-based interventions, such as low-threshold home-visiting programmes by trained mentors, have effectively reduced domestic abuse exposure and depression symptoms, enhancing social support. These findings advocate for integrating community approaches into mental health care to address trauma and promote resilience among survivors.

Cognitive behavioural therapy (CBT) based interventions (Iverson et al., 2011; Kubany et al., 2004) are among the most thoroughly researched interventions in the current body of literature pertaining specifically to victims of domestic abuse. Kubany et al. (2003, 2004) conducted the first clinical trials looking at the efficacy of trauma focussed cognitive therapy for domestic abuse survivors suffering from PTSD which found 'promising' improvements made by women who had undergone trauma focused CBT. Johnson et al (2011) devised the CBT programme to treat women who had experienced recent abuse and were now living in shelters. The Helping to Overcome PTSD through Empowerment (HOPE) programme was found to be effective in reducing the likelihood of experiencing abuse six months after leaving the shelter (12 times less likely than women who did not take part in the HOPE programme) and

improved mental health and wellbeing outcomes: women reported less emotional numbing, improvement in depression severity, improved empowerment and social support. Other studies (Crespo & Arinero, 2010; Kaslow et al, 2010) have supported Kubany et al's (2003, 2004) initial findings that trauma focussed cognitive therapies can be effective in reducing trauma symptoms in survivors of domestic abuse. A comprehensive review conducted by Eckhardt et al. (2013), which investigated the implementation of intervention programmes targeted at both offenders and victims of domestic abuse within the United States also concluded that CBT exhibited the most pronounced effects in the existing literature.

It is worth noting that EMDR and CBT are both modalities that lend themselves to randomised controlled trials and systematic reviews which are considered as the 'gold standard' (Johnstone & Boyle et al, 2018 p 42) of research within the dominant positivist framework and thus feature prevalently within the literature. However, there is still limited evidence of either approach being effective in the treatment of individuals with more complex presentations of trauma (Van der Kolk & Courtois, 2005). While Van Der Kolk (2002) and Herman (1992) suggest that diagnosis of complex PTSD would better encapsulate the effects and symptoms of interpersonal trauma and provide a better foundation for those supporting this population, others, such as Johnstone and Boyle et al, 2018, call for the tool of diagnosis to be abandoned altogether, along with concepts of an objective research stance. Instead, such authors advocate for a formulation model for working with people experiencing mental distress and promote eliciting service user feedback in practice and privilege anecdotal testimony/qualitative data within research.

The right response, according to survivors

Research has highlighted a significant gap in the understanding of the unique experiences and specific needs of women who are affected by domestic abuse , particularly in relation to the trauma they endure (McCarthy et al, 2020). Despite the growing awareness of this issue, the body of evidence remains fragmented, often relying on small-scale studies that do not capture the full spectrum of women's experiences. Existing literature indicates that traditional responses to domestic violence frequently fall short when addressing the complexities faced by women with multifaceted needs (NCDSV, 2019; Sharpen, 2018; Sosenko et al., 2020). In numerous interactions with general service providers, women who are experiencing

domestic or sexual violence, alongside other forms of disadvantage, are rarely prompted by professionals to discuss their experiences of abuse. This lack of inquiry not only reflects a systemic oversight but also signifies a missed opportunity to deliver the tailored support that these women require. The failure to engage in meaningful conversations about their trauma can lead to inadequate responses and perpetuate cycles of harm, ultimately undermining their recovery and well-being (McCarthy et al, 2020).

Furthermore, a significant number of practitioners who participated in Sharpen's comprehensive study (2018) articulated the viewpoint that women experiencing a confluence of disadvantages present a level of complexity that is challenging to address within the framework of Multi-Agency Risk Assessment Conferences (MARACs). These conferences are predominantly designed to concentrate on high-risk domestic abuse situations, with a strong emphasis on facilitating the exit from abusive relationships (McCarthy et al., 2020). However, for many women, the harsh reality is that they may still maintain ongoing relationships with their abusers. Numerous participants in Sharpen's (2018) study revealed that their immediate concerns often extended beyond domestic violence, indicating that issues such as financial stability, housing insecurity, and mental health may take precedence in their quest for support. This highlights a critical gap in the MARAC approach, as it may not fully accommodate the multifaceted needs of women who are navigating complex and intertwined challenges in their lives.

The Changing Lives study (Warnock, 2018) unveiled a significant barrier to effective support for women facing adversity: a pervasive lack of empathy and understanding among professionals regarding the complex situations these women navigate. Staff members involved in the research shared anecdotes about other professionals who openly declared their desire to sever ties with specific women, stating they "wanted nothing more to do with" them. This dismissive stance reflects a broader societal issue of victim-blaming, where the focus is disproportionately placed on the actions of the women rather than on the behaviours of their perpetrators or the systemic factors constraining their choices. Respondents emphasised that such attitudes not only perpetuate stigma but also fail to acknowledge the myriad challenges that victims confront. This lack of understanding can lead to a critical oversight: the failure to recognize the limited options available to these women, who are often ensnared in cycles of trauma and victimization. Instead of offering support and resources, the judgmental lens through which their situations are viewed exacerbates their struggles,

further isolating them from the help they need.

The Fulfilling Lives initiative (2014) summary report (Welford et al, 2022) in the UK highlighted alarming instances where individuals grappling with multiple disadvantages were systematically denied essential assessments. In many cases, symptoms stemming from traumatic experiences—such as substance abuse or behavioural issues—were mistakenly categorised as mere "lifestyle choices." This misinterpretation not only undermines the severity of their situations but also obstructs access to vital support services. As documented in the Fulfilling Lives programme summary by Welford et al., (2022), such misconceptions are detrimental to the well-being of those affected, as they prevent the implementation of appropriate interventions that could facilitate recovery and empowerment. Overall, these findings underscore the urgent need for a paradigm shift in how professionals' approach and understand the complexities of women's experiences, advocating for a more compassionate and informed response that prioritizes their needs and recognizes the systemic barriers they face.

Trauma-informed support services have been said to play a pivotal role in enhancing outcomes for women who have experienced trauma by acknowledging the intricate realities they face as survivors (McCarthy et al., 2020). Rather than adopting punitive measures that might lead to exclusion or premature case closures (Lamb et al., 2019), these services focus on understanding and supporting the unique needs of each individual. Research highlights that when professionals actively normalize and elucidate the varied responses and behaviours stemming from trauma, it fosters a significant improvement in the recovery process and bolsters the sense of safety among survivors. This underscores the necessity for staff to be well-versed in recognizing the manifestations of trauma in behaviour and to respond with empathy and effectiveness (MCDMC, 2018).

Moreover, the prior trauma experiences of clients, coupled with their hesitance to openly discuss these experiences, can severely compromise their ability to establish trust with service providers. This, in turn, can hinder the development of meaningful relationships with support staff (McCarthy et al., 2020). Some survivors may not yet feel ready or willing to confront their past traumas, which is a critical consideration (Tomkins and Neal, 2018). It is essential to approach inquiries regarding potential trauma-related issues with sensitivity and at various points throughout the service engagement, rather than limiting these discussions to initial assessments (Williamson

et al., 2013).

While the importance of cultural and gender competence is widely acknowledged as a cornerstone of best practice, many practitioners may lack a deep understanding of the power dynamics and cultural contexts that influence their work. This gap in awareness can inadvertently lead to paternalistic and disempowering interactions with clients (Sweeney et al., 2018). Numerous studies emphasize the significant benefits of practitioners possessing 'lived experience' or personal recovery journeys alongside relevant professional expertise in domestic abuse support (NCDSV, 2019; MCDMC, 2018; Tomkins and Neal, 2018). For women from Black, Asian, Minority Ethnic, and Refugee backgrounds, it is particularly vital to have specialists who can relate to their distinct experiences, as this facilitates support that is not only linguistically accessible but also rooted in genuine empathy (NCDSV, 2019). Furthermore, allowing women the autonomy to select the gender of their practitioner and providing access to female-only support spaces are recognised as fundamental elements for the healing process of those who have endured trauma or violence (DHSC, 2018).

As noted above, prioritizing client safety, especially at the onset of treatment, is of utmost importance. Sharpen (2018) highlights the critical role of non-verbal communication in service interactions, noting that women who have faced trauma often exhibit heightened vigilance, closely observing body language, eye contact, and the degree of active listening from their support staff. Adopting a holistic "whole woman approach," which transcends mere assessments of needs, is exemplified by the work of Women Centres that support women and families grappling with multifaceted challenges (Duffy and Hyde, 2014). The quality of relationships with support staff has emerged as one of the most valued aspects of assistance, as evidenced by a literature review conducted by Holly (2017). In Sharpen's (2018) study, the reliability and trustworthiness of support staff were identified as essential; if clients found it difficult to rely on staff for minor commitments—such as timely return calls—they were understandably hesitant to confide in them regarding more serious matters. This highlights the importance of building a foundation of trust and consistency in trauma-informed care.

Challenges/barriers to TIA implementation

Berring et al. (2024) concluded that TIC has no overarching structure or clear theoretical underpinnings that can guide practical implementations with various approaches to implementation across different settings and populations, making it difficult to synthesise or evaluate. Similarly, Yatchmenoff et al. (2017) note that, while trauma-informed care (TIC) is now recognised and encouraged across most human service systems, much of the current implementation strategies seem to 'rest on principles and values rather than specific recommendations for action' (Ibid, 2017, p 167). Hopper et al. (2010) highlight the need to distinguish the relative contribution of trauma-informed care, versus trauma-specific services. Becker-Blease (2017) emphasises that, while trauma-informed practices, such as hiring trauma-informed staff or providing trauma-focused treatment, are a step in the right direction, trauma-informed interventions are required not only at the individual but at the organizational levels (2017, 133). McKenzie-Mohr et al (2012) highlight that the successful implementation of trauma-informed systems hinges upon 'community and policy responses that redress inequalities in power and decision-making' (McKenzie-Mohr et al, 2012, p 139).

Trauma-informed care (TIC) is not an evidence-based modality with reliability measures and plainly delineated strategies (Yatchmenoff, et al., 2017) and, to add further confusion, there are multiple definitions as to what constitutes TIC (Hopper et al., 2010). Consequently, the vast majority of research to date has largely focussed on trauma-specific modalities (models of intervention to specifically address trauma), despite stating that they are evaluating trauma-informed service delivery. Trauma specific modalities offered by mental health services have developed in a context that already revolves around standardised assessment and diagnosis (Johnston et al., 2018, 2019; Burstow, 2003), which lends itself to clinical study. While clinically this makes 'intuitive sense' (Hopper, 2010), it has opened up a gap in research focusing on the usefulness, applicability or efficacy of trauma-informed care as a set of principles informing service delivery. Consequently, definitions of trauma and trauma-informed working remain inconsistent, 'fuzzy and complex' (Sweeny & Taggart, 2018, p383) and very few empirical studies have evaluated the implementation of a trauma-informed approach at the organisational level (i.e. inclusion of staff and organisational health).

As Goodman et al. (2016) point out: 'The extent to which programs have successfully translated TI principles into everyday practice remains unclear. Advocates, researchers, and policymakers are eager to learn whether programs have made this

translation successfully,' (Goodman et al., 2016, 759). Service providers and commissioners are calling for more concrete examples of what 'trauma-informed care' actually means for service delivery and for evidence on the most effective strategies at the organizational level to implement this approach at the organisational level (Bunting et al, 2019; Wilton et al, 2019).

Yatchmenoff, et al., 2017 highlight some of the more general challenges in the implementation of trauma-informed approaches within pre-existing service delivery models including: roll out, context, skill set, developing a shared understanding, inconsistent follow-up/maintenance, impact and resistance (p 179). While this information is useful in that it 'normalises the challenges inherent in the work (and the time involved) and sparks ideas for other changes that can be made' (2017, 181), the authors call for 'careful documentation' leading to more 'rigorous research efforts aimed at demonstrating how the significant changes that are occurring across many service systems may be improving outcomes for children, adults, and families in our communities.' (2017, p 181).

When considering how best to support and intervene in the lives of women who have experienced domestic abuse, mental health service providers often report feeling that they lack confidence (Rose et al., 2011) or expertise (Salyers et al., 2004) when working with domestic abuse survivors. Fear around retraumatizing service users (Trevillion et al., 2012b) and offering interventions that do not recognise trauma (Trevillion et al., 2012a) have also been highlighted as a potential barrier to adequate service provision for domestic abuse survivors who require mental health support. This serves to highlight the need for not only trauma-informed service provision but also trauma specific interventions for domestic abuse survivors.

Trauma-Informed Organisations: Impact on Staff

It is widely acknowledged in much of the research on the implementation of trauma-informed approaches at an organisational level (Elliot et al., 2005; Wilson et al., 2015; Yatchmenoff, et al., 2017) that staff at all levels of the organisation should receive training in the core trauma knowledge areas including how trauma 'shows up in service systems' (2017, p 169) which can include detrimental impacts on staff such as burnout, secondary trauma and vicarious traumatisation. Vrkleviski and Franklin (2008) point out that while these terms are often used interchangeably within the research,

their meanings are distinct and should not be conflated.

Burnout (Maslach & Jackson, 1981) is an occupational stress leading to exhaustion, loss of feelings of professional accomplishment and tendency to dehumanise service users and is measured by the Maslach Burnout Inventory (Maslach & Jackson, 1981). Burnout as a construct was not developed from trauma theory but has its roots in general organisational theories (Bell, Kulkarni & Dalton, 2003). Meanwhile the term Secondary Traumatic Stress (STS) was first coined by Figley (1983) which he later referred to as Compassion Fatigue (1995) to describe the negative emotional impact experienced by practitioners working with trauma survivors and those close to the traumatised person (such as hearing about or reading about the traumatic experiences of the survivor).

The secondary trauma stress scale was developed by Bride et al (2004). Symptoms of STS are akin to PTSD (such as intrusive thoughts or avoidance). Within the domestic abuse and sexual violence literature, STS or compassion fatigue (CF) has been identified as a significant issue among advocates (Baird & Jenkins, 2003). Figley asserted that STS is “the natural consequent behaviours and emotions...resulting from helping or wanting to help a traumatised or suffering person” (Figley, 1995, p. 7). Vicarious Traumatization (VT) (McCann & Pearlman, 1990) describes how exposure to the trauma of others can disrupt and permanently alter practitioners’ views of the world and of other people. VT impacts areas of cognition - thoughts and beliefs about benevolence, meaning, self-worth and trust. The standardised measure of vicarious trauma is the Vicarious Trauma Scale which was devised by Vrkleviski and Franklin (2008).

Much of the research on the impacts on service providers working with traumatised survivor groups typically focuses on posttraumatic stress disorder, burnout, and secondary traumatic stress (STS) (Bromley et al., 2024).

Secondary traumatic Stress, Vicarious Traumatization & Burnout in Domestic Abuse Organisations

Baird and Jenkins (2003) examined the relationship between experience, workload, and occupational stress in domestic and sexual violence agency staff (USA). They found that age and job role contributed significantly to burnout variance, particularly emotional exhaustion. They also found that greater client exposure did not correlate

with increased secondary traumatic stress or vicarious trauma, conversely their findings indicated that seeing more clients was associated with lower vicarious trauma symptoms. This could be related to the level of accomplishment reported by more experienced practitioners who have had higher client exposure in a cumulative sense. A level of accomplishment could indicate a stronger sense of self efficacy and control, parts of an individual's cognitive schema that are usually under threat in cases of vicarious traumatisation. The researchers attribute the sample's low prevalence of STS and VT symptoms to effective coping mechanisms and support systems and highlight the importance of structural support and personal accomplishment in mitigating burnout. They recommend further research on the relationship between client characteristics and their impact on practitioner stress levels.

Slattery and Goodman (2009) collected survey responses from 148 domestic abuse advocates working across diverse settings in Boston (USA) to identify workplace factors associated with secondary traumatic stress (STS). The study identified individual contributing factors as well as workplace organisation factors that contribute to the risk of practitioners developing STS. Slattery and Goodman (2009) findings echoed those from Baird and Jenkins (2003) in finding no correlation between direct service hours and PTSD symptoms. Slattery and Goodman (2009) found a strong correlation between survivor status (the practitioner's own past experiences of domestic abuse) and an increased vulnerability to STS.

In relation to mitigating factors, Slattery and Goodman (2009) found that higher coworker support was linked to lower STS symptoms among participants as well as good quality clinical supervision and perceived access to power in the workplace. The multivariate findings point to the importance of environmental protective factors outweighing individual risk factors, particularly the practitioner's perception of shared power in the workplace which was the only statistically significant predictor of STS. In other words, perceptions of shared power can override individual factors such as survivor status and direct service hours. These findings suggest that creating a workplace environment characterised by respect, equality, and mutual decision-making can be more effective in reducing STS than focusing solely on individual factors. This approach aligns with the feminist empowerment model, which emphasizes shared power as a central aspect of support services for both advocates and clients (Slattery and Goodman, 2009, p 1371). The importance of environmental or structural factors was also highlighted by Bober and Regher, (2005) who concluded that environmental/workplace factors such as reducing caseloads (or trauma

exposure) could be more important in mitigating against secondary or vicarious trauma than coping strategies such as self-care, leisure activities or even individual supervision.

Kulkarni et al.'s (2013) study comprised of a web-based survey with 236 domestic abuse practitioners from 'two statewide domestic violence coalitions located in the South and Southwest regions of the United States' (2013, p 119) to examine the key risk and protective factors that might contribute to the well-being of domestic violence service providers. Kulkarni et al.'s (2013) findings are similar to those of Slattery and Goodman (2009) in emphasising a correlation between the workers' perceived level of control over their work and risk of secondary traumatic stress. In Slattery and Goodman's (2009) research the emphasis is on a practitioner's perceived power in terms of decision making and sense of respect and equality at work, which Kulkarni et al (2013) refer specifically control over their work. While not identical, perceptions of power and control within the workplace are obviously related, and these studies indicate that practitioners who reported having little control over their work or low levels of power are significantly more at risk of developing STS.

An older study by Brown and O'Brien, (1998) and subsequent analysis by Glenn and Goodman (2015) points to an even more nuanced and complex relationship between a domestic abuse practitioner's sense of power and control and the development of secondary traumatic stress or burnout. Their qualitative study included interviews with 91 shelter workers found that the more these workers reported symptoms of emotional exhaustion and depersonalization (two of three key components of burnout), the more likely they were to cope by using "mental disengagement" when at work (Brown & O'Brien, 1998, p. 384). Glenn and Goodman (2015) conducted a qualitative descriptive study exploring domestic abuse survivors' experiences of living with domestic abuse shelter rules. The survivors reported a dearth of emotional support from refuge staff and an overly restrictive enforcement of refuge rules and regulations.

In discussing their findings, they cite Brown and O'Brien, (1998) to offer a possible explanation to explain staff behaviour as it was reported by survivors in their study. They suggest that in order to prevent further exposure to distress, 'staff members experiencing STS might use emotional and/or physical distancing to protect themselves from hearing details of residents' trauma, or from feeling overwhelmed by residents' needs' (2015, p 496). These findings suggest that STS and burnout could precede a kind of 'distancing' or 'disengagement' of staff towards survivors or even

that these coping mechanisms could be used as a protective strategy to prevent STS or burnout.

Kulkarni et al. (2013) found that compassion satisfaction is positively associated with higher levels of work experience in domestic violence services and with providers who share the values of their organization. The concept of compassion satisfaction is somewhat similar to the concept of workplace accomplishment, reported by more experienced practitioners who took part in the study by Baird and Jenkins (2003)(discussed above). Both compassion satisfaction and workplace accomplishment are shown to be important protective or mitigating factors for developing STS.

Organizational interventions that protect workers and promote these distinct dimensions of worker wellness can yield vital benefits associated with a healthy workforce such as high-quality supervision and manageable workloads. In relation to the latter, this study differed from Baird & Jenkins (2003) and Slattery and Goodman (2009) in that it did find a significant relationship between workload perceptions and secondary traumatic stress, accounting for 25% of variance. The study recommends that in addition to ensuring manageable workloads, leaders should foster a culture that encourages restorative activities and aligns with service providers' values.

Bromley et al. (2024) carried out a systematic review of empirical research and relevant grey literature, published in English to understand risk (vulnerability) and protective (adaptation) factors for domestic abuse and sexual violence advocates' well-being. The authors conclude that domestic abuse (and sexual violence) advocates may experience unique stressors, such as client situations, upholding refuge shelter rules and high staff turnover in the sector which pose financial and service quality challenges. They found that individual risk/vulnerability factors included neuroticism, communication anxiety, and low self-efficacy, recent life stress and being a younger age. At an organisational level, risks included colleagues' stress perception, poor working conditions, collaboration issues with professionals and negative societal attitudes towards them/their work – these can all pose risks to an advocate's wellbeing. Organisational factors that can help mitigate risks posed to practitioners include supportive colleagues as well as workplace support from their organisation. The authors note that quality supervision is essential but not universally supported in quantitative studies. As with Baird and Jenkins' (2003) study, Bromley et al. found no clear or significant correlation between experience level and workplace wellbeing for

advocates. While others have found a correlation between personal trauma history (Slattery and Goodman, 2009) and workplace stressor vulnerability, Bromley et al. found mixed results in this regard.

Feminist beliefs and occupational stigma were shown to affect advocates' well-being positively and negatively. The authors highlight that specialist domestic abuse and sexual violence organizations arose from the feminist movement, and offer advocacy based upon feminist principles (Hague, 2021). Wood (2014, 2020) asserts that this empowerment-based approach sets advocates apart from other professionals. Kulkarni et al. (2013) also emphasise the importance of practitioner alignment with service provider values but do not elaborate on the specific value base in question. Bromley et al. (2024) found that in relation to a feminist value base, advocates who endorsed strong feminist beliefs could be met with hostility resulting from negative occupational stereotypes. Meanwhile they could receive idealisation, encouragement or even sympathy resulting from favourable occupational stereotypes. While the negative occupational stereotypes can lead to avoidance and increased risk of burnout, the positive occupational stereotypes could lead advocates to experience 'higher levels of external social support and subsequently a reduction in feelings of burnout' (2024, p 1122). The study illustrates the same factors could lead advocates to experience both distress and positive reinforcement simultaneously

Summary

The chapter focuses on the evolution of trauma-informed service provision for women and starts with a contemporary definition and conceptualisation of trauma from the UK Women's Aid Federation which is the umbrella organisation to which both services included in this study belong to. The chapter charts the chequered history and evolution of how trauma knowledge has been utilised within women's service provision including the dangers of employing trauma theory in a way which dismisses the subjective lived experiences of women or omit a structural critique of conditions that render women particularly vulnerable to certain adverse experiences. The chapter goes on to discuss the development of the anti-violence movement, gender neutrality and commissioning as well as the influence of the consumer movement and gives some insight into the confluence of trauma theory and the domestic abuse sector. The chapter then goes on to examine how the introduction of training standards and

professionalisation of domestic abuse advocacy has influenced contemporary service provision. The chapter concludes exploring the literature on more contemporary manifestations of trauma-informed service provision more broadly before focussing on the seminal research on trauma-informed service provision for domestic abuse survivors.

The literature reviewed in this chapter was particularly pertinent to this study in its examination of the compatibility and dissonance with the ideological roots of women's service provision. The services included in this study both belong to the Women's Aid Federation which has an explicitly feminist working definition of trauma and trauma-informed service provision. It will be important to explore the ways in which the practitioners in this study are inhabiting their own professional identity as both women's advocates and trauma-informed practitioners.

On reviewing the literature on secondary traumatic stress, vicarious trauma, and burnout in relation to domestic abuse advocates it was interesting to see none of the research found a correlation between practitioner contact hours (with trauma survivors) or workload with the development of secondary traumatic stress but instead personal trauma history, unsupportive work environments and low job satisfaction rates and a perceived lack of control or power were all cited as significant risk factors. The psychological coping strategies employed by advocates in an attempt to cope with or avoid STS, burnout or VT included mental disengagement or distancing, which somewhat echoes a withdrawal or avoidance response associated with C-PTSD and PTSD. While this could be helping practitioner to cope in the short term it may have a longer-term detrimental effect on their ability to provide trauma-informed support to survivors. It will be important to identify the coping mechanisms employed with the practitioners in this study as well as the awareness of and support for STS, burnout and VT within each of the services.

The next chapter is the methodology chapter, which will outline methodological approach, research design and ethical considerations.

CHAPTER 5: METHODOLOGICAL APPROACH

Introduction

This chapter describes the methodological process undertaken to research trauma-informed service delivery using an in-depth case study focussing on two domestic abuse organisations in the Northeast of England. The research questions on which the study is based are defined at the start of the chapter followed by an account of the case study approach adopted. This section starts with the research aims and questions, followed by an explanation of the epistemological approach and positionality, research design, selection of participating organisations, designing the research tools, adaptations to and reflections on the research design. The chapter then describes the ethical framework, data collection and data analysis.

Research Questions

As discussed in the previous chapter, although a significant number of studies report on the efficacy of specific trauma focussed modalities with survivors of domestic abuse, qualitative research exploring the experiences of practitioners and survivors accessing trauma-informed domestic abuse services is currently limited. This research provides a detailed case study of the views and experiences of practitioners working in two trauma-informed domestic abuse services (Services A and B) and of survivors they support. In identifying this gap in the current knowledge base, this study aims to contribute by considering the following research questions:

1. How is a TIA being harnessed in the context of two specific domestic abuse service provisions?
2. How do domestic abuse practitioners understand and experience a TIA?
3. How do domestic abuse survivors understand and experience a TIA in relation to domestic abuse?
4. What are the key barriers and facilitating factors to implementing a TIA within domestic abuse service provision?

Epistemological Base

Consideration of Feminist Methodology

The site of this research is two sister organisations working to support women who have experienced/are experiencing domestic abuse. When considering my methodological stance in researching domestic abuse support services, it is important to highlight feminist research practice and its evolution in valuing women's distinctive and situated experiences as knowledge (Gloria Bowles & Duelli Klein, 1983; Smith, 1987, 1990; Stanley and Wise 1983). The properties and goals of feminist research in comparison to other traditional epistemological orientations have been the source of much debate (Harding, 1986; Hawkesworth, 1989; Nielsen, 1990) with many feminist scholars arguing for rejection of the positivist ideals of detached, emotionless and 'value free' enquiry (Harding, 2016, p 59).

The notion of the researcher as 'detached expert' may conjure images of colonial explorers, dismissing native populations as primitive, prioritising notions of rationality as a tool for dismissing the lived experience and cultures of those they wished to 'research' (Smith et al, 2013). Postmodernists and relativists have long argued that the very same ideals can be found across disciplines that promote the idea of 'experts ruling over other groups' (Cancian, 1992, p 623). This expert position conveniently avoids scrutiny of the researcher, or research practices, which one could argue defeats the very ideal of objectivity. In contrast, a key tenet of feminist research is reflexivity, which entails the researcher recognizing and examining how their own 'social backgrounds and assumptions can intervene in the research process' (Hesse-Biber & Leavy, 2010, p 120). Feminist research theorists encourage novice researchers to acknowledge and address issues of power and privilege within their research (including their role as the researcher) in a 'discursive' or 'active' way throughout the data collection process (i.e., in an interview situation with a participant), not merely in a retrospective or 'confessional' sense (Cooper & Burnett, 2006, p 120).

The concept of intersectionality (Crenshaw, 1989) illuminated dynamics between varying forms of oppression historically overlooked and oversimplified by the white feminist movement, or as bell hooks states, 'challenged the notion that gender was the primary factor determining a woman's fate' (2000 p xi). If the goal of research is to influence or bring about positive change, it is important to consider varying layers of resistance, from old epistemological hierarchal ideals which may seek to invalidate

intersectional feminist research, to wider socio-economic difficulties brought about by capitalist neo-liberal values, inhibiting the allocation of resources to services supporting women and girls.

In addition to valuing women's unique and situated experiences as knowledge, some feminists make the case for validating the importance of emotions and values as a critical lens in research (Jaggar 2000; Sprague & Zimmerman, 1993). Jaggar (2014) recognises emotion as a central aspect of knowledge building and argues that it is unrealistic to assume emotions and values do not surface during the research process. Emotions are an integral part of why a given topic or set of research questions is studied and how it is studied. The positivistic dualism between rational and emotional becomes a false dichotomy. In this study some questions were framed in a way that sought to foreground the sensory and embodied experience, for example "what does safety or trust feel like to you?". These questions sought to acknowledge the role of the body as an active and integrated component in the construction of narrative in relation to the experiences of domestic abuse survivors seeking support from domestic abuse services.

DeVault (1999) explains that because historically, women's perspectives have been silenced or ignored, there is an increased responsibility to listen to what women do not say as much as what they do say, and consider 'what meanings may lie beyond explicit speech?' (1999, p 217). DeVault speaks about the importance of listening for the gaps, attending to what is not said, but is present, such as hidden meanings of terms like 'you know?'. Qualitative research methods such as semi-structured interviews afford this opportunity, and these have been incorporated into the research design for this study.

The ontological position in relation to objective and subjective phenomena about trauma is complicated, not least because the concept of trauma has historically been defined and studied through a positivist lens within a medical paradigm, largely relying on randomised control trials (RCTs) that have been used to measure symptoms as well as treatment efficacy in symptom reduction. The ontological and epistemological framework for this research could best be categorised as interpretivist. In conducting this research, I aimed to understand subjective knowledge by eliciting participants' views and experiences around the implementation of the components of trauma-informed care and the principles of trauma-informed care within the context of domestic abuse service provision.

The ontological and epistemological approach to this case study has also drawn from embodied realist or phenomenological critiques of constructivism (Ringmar, 2015). Embodied realism holds that reality neither possess a fixed essence independent of perception (positivism) nor does it fully depend on the institutionalization of interpretations and practices (social constructionism). Rather, our bodily experience and ongoing patterns of interactions with the physical world are central to structuring our thoughts, interpretations, and actions through the transfer of conceptual correspondences from this experience to more abstract domains (Lakoff & Johnson, 1999). The embodied understanding of trauma acknowledges the physical manifestations of trauma at the level of the body, not least its impact on cardiovascular, respiratory, endocrine and neurological functioning (see Felitti et al 1998; Harris, 2015; Van Der Kolk, 2014; Cozolino, 2002; Rothschild, 2006; Maté, 2011).

In advocating for a 'both and' approach - a methodological co-operation between psychological and cultural enquiry - Overton (1997) argues that developmental cultural psychology needs to acknowledge the bi-directional influence of structure and agency, in that we must 'carefully identify the nature of the person who enters, who defines and is defined by the cultural context' (1997, p 316). As the researcher, I acknowledge that objective realities pertaining to physiological impacts of traumatic experiences and the subjective thoughts and feelings people hold about traumatic events as well as trauma recovery are intrinsically linked and bi-directional in their influence.

This study focuses on how the concept of trauma is understood and addressed within a situated context of specific domestic abuse service provisions, through the eyes of practitioners and survivors. The acknowledgement of feminist theories of gender and violence in relation to this type of trauma incorporates a social constructionist lens which acknowledges the socially constructed nature of gender and violence (Herman, 1992; Humphreys & Thiara, 2003; Tseris, 2013).

Positionality

My positionality as a researcher is being acknowledged in an attempt to further separate myself from the positivist notion of the impartial or objective observer. 'Objectivity' implies that the researcher or observer's opinions or values play no part in

the research process. This assumption suggests that 'the greater the distance there is between direct experience and its interpretation, the more reliable the resulting knowledge' (Beresford, 2016, p 29). This 'view from nowhere' stance has long been criticised by standpoint theorists such as the feminist philosopher of science Sandra Harding (1986, 2020) and many others (e.g. Allen, 1996; Collins, 2015; Hartsock, 1983; Prilleltensky, 2017; Sarason, 1981). Instead, standpoint theorists adopt a 'view from somewhere' approach, used to acknowledge a cultural, experiential and mental position from the world observed and interpreted. Harding and others have argued that these ideas particularly cannot be overlooked in relation to the study of life and human sciences with their tradition of sexism, heterosexism and racism (Harding, 1986, 2000).

In my social work training, I was introduced to ideas such as anti-oppressive practice, drawing from progress made by feminist and civil rights activists, intersectional scholars and survivor advocacy groups. As I progressed in my therapeutic training, much of my learning hinged upon ideas promoted by the 'cognitive turn' in psychology (Sampson 1981 cited in Johnstone and Boyle 2018 p 45) and the publication of the DSM-3 in psychiatry, which both placed high values on purportedly intrapsychic attributes, such as aspiration, motivation, internal locus of control, self-esteem, character and resilience, rather than acknowledging the role and influence of social institutions or structures. Johnstone and Boyle (2018) note the parallel shifts happening at this time (late 70s/early 80s) in political and economic approaches, such as the rise of neoliberalism which also placed emphasis on individual freedom, autonomy, choice, self-sufficiency and responsibility.

Beresford (2015) and McWade (2016) go further and state that the notion of 'recovery' in relation to mental distress has been co-opted in that personal responsibility for one's own recovery is increasingly advocated for, with an emphasis on returning to the labour market. I aim to reach beyond an emphasis on 'personal motivation' as this would inevitably place my research in the positivist or natural science paradigm and thus deny the impact of social injustice on people's lives. The dominance of the medical model in addressing impacts of domestic abuse (with a focus on symptom reduction or recovery) is reinforced by a positivist research paradigm being used to evaluate the efficacy of service provision based on the ability of the service to evidence symptom reduction. While I have worked in a variety of mental health and voluntary settings largely focussing on 'symptom reduction' and recovery, I question the emphasis being placed at the level of the individual, in its refusal to see the dynamic interplay of all elements of reality (Mbaegbu, 2016). This approach obstructs any acknowledgement

or investigation of the operation of power in people's lives such as oppressive structural processes and inequalities that shape women's experiences of abuse (Sweet, 2019). I wish to acknowledge the context in which I am situated and how best I might accommodate my research aims within that context. In choosing my area of study and committing to doctoral research, my aim was to produce findings that could contribute to bringing about meaningful change in the way that domestic abuse advocates, services and researchers understand and address trauma in relation to domestic abuse. While I may reject some of the philosophical underpinnings of medical and positivist intervention and research paradigm, I also acknowledge the importance of people using services being able to feel and report benefits or challenges they encounter through their engagement with service providers. My social work training and systemic practice training have both led me to consider how various aspects of an individual's context and environment interact to perpetuate or ameliorate the challenges any individual may face.

A systemic approach

Systemic theory has been criticised for 'failing to build bridges' (Loras & Sundelin, 2018, p 409) between the positivistic epistemological stance that underpins most real-world service provision contexts and social constructionist ideas that form the basis of much traditional systemic therapeutic training programmes. Loras and Sundelin (2018) point out that social constructionist ideas such as the 'not-knowing' position, introduced by Anderson and Goolishian (1988) has led to a conflation between the ethical position of the systemic practitioner and their knowledge base. The authors point out that the 'not-knowing' position actually describes the ethical position as a 'respectful conversational partner' to the client and should not in any way negate the systemic practitioner operationalising their knowledge about 'processes of therapeutic change and other sources of knowledge (i.e., bio-psycho-social models and well-known risk and protection factors)' (Loras & Sundelin, 2018, p 410). Another concept central to systemic theory and practice is the 'both-and' stance, which acknowledges multiple truths about any given phenomenon, rejecting the notion of one truth viewed as representative of 'the Truth' with a capital T (Hertz, 2003). Consequently, Loras and Sundelin (2018) have called for the need for systemic research to adopt a multi-epistemological position which consists of social constructionism, constructivism and critical realism which can acknowledge the value of survivor knowledge and practitioner expertise. While my research and interview schedules utilise categories

and definitions of trauma-informed care born out of positivist research, it aims to reach beyond pathology and symptom reduction and fully acknowledges the constructed nature of trauma and trauma-informed approaches.

Another useful concept from systemic theory is the social GRRAACCEESS acronym, which has been developed between Burnham (1992, 1993) and Roper-Hall (1998, 2008) since its origins in 1990. The GRRAACCEESS are used to encourage practitioners and supervisors to consider aspects of identity and experience such as Gender, Race, Religion, Age, Ability, Class, Culture, Ethnicity, Education, Sexuality and Spirituality which influence any given interaction. Burnham et al. (2008) suggest that issues of social difference are 'instrumental in the co-creation of contexts' (cited in Birdsey and Kustner 2021, p 431) for therapists and supervisors but application to researchers is scarce in the literature. While the GRRAACCEESS are not traditionally used by researchers, the intersectionality strands captured within the acronym clearly lends itself to any researcher reflecting on their positionality and considering the interpersonal impact of similarities or differences between researcher and research participant. Burnham later extended this framework to consider the visibility and non-visibility, and the voiced and unvoiced aspects of similarity or difference (Burnham, 2012).

Gender, age, education and work experience were all elements of my own identity that I have reflected on before, during and since conducting research interviews. Due to Covid 19 restrictions, I was only able to undertake two out of six survivor interviews and one out of 15 practitioner interviews face to face (see more on this in Covid 19 section). The rest were taken place over the phone rendering certain aspects of my identity invisible that would have been visible had we met in person such as age and gender. It is safe to assume that my gender (while not visible) was voiced through my verbal interaction with research participants and through sharing my name with them. As a woman, interviewing female practitioners and female survivors about a traditionally gendered concept (domestic abuse) could have afforded me a kind of 'insider' status (Merton, 1972; Hill-Collins, 1986; Mullings, 1999). Insider status can be helpful in facilitating access to research participants, particularly survivors in this case. Meanwhile, feminist scholars have highlighted some of the complexities of insider-outsider positioning of the researcher in relation to research participants (Hill-Collins, 1986) and emphasised the need to examine how notions of 'insider' and 'outsider' are constructed (Mullings, 1999).

While my age was not explicitly disclosed, there was some indication of my age through my voice. Conversely, survivor research participants shared their age with me on their participant information and consent forms (Appendix F), which allowed me to know that I was younger in age than all but one of the survivor participants. There were other aspects of shared experience or identity I had with both practitioners and survivors that remained invisible and unvoiced such as my professional experiences in working for the statutory and voluntary sectors and my own personal experiences of domestic abuse. My instinct was to keep these aspects of my identity in the domain of the 'hidden self' (Johari Window; Newstrom Rubenfeld 1983) or unvoiced and invisible (Burnham, 2012) in all but two interviews with survivors, when I voiced that I had previously been a social worker. I chose to mostly keep these aspects of my identity hidden as a way to maintain an open curiosity; I worried about over-identification with my research participants and the ways in which this could stifle curiosity. I chose to share my previous work experience as a social worker with two survivor participants who spoke a lot about their experiences with social workers and posed questions to me such as 'I'm not sure if you know how it all works...', to which I felt it was appropriate to disclose that I had trained as a social worker and spent some time working in that field before working for a university. I shared that I am now involved with teaching and training new social workers and reiterated how important it is for new social workers to learn about survivor perspectives and work to improve service provisions, hoping that this would reassert my own ethical 'not-knowing' position of respectful curiosity and conversational partner in a joint effort with each survivor participant in working towards positive change.

My identity in relation to education status was explicit in my invitation to all research participants to take part in doctoral research interviews, affording me student status which could have been helpful through an implicit association with a 'not-knowing' position of respectful curiosity, seeking information from each participant as the expert on their own experiences. However, my own levels of inexperience as a researcher undoubtedly limited my competence and confidence, which could perhaps best be characterised as 'conscious incompetence' (Broadwell, 1969).

Research Design

The research design of this study underwent some changes due to unforeseen barriers to data collection which included COVID 19 lockdown restrictions, lack of access to

original training materials and low questionnaire response rates.

The research design was originally proposed as a single organisation case study (Service A) which would include multiple data collection methods including semi-structured interviews with practitioners and survivors, document analysis (particularly training materials and service user outcome data) and survivor trauma impact scales.

Due to increased demand on Service A, as well as staffing pressures during the COVID 19 lock down restrictions, recruiting survivors through practitioner gate keepers within Service A became increasingly challenging. Through consultation with the supervisory team, it was decided to extend the survivor participant interview sample to other survivors accessing a nearby connected organisation (Service B) which led to the inclusion of two more survivor participant interviews.

In relation to document analysis, Service A was able to provide an outline of the VOICES framework, the VOICES planner document (included in VOICES section below) and the VOICES reflective tool (a worksheet which mirrors the planner document). While I was also able to observe one training session (Service A), I was not provided with the full VOICES training materials. When Service B staff were asked about access to their training materials (TIME training) they expressed reservations about sharing their intellectual property with someone outside the organisation. While document analysis of training materials from Services A and B was therefore not possible, however, I ensured that the practitioner interview schedule included questions about the content and applicability of the trauma training packages they had received (Service A; VOICES training, Service B; TIME training).

The final amendment to the research design was around the inclusion of a trauma impact scale which survivor participants would be invited to complete before conducting their research interviews. It was planned that the scale would be introduced to survivors by their known practitioner who could also assist them in completing the scale and offering IT support to send the document back to me. While some survivors who initially indicated they would like to take part did complete the scales, only two survivors who went on to take part in research interviews actually returned completed trauma impact scales. Given the difficulty in recruiting survivor participants, the increased pressures experienced by services during COVID 19 and the limited time remaining to recruit, interview and analyse survivor interviews, it became clear that ensuring that impact scales were completed by every survivor before taking part in an

interview became an unrealistic goal.

The changes discussed above led to an adapted case study approach, within which practitioner and survivor interviews would be the central form of data collection.

The primary benefit of including Service B within the unit of analysis (the case) rested on the fact that it enabled two more survivor interviews and one additional practitioner interview to take place. The management and supervisory team from Service B were heavily involved in introducing and piloting the VOICES framework in Service A and other practitioners interviewed from Service A had previously worked for Service B. These factors as well as their neighbouring geographical locations all strengthened the case for including both services within one unit of analysis. The differences between services A and B are discussed in more detail below (see section on Selection of participating organisations).

Case Study

What is a case study approach?

Merriam (1998) asserts that researchers can identify a case as long as they clearly articulate the phenomenon of interest and define its boundaries, effectively 'fencing in' the area of investigation.

A case study entails the detailed exploration of a specific case, situated within an everyday context (Yin, 2009; Bryman, 2016). Stake (1995) observes that case study research is concerned with the complexity and particular nature of the case in question. Cases are 'bounded by time and activity, and researchers collect detailed information using a variety of data collection procedures over a sustained period of time' (Abdulai & Owusu-Ansah, 2014, p 10). Patton (2014) described the case study approach as the researcher seeking to illustrate the phenomenon or case in rich, intense, detail as the experiences unfold.

Yazan (2015) points out that the case study methodology has 'long been a contested terrain in social sciences research which is characterised by varying, sometimes opposing, approaches espoused by many research methodologists' (2015, p 134).

Yazan compares the works of three prominent methodologists, namely Yin (2002, Merriam (1998) and Stake (1995), highlighting areas where their 'perspectives diverge, converge and complement one another in varying dimensions of case study research' (2015, p 134). While Yin follows a more positivist approach, Stake and Merriam's perspectives on case study research design and epistemology are more well suited to my own epistemological and theoretical position in their preference for a more constructivist approach to case study research. Merriam and Stake both hold the philosophical view that qualitative researchers focus on how individuals perceive and understand their experiences in the world. While Merriam's approach to meaning making in research aligns with Stake's idea of multiple layers of reality or constructing knowledge, it differs in that she does not expect readers to engage in the process of constructing or interpreting that knowledge.

Creswell (2007) suggests that researchers consider the most beneficial type of case study to employ based on their objectives. The cases can vary; they may be single or multiple, typical or atypical, but they must always be selected through purposeful sampling. As defined by Patton (2002), 'Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research' (Patton, 2002 cited in Hall, 2010 p 5). This emphasizes the importance of selecting cases that provide valuable insights relevant to the research goals.

Why is it appropriate in this research?

The single organisation case study design of this study was adapted and expanded but still constituted a single unit of analysis, in accordance with Merriam's (1998) characterisation of a 'case' as 'a unit around which there are boundaries' (p. 27). In her framework, a case can refer to various subjects, including individuals, programmes, groups, or specific policies, which significantly expands upon the definitions given by Yin (2002) and Stake (1995).

As stated above Merriam (1998) and Stake (1995) assert that qualitative research is focused on

how individuals perceive and understand their experiences in the world, and as such, advocate for a more constructivist approach to case study research. This epistemic position privileges the interpretation of views and experiences of those who are bound within the case 'unit', over the analysis of outcome measures, policies or training manuals. Practitioners within this study shared their views and experiences associated

with policies, training, and using outcome measures, enabling the collection of rich and nuanced data providing insight on how these aspects of service provision impact them.

Furthermore, this study focuses on how the concept of trauma is understood and addressed within the context of domestic abuse service provision, through the eyes of practitioners and survivors. Flybjerg (2011) points out that case studies can be a powerful research tool for understanding the dichotomy between theory and practice and can offer concrete, context dependent knowledge and develop expertise. Flybjerg (2011) states that expertise at any given activity requires intimate knowledge of multiple distinct and concrete cases, and the knowledge must be context dependent (multiple cases, multiple contexts) to move beyond simple rule based or textbook knowledge. Flybjerg's emphasis on real world contextual learning is an important part of the rationale for employing a case study methodology in this research, as it explores how specific concepts are not only understood, but applied within two real world contexts, Service A and Service B. The case study allows for nuanced view of reality and human behaviour; 'not in the hope of proving anything, but rather in the hope of learning something!' (Eysenck, 1976 cited in Flybjerg, 2011 p 303).

George and Bennett (2005, pp. 6–9) found that case studies are especially well suited for theory development, in part because they enable a deeper understanding of the sensitivity of concepts to context. This benefit of case study research seems particularly pertinent to the research aims of this current study, in that the research is focussed on how the concepts of trauma and trauma-informed approaches are understood and applied in two specific and distinct contexts.

Another cited advantage of the case study is that 'it can 'close in' on real-life situations and test views directly in relation to phenomena as they unfold in practice' (Flybjerg, 2011 p 309). Given that this current study aimed to include views of practitioners as well as survivors from two organisations (A and B), it provided some opportunity to 'test' out how trauma theory or training is utilised by domestic abuse practitioners in these two services (A and B). The use of semi-structured interviews was considered appropriate as they allow practitioners to share examples from their practice, as well as describe how their perspectives have changed or shifted over time, drawing links between causes and outcomes (George & Bennett, 2005, pp. 6–9). However, this ability to test views as they unfold in practice would have been enhanced by carrying out multiple interviews with each participant, to properly track changes over time. The fact that this case study includes interviews with both domestic abuse practitioners and

survivors lends itself to another kind of 'test', specifically the opportunity to test the assumptions and assertions embedded within the cannon of 'trauma informed' literature and advocacy.

This research adheres to the case study criteria offered by Edwards (1998 cited in Hall, 2010 p 9) in that multiple cases (Services A and B) within a bounded system are being investigated. The bounded system is recognizable from other cases of similar phenomenon in that both organisations are under the Women's Aid Federation umbrella and both organisations in the Northeast of England. Hall (2010) states that a case study is a 'good choice when the researcher has specialised cases that fit within a bounded system and the researcher wants to provide an in-depth understanding of those cases or an association of several cases' (2010, p 9). A case study is an appropriate method for this qualitative inquiry into the experiences of domestic abuse practitioners and survivors because the study focused on specific populations in specific contexts (Stake, 1995).

The 'case' in this study consists of two sister organisations in neighbouring local authorities offering support to survivors of domestic abuse, and the location of the services in the Northeast of England is an interwoven unit of analysis as the systemic implications for the service in terms of social political factors will feature within the data analysis.

Selection of Participating Organisations

Selection of the domestic abuse organisations that would participate in the study was informed by the fact that this doctoral research project was funded by the University of Central Lancashire and the Roadmap for System Change Commissioners. While this research does not feed directly into the findings of the Roadmap evaluation (Stanley et al., 2021), it draws on and is informed by this larger study and it was felt that the selection of service/services included in this study should align with those included within the Roadmap for System Change Evaluation.

Service A and Service B were two of the seven Women's Aid Federation member services piloting the 'Expert Voices' intervention as part of the Change that Lasts programme (Ctl) (Change that Lasts Briefing, 2018-2019). Both services were initially listed as delivery sites to be included within Roadmap evaluation but due to capacity issues Service B dropped out of the evaluation. Subsequently, only three out of the initial five delivery sites of the Expert Voices programme were included within the Roadmap evaluation study, one of which was Service A (Stanley et al, 2021).

As the initial research interest of the researcher was around trauma-informed practice, the Expert Voices intervention was adopted as the focus of exploration as it was understood to incorporate a trauma-informed approach. Out of the three delivery sites delivering the Expert Voices intervention, Service A was initially selected to be the unit of analysis for this study, due to its close geographical location to the researcher. As previously stated, (Research Design Section) the unit of analysis was later broadened to include Service B, in order to recruit additional survivor research participants. The final survivor sample included four survivors accessing service A and two survivors accessing service B.

Service A

Local context

The area holds a population of over 270, 000 residents (ONS, 2022). The area has an industrial heritage of shipbuilding and coal mining and is now an area of high deprivation, particularly in the employment and health domains. In relation to education and health outcomes, this area falls within the top 20% most disadvantaged areas in the country (IMD, 2015).

According to incident reports held by the local police authority, in this area, 2,026 incidents of domestic abuse were reported across the geographical region in the first half of 2020, with 461 reports (22 %) pertaining to the district in which this pilot site is situated:

Organisational structure

Service A provides 'accessible community-based services to women and children at risk of, or suffering, abuse' ([Service A] website 2021). They are a full member of the Women's Aid Federation England (WAFE) and part of a national network of providers working together to ensure safe spaces for families in need. Service A accepts referrals from across [area A], with two refuge provisions (one complex need and one generic) that also 'support women and children who need to escape to safety away from their local area.' ([Service A] website 2021).

Service A provides various forms of support for domestic abuse survivors including outreach support, generic refuge support, recovery support for women with complex needs and counselling.

WAFE staffing data (2018) indicates that, when the new CEO was appointed and around the time that the provision of the Change that Lasts programme commenced, the organisation employed 29 staff (25 FTE) including several IDVAs and volunteers as well as refuge practitioners.

At the time this research commenced, Service A had undergone a great deal of organisational change and the appointment of a new CEO. The appointment of this new service manager was significant to this study in that she had previously overseen the implementation and delivery of a service wide trauma-informed model (Trauma Informed Empowerment Model [TIME]) in another service, Service B. Her interest and promotion in bringing a TIA to front-line domestic abuse service delivery has been a key influencing factor in the restructuring of service delivery at the organisations featured in this case, in addition to the organisation's involvement in the Change that Lasts pilot programme.

Since their participation in this study, Service A achieved their National Quality

Standards certification from the Women's Aid Federation. This certification is gained after a service is assessed on its:

'Expertise, knowledge, and effectiveness of specialist domestic abuse services as well as the services' ability to evidence, maintain and promote survivor led outcomes that are designed for services that centre the long-term safety and recovery of survivors, as well as the prevention of further harm'. (Women's Aid Website, 2024)

The Women's Aid National Quality Standards are referenced in the government's statutory guidance (Home Office, 2022) as best practice.

EXPERT VOICES

Expert Voices (VOICES) was the last of the Change that Lasts interventions to be implemented and was introduced from September 2019. The VOICES framework was designed to introduce a trauma-informed, needs led, strengths-based approach to be delivered by practitioners in specialist domestic abuse organisations. The VOICES model aimed to build skills and competence in assessment and support in specialist domestic abuse services. VOICES is both a framework and set of tools for practitioners and service users, which includes; the VOICES planner and the space for action diagram, information sheets such as the complexity assessment and protected characteristics form, as well as team building exercises and reflective templates for staff teams.

VOICES was also designed to address the limitations of an increasingly gender-neutral, risk based standardised response to domestic abuse. Women's Aid note that, due to growing economic strain on public services and a reduction in open access community responses there has been 'an erosion of trust in survivors as the experts of their own experience, and a well-documented growing crisis of unmet need' (Change that Lasts Briefing, 2018, p3). The VOICES framework and tools aimed to address this by shifting the focus onto the woman's needs, reconnecting domestic abuse services to a strengths-based, needs-led, trauma-informed approach (Change that Lasts Briefing, 2018, p3).

The implementation of the VOICES framework and service model included the introduction of three paper-based tools and a series of training sessions. The three

tools are the Space for Action framework, a visual needs assessment and a reflective practice prompt. The introduction of the VOICES framework here and across the other CtL sites, promoted the importance of reflective practice and a more consistent, needs led, strength based and trauma-informed approach to service provision. Another central component of the VOICES framework was to increase the job satisfaction of the staff team, increase the well-being of the organisation and enable the service to better meet the needs of domestic survivors (Expert Voices Practice Framework, 2019).

The VOICES programme was starting to be implemented across all areas of service provision in service A at the time that this doctoral research was started (November 2020). Implementation of the VOICES framework included VOICES training and reflective workshops for practitioners. At these events, a representative from Women's Aid (central) would speak with members of the staff team about what was meant by a 'Needs Led' and 'Trauma-informed approach' to domestic abuse service provision, including the impact of burnout, compassion fatigue and vicarious trauma on staff teams. The VOICES framework was introduced to workers (Figure 10 see below) as not only a way of organising case recordings but also a way of approaching intervention work, acting as a template for staff to use in guiding their interactions with survivors to incorporating various domains of a survivor's life i.e. community, family, health and wellbeing etc.



Figure 10 : Voices Planner Design, 2019

The Roadmap evaluation report (Stanley et al 2021) points out that the programme 'took longer than anticipated to plan and develop, and its focus and content changed

during the development process'. The Roadmap evaluation also highlighted the ways in which the development and implementation of the VOICES framework were negatively impacted by the COVID-19 pandemic, 'as the intervention was newly developed, had not been piloted previously and had been delivered for less than six months at the start of lockdown' (Stanley et al, 2021, p 40).

Initially the development and design of the VOICES programme was to be carried out by the coordinators in each of the three sites. However due to additional work pressure brought about by other aspects of the Change that Lasts programme implementation (including the 'Ask me' and 'Trusted Professional' interventions), the coordinators were unable to support the development as intended. The development of VOICES was absorbed centrally by the Women's Aid Federation who aimed to co-produce the programme with eight member services as well as survivors, which proved to be resource and labour intensive.

Other barriers to implementation of the VOICES framework across the three delivery sites included 'resistance to new ways of working...lack of time to introduce or understand the changes or to complete new paperwork...long gaps between initial VOICES training and implementation...VOICES seen by staff as repetition of what they were already doing (i.e. strengths based)...inconsistencies between VOICES framework record keeping and existing database' and inconsistencies of how VOICES was being implemented across different aspects of service provision (Stanley, 2021, p 40).

Service B

Local context

Service B is in a large town to the south of Service A, an area which suffers significant deprivation and high levels of crime. In 2017, a needs assessment was carried out on behalf of the domestic abuse strategic partnership for this area by the domestic abuse Operational Coordinator for Community Safety. The executive summary states that this area is the 'second highest, by [police] force area, of all forces in England in relation to rates of domestic abuse related incidents and offences recorded by police per 1000 of population. [Service B locality] continues to be the area with greatest need for

support' (Moore, 2017, p 3). The report used data from Police systems outside of the regulatory statutory data returns, published nationally and locally and concluded that 44.8 % of reported domestic abuse incidents were converted to a domestic abuse criminal offence. The majority of domestic abuse victims in this area were women (78.7 %) between the ages of 20 and 39 years old (63.2%) (Moore, 2017 p 3).

Specialist domestic abuse counselling service monitoring included within this report identified that 'if domestic abuse is identified as the primary need they are often referred into specialist domestic abuse counselling service for individuals accessing psychological therapies' (Moore, 2017 p 51). Service B included in this current study is the only organisation in this area that explicitly list trauma therapy for domestic abuse survivors among their service provisions. The majority of referrals into this service are self-referrals followed by referrals from the criminal justice system and mental health services (Moore, 2017 p 73). The service has been recognised for its robust outcomes and trauma-informed practice and was chosen by CORE Information Management systems as one of eight top performing therapeutic services in the country to become a 'service improvement learning collaborative' (SILC) demonstration site, to take part in research with Birmingham University.

Organisational structure

Service B does not have a refuge provision but offers support via specialist trauma therapy (adults and children), Independent Domestic Violence Advocates, group work programmes, outreach support, instant access service and late opening times for women in crisis and trauma-informed training for professionals. The counselling service provision in Service B has a high volume of referrals from mainstream therapeutic services who refer if domestic abuse is identified as the primary need. Service B has a full-time manager who is responsible for coordination, clinical supervision and support over a team of sessional therapists.

Trauma-Informed Empowerment Model (TIME)

While service B had initially been included in the delivery cites for the Change that Lasts pilot programme (while included the VOICES framework) the service had previously developed another model which was TIME (Trauma-Informed Model of Empowerment) is an evidence and practice-based model developed by the clinical lead/counselling manager at Service B. The model (shown in Figure 12) offers a trauma-informed framework to assist practitioners and organisations to support survivors of domestic abuse .



Figure 11: TIME (Trauma-informed Model of Empowerment) graphic taken from the domestic abuse commissioner 'Festival of Practice' workshop presentation (2022).

TIME is described by Service B as an 'evidence and practice-based model that practitioners and organisations to support survivors of domestic abuse. Alongside drawing upon a wealth of research addressing trauma, trauma informed practice and domestic abuse, it draws on [Service B's] experience of delivering effective trauma informed therapy to female survivors of domestic abuse for over 16 years and embedding trauma informed principles within all areas of its work' (Service B website).

The TIME Module Training Programme recognises the need for all parts of an organisation to have an understanding and awareness of trauma and how it can impact on survivors, practitioners and organisations. TIME aims to ensure that:

'practice is delivered in a trauma-informed manner to avoid risk of re-traumatisation and support recovery from trauma; the needs of the survivor, practitioner and organisation are considered; and that when identifying and supporting the needs of trauma survivors, provision is accessible, responsive, adaptable and effective at all levels of contact with a survivor.'

(Service B website, 2023)

Relationship Between Services A & B

Service A and service B are located in neighbouring localities. At the time of starting this research, Service A had recently undergone a change in management structure and the new service manager was seconded from Service B, who in turn brought other clinical and outreach staff with her from Service B. Additionally there were other practitioners included within this study who were currently working in Service A that had previously worked for service B but had not been seconded. The fact that the service manager and clinical lead had already successfully piloted, integrated and formalised a trauma-informed service delivery model (TIME) in Service B placed her in a strong position to oversee and guide the implementation of a system-wide model of service delivery that included trauma-informed service delivery as one of the components.

While most staff at Service A had undergone VOICES training, most staff at Service B had completed TIME training, but some were also familiar with the VOICES framework.

The trauma-informed approach being adopted by Service B (based on the TIME training) long preceded the introduction of VOICES in Service A, and as such, Service B were viewed as more competent and experienced in trauma-informed working. As well as bringing the service manager over from Service B to help them develop and implement CtL, the clinical supervisor from Service B was central in designing the Trauma-Informed Empowerment Model and the accompanying training package was also seconded over service A for part of the week to support the counselling service and staff supervision.

The majority of data was taken from service A (14 practitioners and four survivors), the organisation using the VOICES framework, with an additional two survivor interviews and one practitioner interview obtained from service B, the organisation using the TIME model.

Designing The Research Tools

Practitioner Interviews

The interview schedule was designed to elicit respondents' views and experiences of utilising a trauma-informed approach in their practice with survivors of domestic abuse. The term semi-structured interview refers to a context of interactional talk between the interviewer and the respondent (Holstein and Gubrium, 2004) in which the interviewer has a series of questions in the form of an interview guide, but is able to vary the sequence of questions, and can ask further questions in response to what are perceived to be significant replies (Bryman, 2016). In this sense, the semi-structured interview utilised for this study followed a general framework of themes and questions, whilst new ideas were explored in response to what the interviewee said when this was considered to be applicable.

The interview questions focussed on themes including direct practice with survivors, programme delivery, organisational structures, working in a multi-agency context and, since the study was undertaken in the wider context of the Covid-19 pandemic, how Covid 19 had impacted front line service provision. The interview schedule was amended after the piloting phase to draw out more examples of how practitioners were applying trauma-informed principles in their work (see adaptations of and reflections

on research design). Interview questions with staff focussed on their views and experiences of working for a specific trauma-informed service, covering their training on trauma, their experiences of working with traumatised clients, how their organisational structure had been shaped by explicitly adopting a TIA and any barriers or challenges they had experienced in implementing a TIA.

Semi-structured interviews

While the questions and prompts in the interview schedule were structured and ordered in adherence to Hanson and Lang's (2016) empirical framework on the components of trauma-informed care, the use of semi-structured interviews accommodated a flexible and inclusive approach to data collection. It enabled the extraction of rich and idiosyncratic data such as individual backgrounds and motivations, examples from staff's own practice and their lived experiences of working for a 'trauma informed' organisation. It accommodated a focus on experiences, usefulness, barriers and effectiveness of a trauma-informed approach from the perspective of the workers and service users.

The interviews conducted with managers and practitioners explored workers' experiences in relation to the fifteen components of trauma-informed care as based on identified through Hanson and Lang's (2016) mapping exercise (see components in Figure 13 below). Components of trauma-informed care focussing on three areas of enquiry: workplace development, trauma focussed interventions and organisational context.

Table 2. Core Domains and Components of Trauma-Informed Care.

Domain	Component	Source(s)
WD	Required training of all staff in awareness and knowledge on the impact of abuse or trauma	SAMHSA, NASMHPD, AG, NCTSN, JRI, NCTIC, H&F
WD	Measuring staff proficiency in defined criteria to demonstrate trauma knowledge/practice	NASMHPD, JRI
WD	Strategies/procedures to address/reduce secondary traumatic stress among staff	SAMHSA, NCTSN, JRI, H&F
WD	Knowledge/skill in how to access and make referrals for evidence-based trauma focused practices	SAMHSA, AG, NCTIC, JRI
TFS	Use of standardized, evidence-based screening/assessment measures to identify trauma history and trauma-related symptoms or problems	SAMHSA, NASMHPD, AG, NCTSN, JRI, NCTIC, H&F
TFS	Inclusion of child's trauma history in child's case record/file/service plan	Not specified (suggested by screening in SAMHSA, NASMHPD, AG, NCTSN, JRI, NCTIC)
TFS	Availability of trained, skilled clinical providers in evidence-based trauma-focused practices	SAMHSA, AG, NCTIC, JRI
ORG	Collaboration, service coordination, and information sharing among professionals <i>within the agency</i> related to trauma-informed services	Not specified (suggested by cross-system collaboration definitions from SAMHSA, NASMHPD, AG, NCTSN, NCTIC)
ORG	Collaboration, service coordination, and information sharing among professionals <i>with other agencies</i> related to trauma-informed services	SAMHSA, NASMHPD, AG, NCTSN, NCTIC
ORG	Procedures to reduce risk for client re-traumatization	SAMHSA, NASMHPD, AG, JRI, NCTIC, H&F
ORG	Procedures for consumer engagement and input in service planning and development of a trauma-informed system	SAMHSA, NASMHPD, AG, JRI, NCTIC, H&F
ORG	Provision of services that are strength-based and promote positive development	SAMHSA, NCTSN, H&F
ORG	Provision of a positive, safe physical environment	SAMHSA, AG, JRI, H&F
ORG	Written policies that explicitly include and support trauma informed principles	SAMHSA, NASMHPD, AG, JRI, NCTIC, H&F
ORG	Presence of a defined leadership position or job function specifically related to TIC	NASMHPD, NCTIC

Figure 12: Core Domains and Components of trauma-informed care (Hanson and Lang, 2016, p 98)

While the domains offered by Hanson and Lang offered a general framework of themes and questions, the use of semi structured interviews also enabled new ideas to be explored in response to what the interviewee said. This means of data collection facilitated rich discussions that centred around each practitioner's professional experiences and allowed me to elicit their views about their own practice. Practitioners were encouraged to provide examples from their work with service users or with their colleagues, which specifically pertained to the principles of trauma-informed care, safety, trust, choice, empowerment and collaboration.

The primary purpose of conducting semi-structured interviews with practitioners and managers was to elicit their testimony and their views about working within an organisation that explicitly promoted a trauma-informed approach to domestic abuse service provision. The semi-structured interview method enabled me to gain a sense of what each practitioner felt was important to discuss, allowing for some co-creation in the agenda setting for each interview, yielding a richer variation of responses around possible factors that could help or hinder the implementation of trauma-informed working, i.e. physical space (refuge building), peer support or multi agency cohesion. The interview schedule was designed to enabled me to listen to their stories and prompt or seek clarification by asking for examples from practice or elaboration on their thoughts or views. It allowed me to 'check out' with each interviewee the meaning they ascribe to jargonistic or complex language and offered them a chance to seek clarification from me in return. Interviews were recorded and transcribed using a clean

verbatim transcription (Davidson, 2009), as elements of intonation, pauses or repetitions were excluded.

Piloting The Research Practitioner Interview Schedule

While piloting or testing specific research instruments is traditionally associated with quantitative research methods, piloting aspects of data collection has become increasingly common in qualitative research. Regardless of the research paradigm, pilot studies play a crucial role in preparing for comprehensive investigations (Tashakkori & Teddlie, 2003). They can be used to identify potential practical challenges in subsequent research processes (Van Teijlingen & Hundley, 2002) and to test the questions being posed. For instance, in her 2016 pilot study, Castillo-Montoya demonstrated that interview protocols could be enhanced through preliminary testing of the interviews.

The pilot process in this current study aimed to test the interview guide for practitioners according to the participants' feedback, allowing me to reflect on the clarity of the questions, and make any necessary amendments to the structure and time frame needed for the interview. This process helps to identify any flaws or limitations in the interview design, enabling essential adjustments before the main study (Kvale, 2007). Harding (2013) noted that the necessity for piloting qualitative interviews may not always be evident, as the quality of the interview guide tends to improve throughout the interviewing process. Creswell (2017) argues that such flexibility is essential for research focused on human experiences, allowing researchers to adjust their research questions to fit the specific context of their study.

Additionally, both data collection and analysis can be adapted in real-time as new insights emerge. This adaptability is a hallmark of qualitative research; for instance, if a researcher discovers during an interview that certain questions fail to meet their objectives, they can modify those questions on the spot. Conversely, De Vaus (1993, p. 54) cautions against this approach, stating, 'Do not take the risk. Pilot test first.' The literature emphasizes the necessity of conducting a pilot study from both the researcher's and the subjects' viewpoints. Harding (2013) emphasised that piloting the interview questions and refining the guide prior to the main study is particularly advantageous. The interview guide serves as a vital tool that ensures the researcher

maintains consistency during the process (Krauss et al., 2009).

The pilot took place in November 2020 and included two research interviews with team leaders in the first organisation. It brought insight into the interview process, as well as the operational realities of the application of the VOICES framework. These new insights brought about changes to the focus and scope of the research questions, specifically, the importance of including questions that captured data beyond the utilisation of the VOICES framework.

Once interviewees had provided informed consent via email, arrangements were made to meet via video link using Microsoft Teams software at a pre-arranged time. Before the interview, they were sent an information sheet (Appendix B) along with the consent form (Appendix C).

Survivor Interviews

Lim et al (2015) argue that semi-structured, open-ended interviews that provide an opportunity to explore an individual's experience of interpersonal traumatic events offer a better understanding of survivors' experiences of abuse. The research set out to include the views and opinions of women seeking support from domestic abuse programmes about the five core principles of trauma-informed care without attempting to evaluate their recovery journey. This research drew on feminist principles of data collection such as those identified by Acker, Barry, and Esseveld (1983):

' . . . research should contribute to women's liberation through producing knowledge that can be used by women themselves; should use methods of gaining knowledge that are not oppressive; should continually develop a feminist critical perspective that questions dominant intellectual traditions and can reflect on its own development.' (p. 423).

domestic abuse is a 'complex, multi-faceted phenomenon, occurring within a social context that is influenced by gender norms, interpersonal relationships, and sexual scripts' (Testa et al., 2011, p237). Speaking directly to survivors affords an opportunity to capture each person's subjective experience as well as the variation in meaning-making (Lim et al., 2015). In gaining a broader sense of survivor needs, interviews provided an opportunity for survivors to clarify and prioritise their main concerns, such

as children (Lein et al, 2001), connection with community, or financial security (Tolman & Raphael, 2000).

This study does not seek out singular causal links which could be seen as reductive oversimplification (e.g. a service user does not engage with their worker because they are using drugs/alcohol), or determinism (e.g. the service user will become depressed because she has experienced domestic abuse). Instead, the interview schedule was designed to prompt conversation with participants about many facets of their experiences, with a presupposition that personal meaning mediates the impact of any given event or, as Allen (2008) states, 'trauma is in the eye of the beholder (p21).

The survivor interview schedules were designed as a kind of mirror to the practitioner schedules in the hope that the same concept or topic could be viewed from two distinct perspectives. This seemed to work well in terms of seeing the different principles that were prioritised or more dominant within the interviews with practitioners and survivors. This enabled some exploration and analysis of any obvious similarities or differences in the interpretation of trauma-informed approaches to domestic abuse service provision as well as more nuanced interaction between themes generated from practitioner interviews and survivor interviews.

For survivors, the number of questions within the interview schedule design was greatly reduced to provide as much space as possible for survivors to elaborate on more abstract matters such as feelings and experiences. While the principles of trauma-informed care were a central focus in the interview schedule, the questions were posed in a manner that aimed to reach beyond the survivor's 'assessment' or evaluation of their practitioner, instead, they invited survivors to reflect on how they felt and understood the principles of trauma-informed care in relation to their intervention. The questions also searched for evidence of a level of relational attunement between survivor and practitioner through the use of circular questions (Selvini-Palazzoli et al., 1980), such as 'what do you think your practitioner would say?'.

Care was taken in the design and structure of the research schedule to ensure a sensitive approach to the sample group and the topic and to avoid re-traumatisation. Subsequently, there was only one question included pertaining to the reason survivors came into contact with the service initially. Instead, the interviews borrowed from systemic and narrative communication models which focus on revealing unknown stories (Pearce & Pearce 1998), reflections and new insights which serve to thicken

the narrative (White, 1995) around service user experience in relation to a trauma-informed approach. While the risk of harm is an important consideration for any researcher and ethics committee, Beckett (2024) notes that one should question 'simplistic and deterministic ways in which this can be understood within ethical decision-making, and the unnecessarily risk-averse decisions that can ensue' (2024, p 1) when researching sensitive issues such as abuse.

Adaptation Of and Reflections on The Research Design

Covid-19

Some challenges remain inherent to research involving busy front-line services and survivors accessing those services which amplified my own inexperience as a researcher, organisational changes happening within the service and carrying out qualitative research during a global pandemic. This study was undertaken during the Covid-19 pandemic in the UK. Regional differences in lockdowns meant that the region experienced greater amounts of time in the higher and more restrictive tiers, compared to the other three sites included in the Roadmap study (Stanley et al, 2021). In all sites, domestic abuse services were required to pivot to providing services remotely while experiencing staff shortages due to the pandemic. This meant that the majority of interviews were conducted remotely, through phone calls or video calls using Microsoft Teams.

On reflection the sole reliance on online and virtual communication methods enforced through lockdown restrictions acted as a barrier to building working relationships with Service A. There were limited chances for me to visit the team in person as had been done in the initial meetings (pilot phase) and emails about the research were often lost in the sea of other tasks and responsibilities placed upon practitioners. Ideally, there would have been more consultation with workers and managers and survivors throughout the data collection phases. For example, it would have been better to co-design an impact questionnaire with practitioners which would be easily accessible for survivors. It would have also been beneficial to invite all survivor participants to an initial group meeting on site at one of the service provisions, allowing them to meet the researcher, meet one another, complete impact scales in person and engage in a reflective feedback discussion about the scale.

Broadening the Focus: Beyond the VOICES framework

Based upon the discussion with each research participant at the end of the interview, my own observations and reflections and subsequent discussion with academic tutors, the decision was made to shorten the interview practitioner schedule (Appendix A) and place a greater focus on gleaned examples from practice. Through piloting the practitioner interview schedule with practitioners from Service A, it became clear that focussing questions and prompts solely on the application of the VOICES framework was too reductive and would not fully illuminate the nature of the work practitioners were undertaking, particularly as to how it related to a trauma-informed approach.

Practitioners interviewed in the pilot stage became overly focussed on critiquing the introduction of the VOICES framework instead of illustrating their conceptualisation and application of a trauma-informed approach in their work. Some practitioners from Service A voiced some sense of confusion regarding the precise function or applicability of the VOICES framework in relation to trauma-informed working practices. Many of the generic refuge or outreach practitioners interviewed initially pointed towards the practitioners who worked in newer complex needs recovery refuge unit as more focussed on trauma-informed ways of working.

The interview schedules with practitioners were re-designed in a way which drew focus onto the ability of practitioners to discuss how they enacted principles of trauma-informed care (SAMHSA, 2014) in their front-line practice. This aligned well with my intentions and goals in amending the practitioner interview schedule (discussed above in Chapter 5: Piloting the Research Practitioner Interview Schedule section) in that it did seem to enable practitioners to focus more on practice examples in their answers.

It was clear that shifting focus or adding specific questions that pertained to how they were able to implement some of the principles of a trauma-informed approach would enable practitioners to share a broader range of examples that would lead to a more exploratory conversation about trauma-informed approaches to domestic abuse service provision, and move away from an evaluation of organisational change through the introduction of one specific framework.

On reflection, broadening the practitioner participant sample to all staff members working across every aspect of service provision was the right decision as it allowed for a broader range of practitioner voices and a richer more holistic account of domestic

abuse practitioner experiences, better aligning with the concept of a 'case study' providing a snapshot of the organisation as a unit for analysis.

In this sense piloting phase helped to provide a 'clear definition of the focus of the study,' (Frankland and Bloor, 1999, p. 154) allowing for a concentrated approach to data collection on a narrower range of analytical topics. Van Teijlingen and Hundley (2001) further explain that qualitative data collection methods, such as interviews, tend to be iterative and point out that subsequent interviews should improve upon earlier ones as the interviewer gains insights that can enhance interview schedules and specific questions. This shift in focus enabled a clear distinction between my research aims and the research aims of the Roadmap Evaluation study (Stanley et al., 2021) and helped me to refocus on my own research intention, which was not to evaluate, but to explore people's experiences relating to adopting a trauma-informed approach to domestic abuse service provision.

Broadening the Sample: Inclusion of Service B

Originally, the case study methodology was applied to a single organisation (Service A) but was expanded to include a second organisation (Service B) due to difficulty in recruiting survivor participants during the COVID-19 pandemic. Relying on domestic abuse practitioners/managers to refer survivors to take part in the study became increasingly unrealistic as their attention was solely and understandably on maintaining service provision during this difficult time.

Practitioners had recently taken part in the broader Roadmap Evaluation study and there was some sense among practitioners in Service A that they were being 'evaluated to death'. Researchers must be mindful of the additional labour involved in services agreeing to open their doors to researchers, especially during a time of organisational change, high staff turnover and wider environmental challenges, such as the COVID-19 pandemic. A sense of research or evaluation fatigue has been cited by other researchers (Ashley, 2021, Patel et al, 2020) and was certainly something that service managers and team leaders cautioned me about during my early communications with them. Meanwhile, practitioners and managers who did agree to take part in research interviews were very open, reflective and accommodating.

Extending the sample to include a second service, Service B, at a later point in the

research schedule allowed for the inclusion of more survivor voices. It was also important to include an additional practitioner voice from this second organisation. The practitioner who referred the two additional survivor participants was interviewed for this research.

Trauma Symptom Checklist Scale

When the interview schedule for practitioners was piloted, it became evident that service A did not routinely screen for trauma with survivors accessing their service or use any scale/measure focusing on capturing the physiological impacts of traumatic stress. As discussed within the epistemological section of the methodology, this research adopts a both/and position in acknowledging both the physical and embodied experiences of survivors as well as the constructed nature of trauma as a concept. It seemed important to use a scale (adapted version) which explicitly acknowledged the physical impacts and embodied experience of domestic abuse survivors, as well as capturing their qualitative testimonies, which focused more on their meaning-making of trauma and their experiences of services. Including and borrowing from both the positivist (symptom scale) and interpretivist paradigms through these two means of data collection would have enabled the research to compare survivor impact scales with their testimonies and generate patterns or contradictions between the two data sets, which each data set enriching the other. Gathering multiple sources of data in this way would have been well suited to the case study methodology, and exploring the relationship between multiple layers of experience and multiple contexts (i.e. the body, the interpersonal and the community) would have been consistent with the ecological perspective.

While service A is not a 'trauma specific' service which would provide focussed interventions and treatments designed to address trauma symptoms (DeCandia, 2013, Hopper et al., 2010; SAMHSA, 2014; Sweeney et al., 2016; Addis et al., 2020; McCarthy et al., 2020), the VOICES framework is characterised as a 'trauma-informed' intervention. Adopting a trauma-informed approach to all aspects of service delivery would usually involve some mechanism whereby a service can track/monitor the well-being of their service users as well as the impact of their intervention. Service A uses scales such as the chaos index scale, the CORE-34 and the Warwick Edinburgh Wellbeing scale. None of the aforementioned scales looks specifically at the physiological symptoms of traumatic stress. Practitioners explained that they preferred

a more conversational or relational approach to tracking traumatic experiences and symptoms without adding another form.

While this approach to monitoring the well-being and progress of service users makes intuitive sense and could certainly have benefits for both service users and practitioners, the Change that Lasts programme, within which the VOICES intervention sits, was designed to look at improving service delivery for survivors. Therefore, it was felt that focusing on an area (physiological impact/symptoms of domestic abuse survivors accessing services) that may have been previously overlooked or at least not well captured within the previous Roadmap evaluation could provide added value for all stakeholders. However, due to a low response from survivors, it was decided that this dataset would not be included within this doctoral study. On reflection, it seems that the response rate was greatly impacted by the research design and by the context of the research. Some survivor participants were interviewed during the COVID-19 pandemic lockdown restrictions which meant that these initial interviews were arranged via email and conducted over the phone or on Microsoft Teams. All initial arrangements were made via email and through practitioner gatekeepers.

While all survivors returned the consent sheet, most did not return a completed TSC scale and when asked they stated that they had forgotten but would be happy to complete one after completing the interview, however, most did not. While none of the survivors said they were uncomfortable with the idea of completing the scale, most did not return a completed impact scale. It is important to point out that they had no previous association or familiarity with me, and they may not have felt comfortable in explicitly objecting to the request to complete an TSC scale. Survivors may have felt uncomfortable in completing the scale which asked about various potential psychical and psychological symptoms of trauma.

Considering the sensitivity of the information being requested and the nature of their experiences before accessing a domestic abuse service, efforts were made to mitigate against any potentially harmful effects of completing the scale by involving their practitioner in this initial process to offer support. It was originally suggested that the scale could be printed off by practitioners and discussed or completed at a time when they were together, however on reflection, this was a significant additional responsibility to outsource to practitioners who were already busy and working in the context of a global pandemic.

Another possible barrier to completing the scale may have been technological literacy (unable to complete on a computer) or the inconvenience of having print out, complete, scan and email the TSC scale back to me. Taylor-Dunn et al. (2023) identify some of the practical challenges of carrying out gender-based violence remotely during a pandemic which include the risks of 'digital exclusion', particularly where survivors may be experiencing financial hardship, financial abuse or are prevented from accessing the internet by their abuser (2023, p 288). Sevelius et al. (2020) reiterate this concern, highlighting that individuals in marginalised groups may not have access to the technology enabling research participation.

Ethical Framework

The application for ethical approval for this research emphasised commitment to the principles of informed consent, protection and ensuring privacy and confidentiality and ethical approval was received from the University of Central Lancashire Ethics Committee in September 2020 (BAHASS2 0143; Appendix G) before data collection began. I subsequently submitted three sets of changes to the ethics committee around changes in wording on the practitioner and survivor consent forms as well as the research schedules for both practitioners and survivors.

Ethical practice remained central to the research process throughout, and it is acknowledged that ethical considerations, which are ongoing throughout the duration of a research study, cannot be fully determined or resolved before fieldwork begins. The ethical approval process enabled deeper reflection on ethical questions regarding the methodology, data collection, access to participants and impact on their wellbeing, particularly in relation to survivors around issues of safety, psychologically revisiting traumatic experiences and consent. Due to the sensitive nature of conducting research with survivor participants who have experienced or who are at risk of experiencing domestic abuse among other adverse or traumatic experiences, survivors' interviews were delayed allowing closer inspection of language use, particularly in light of the risk of re-traumatisation. Care was also taken to ensure that the focus of the questions was less around traumatic experiences and more around experiences of trauma-informed principles.

The ethical considerations regarding each phase of data collection will now be discussed, including advertising and recruitment, informed consent, conducting interviews, debriefing and confidentiality.

Advertising & Recruiting

Practitioners as gatekeepers

The practitioner research participants in this study were also gatekeepers in terms of inviting/giving access to survivor participants. Recruiting through specialist services has advantages in terms of 'ensuring participants can access support and safety issues can be addressed' (Taylor-Dunn et al., 2023, p 286) which is cited as good practice in WAFE's research integrity framework on domestic violence and abuse (2020). However, some research highlights that recruitment via gatekeepers is also inherently challenging (Breckenridge et al., 2017). While organisations mitigate risk in relation to survivors' involvement in social research, it is crucial to ensure that informed consent is given and ensure participants are not coerced, either directly or indirectly, to take part (Abrams, 2010). Other research has shown that gatekeepers such as practitioners can be overprotective (Sullivan and Cain, 2004) and are more likely to exclude service users from taking part in research rather than encourage them to participate against their will (Brunovskis & Surtees, 2010). Practitioners were reminded that survivors often value the opportunity to tell their story to a third-party which can even have therapeutic effects (Brennan, 2005). This anxiety was alleviated somewhat through reiterating to practitioner gatekeepers that survivor participants would not be asked to discuss the abuse they had experienced, but rather their experiences relating to seeking support.

Practitioners in Service A were familiar with the wider Roadmap Evaluation and many referenced previous calls they had received from academic researchers. There was some concern that this acted as an additional level of strain placed upon workers across refuge and outreach settings who chose to take part in research interviews, in amongst their various other responsibilities as noted earlier. Breckenridge et al. (2017) also emphasize the researcher's

'Ethical responsibility to work with gatekeeper organisations in a way that is sensitive to the financial pressures they face, particularly organisations within the charity sector. Researchers should work to minimize the demands placed on gatekeeper organisations and may wish to consider financial recompense for gatekeepers as part of the research planning process' (2017, no page

number).

In an effort to minimise the demands the research was placing on practitioners in Service A, it was decided to extend the sample to include a second service, Service B, at a later point in the research schedule in order to include more survivor voices. It seemed important to include an additional practitioner voice from this second organisation, specifically the practitioner who referred two additional survivor participants who agreed to be interviewed for this research.

In approaching Service B, additional apprehensions emerged, such as being anxious about the nature of the research questions as well as caution around the impact the questions might have on survivors. I chose to share my survivor interview schedule with the service to offer reassurance and foresight for practitioner gatekeepers and survivors. While it became clear that interview schedules shared with clinical team lead of Service B were not shared directly with survivors, it seemed to provide the service practitioners with enough reassurance to approach survivors on my behalf, inviting them to take part in the research.

Remote interviews with survivors

A primary ethical consideration was the impact of COVID-19 restrictions on the research which limited the amount of face to face contact I was able to have with survivors. As outlined by Taylor-Dunn et al. (2023), the safe recruitment of domestic abuse survivors in research is crucial and their research found that the pandemic posed some 'unique challenges in this respect' (2023, p 290), not least in choosing a safe location to carry out remote interviews. While a small number of survivor research interviews (post lockdown) were able to be conducted in a community venue (Service B's offices) that had been risk assessed to help ensure participants' safety and comfort, most remote interviews were conducted in the participant's home which would usually prompt domestic abuse researchers to consider the 'increased risk this could pose to the participants' (Taylor-Dunn et al., 2023 p 290). It is important to note that none of the survivor participants in this study were currently living with their abusive partners/ex partners but it was still necessary that I understood the current situation participants were in and could get a sense of their wider support network (should they need to access it following their involvement), as recommended by Taylor-Dunn et al. (2023).

Trauma-informed recruitment of trauma survivors

Trauma research is often conducted with the aim of enhancing services for survivors (Campbell et al., 2019; Taylor-Dunn et al., 2023). While changes to systems may eventually benefit other survivors, immediate improvements for those participating in the study are unlikely (Campbell et al., 2019). I was careful to highlight the realistic nature of the potential benefits for survivors in choosing to take part in this research, by stating clearly that while the immediate benefits are limited to a voucher and the opportunity to share their views openly, system change is a longer-term goal which may not directly impact their experience with services.

Nonetheless, numerous studies indicate that many female survivors of domestic violence and sexual assault report positive outcomes from sharing their experiences in research settings (Dragiewicz et al., 2023; Campbell et al., 2009). More specifically in relation to trauma-related research, an increasing number of studies suggest that few participants experience distress from taking part in such research (Yeater et al., 2012; DePrince & Chu, 2008; Carter-Visscher et al., 2007; DePrince & Freyd, 2006; Newman et al., 2001).

However Jaffe et al. (2015) carried out a meta-analysis examining trauma studies, including those with survivors of domestic abuse and found that, contrary to common concerns from research ethics committees about the potential for 'asking participants about prior traumatic experiences [to] induce extreme distress' (2015, p. 40), the majority of participants had a positive experience. The analysis encompassed 70 studies with a total of 73,959 participants and revealed that while some individuals may experience immediate psychological distress, this distress is typically not severe. Moreover, participants reported minimal regret over their involvement in the research and low levels of concern about coercion or the personal nature of the research questions (Jaffe et al., 2015). When recruiting survivors to take part in this study, I ensured that the advocates and service providers were willing to provide follow-up support to the survivor following the interview if they needed it. This offer of support was also included in the survivor information document, and I also checked in with each survivor at the end of the interview to ask if they required any support from their advocate. None of the survivors requested any additional support and most shared that they had enjoyed taking part in the research and appreciated having the opportunity to contribute towards the improvement of service provision.

Some research on the neurobiology of trauma has emphasised the need for careful consideration of what researchers or practitioners ask of survivors when they are recovering from a traumatic experience, as multiple areas of the brain can be adversely affected (Campbell et al., 2019, p. 4772). I was aware that asking survivors to discuss their experiences of domestic abuse could be re-traumatising, so I framed the questions towards the help and support they had received. Some survivors freely spoke about the experiences that brought them into contact with domestic abuse and statutory services, and I reminded each survivor to only share what they were comfortable with.

One option to mitigate or eradicate the risks posed to survivors by research could be to explore whether alternative sources of information could address the research questions at hand such as victim advocates or other practitioners, as well as archival data (Campbell et al., 2009; Du Mont et al., 2012; Maier, 2008). Additionally, researchers might introduce the study to victims when they are actively seeking help but defer data collection until a later stage when they may be better prepared to participate. I chose to include the voices of survivors as well as practitioners and I maintain that survivors should be given the opportunity to discern their own ability or willingness to engage in research, through a process of informed consent which includes the survivor reserving the right to change their decision within a designated timeframe. This enables the researcher to enact the principles of trauma-informed practice (SAMHSA, 2014), balancing the principles of safety and trust with choice and empowerment

Informed Consent

It was important to ensure that all participants were able to read and sign an information sheet (Appendix E) as well as a consent form before taking part in a research interview. Practitioners and survivors were given an information sheet at least one week before taking part in the research interview. The information sheet offered information about who was conducting the research and why, as well as the nature of the research and focus/aims of the research.

Campbell et al. (2019) note that many studies focussing on more sensitive topics and hoping to recruit survivor participants opt for vague descriptions of research during the initial recruitment and invitation phases so as not to deter or indeed endanger

participants. Campbell et al. (2019) reiterate that while these practices are considered accommodated with the Belmont Principles' (1979 cited in Miracle, 2016) which include (1) respect for persons, (2) beneficence, and (3) justice, a trauma-informed approach to research may 'go above and beyond the ethical mandates required by the Belmont Principles' (2019 p 4773).

In this study, the focus of the research was clearly set out for any survivor accessing service A or B who were considering taking part in the study, and they were given ample opportunity to review the information in order to enable truly informed consent. Trauma-informed principles encourage empowerment, choice, and control and it was important that none of the research practices used in this study sought to limit participants' knowledge about the topic of study (Campbell et al, 2019). Importantly, the information sheet described a process of dynamic consent which offered each participant a two-week window (after taking part in an interview) to withdraw consent, after which time their data would be anonymised making it more difficult to withdraw the data from the study. Scholars have highlighted the importance of being clear about each aspect of the research process to ensure that survivor participants do not feel deceived by researchers (Ortmann and Hertwig, 1997; Campbell et al., 2019).

The information sheet also provided details about how and where their data would be stored, as well as the potential risks and benefits of taking part in the research. The Belmont Principles necessitate that researchers assess both the potential risks and benefits and associated with study participation. Cobban et al. (2008) highlight the importance of researchers addressing the various potential risks and benefits of taking part in research and sharing data in the consent form. Campbell et al. (2019) assert that a trauma-informed approach emphasizes the importance of cultural competency, 'so researchers need to be aware of past abuses committed by the scientific community [on different marginalised groups] and allow participants to make decisions about the use of their data' (Campbell et al 2019, 4780).

The consent form asked about reading and understanding the information sheet, consent to recording the conversation, consent to talk about work undertaken with their service practitioner, understanding of / agreement with confidentiality and safeguarding protocols and anonymisation. An additional concern highlighted by Campbell et al. (2019) considers the issue of informed consent when including participants who have experienced trauma. The authors pose the question: 'Are trauma victims in a mental and emotional space to make an informed decision about

study participation in the immediate aftermath of a traumatic event?' (Campbell et al., 2019, p 4771). This question illuminates the potential tension between trauma research and trauma-informed practice but also points to the potential risks of testimonial injustice, should professionals seek to occlude survivor voices on the grounds of psychological or emotional difficulties. To invalidate or omit survivor voices through taking the decision that they should not be invited to take part in research seems ethically unsound.

In this study adult domestic abuse survivors were being invited to take part in research by their domestic abuse support practitioners who were in no way obligated to obtain or ensure survivor participation. In this sense, survivor participation underwent two layers of discernment or consideration, initially by domestic abuse practitioners and then by the survivors themselves. While there is no way to fully ascertain the selection process undertaken by practitioners in terms of which survivors they invited to take part in this study, it seems safe to assume that the 'mental and emotional state' required to give informed consent was assessed by both practitioner gatekeepers as well as each survivor themselves.

Conducting The Interviews

Most interviews were conducted over Microsoft Teams or over the phone, to ensure that those who could not access Microsoft Teams were able to take part. Offering survivor participants, a choice of online or phone interviews was an attempt to address or mitigate against the risks posed by digital inequality and the impact of this on research participation (Yu et al., 2018). This may have acted as a barrier to rapport building in the interviews with practitioners and some of the survivors (two were interviewed face to face) and consequently their level of comfort in carrying out research interviews. Taylor-Dunn et al. (2023) found that while domestic abuse researchers included in their study highlighted this as a potential concern, particularly when interviewing over the phone where the researcher and survivor cannot see one another (p 290) most were able to build rapport through tone of voice and empathic responses. The authors did note that domestic abuse researchers included in their study felt restricted 'in terms of being able to comfort participants which subsequently impacted negatively on their own emotional wellbeing' (Taylor-Dunn et al., 2023, p 293).

There is some expectation that trauma researchers have a plan in place for addressing participants' distress during the study (Campbell et al., 2019, p. 4775). The trauma-informed principles established by Elliott et al. (2005) encourage researchers to weigh the risks and benefits of the study considering the lasting effects of trauma. These principles emphasize placing the recovery of survivors as the core objective of research, ensuring that survivors feel respected and safe throughout the process, and focusing on their strengths and resilience instead of viewing their experiences through a pathological lens. Given this context, it is important to consider the potential obligations researchers have in relation to managing participants' distress.

In alignment with the principles of trauma-informed practice proposed by Elliott and her co-authors (2005), researchers should aim to reduce the likelihood of retraumatisation and foster an environment that prioritizes respect and safety for all participants (Campbell et al., 2019, p. 4776). It is important to emphasise that within this study participants were not being asked to describe traumatic events such as experiences of domestic abuse, but rather about their experiences of seeking support. Nonetheless, my own professional background and experience led to an anticipation that research questions relating to seeking support could trigger conversations relating to traumatic experiences that led survivors to seek support. In this regard, I anticipated a kind of 'dual role of data collector and support provider' (Campbell et al 2019, p 4776). When participants displayed distress during an interview, I adhered to qualitative and feminist approach, responding with a level of care, empathy and compassion commonly regarded as appropriate within the professional boundaries of a researcher's role (Campbell et al 2010; Morse et al., 2008; Corbin & Morse, 2003).

In the context of trauma research, it is important that researchers are knowledgeable about trauma symptoms and respond with appropriate resources to aid in survivors' recovery. Carter-Vissche et al. (2007) and Griffin et al (2003) note that more severe trauma symptoms such as flashbacks, dissociation or disclosure of suicidal ideation are uncommon in the context of research participation. There is some disagreement within the literature base surrounding the appropriate boundaries of the researcher-participant relationship and what researchers can and cannot provide for participants who demonstrate significant need for supports and services (Campbell et al., 2019; Kendall & Halliday, 2014). In this study, it was decided that practitioners who required additional support would be directed towards the employee support scheme (a confidential external support line) and survivors would be asked if they needed post interview support by their domestic abuse support worker.

Despite this concern, all practitioner and survivor participants stated that they enjoyed taking part in the research interviews. When offered, no members of staff requested any follow up support from line managers, colleagues or the independent employment support helpline following the interview and no survivors requested immediate support needs following the interviews. Self-care was discussed with every participant towards the end of the research interview and care was taken to structure the research schedule on a positive note. For example, practitioners were asked questions such as 'what is the most rewarding aspect of your job?'. Many practitioners noted that they valued having the space and time to reflect on their own practice in addition to feeling part of research seeking to improve survivors' experiences of domestic abuse service provision going forward. Survivors were asked about why they wished to engage in research interviews, and most discussed the importance of raising awareness and improving service provision for domestic abuse survivors.

Confidentiality

The widely held belief is that data can be effectively de-identified and anonymised, leading to the conclusion that all data can and should be shared. However, Finkel and his colleagues (2015) challenge this view. They provide instances where publicly available 'de-identified' data have been successfully re-identified, thereby exposing the study's context and potentially revealing the identities of individual participants. They warn that typical anonymization methods may fail to adequately safeguard confidentiality (also see examples in Ross et al., 2018). While 'outsiders' might evaluate the data and conclude that it has been properly de-identified, 'insiders' could still easily ascertain identities. This risk is particularly pronounced in qualitative research, which is more susceptible to re-identification (Ross et al., 2018). Research should clearly outline the measures researchers will take to ensure the safety, privacy, and confidentiality of participants if they plan to share or archive the data (Campbell et al., 2019, p. 4782) to address these concerns.

Participants' rights to confidentiality were highlighted in the information sheets and verbalised before each of the interviews and focus groups commenced. Individual identities in the transcript data were anonymised, with all interviewees given a unique identifying code. Digital voice recordings were anonymised and all personal data including consent forms and survey data were stored securely in a password protected laptop. All participants were advised both in the written information sheets and at the start of the interviews that any quotes used in the thesis and subsequent reports would not reveal a participant's identity. Participants' rights to confidentiality were highlighted in the information sheets and verbalised before each of the interviews commenced.

Conducting the Research

Practitioner Sample

Initially, the target group for data collection was practitioners at this organisation who were involved in delivering the VOICES intervention programme (Service A). As I became more familiar with the various services the organisation provided and the Change that Lasts programme became more embedded, the decision was taken to widen the invitation to incorporate any/all practitioners including managers, supervisors, refuge, outreach, and complex needs recovery unit practitioners. It was then decided to widen the sample further to include one practitioner from Service B (as explained previously) from which the manager in the initial organisation as well as some of the therapeutic staff had been seconded. In this sense, the study utilises convenience and purposive sampling, specifically practitioners from the two included organisations who have worked (directly or indirectly) with domestic abuse survivors accessing support from their organisations. Fifteen practitioners agreed to take part in research interviews, all of which were conducted via video call software due to COVID-19 restrictions.

Data Collection: Practitioners

This first stage took place between November 2020 and April 2021, during which time 14 research interviews with staff from Service A (including managers and supervisors) were conducted and fully transcribed. The variety of participants and the in-depth accounts are a strength in achieving the study's aim and objectives, and a range of differing experiences, knowledge, engagement, and access to resources around TIAs has been captured. In 2022 an additional practitioner interview was secured from and

independent domestic violence advocate working for service B.

Survivors

The second target group for data collection was domestic abuse survivors accessing the organisations included within the study. After eight months it had only been possible to recruit four survivors which led me to broaden my recruitment strategy and invite survivors accessing another service provision (Service B), from which two additional survivor participants were recruited, totalling a sample size of six survivor participants.

While I had hoped to recruit more survivors, time constraints and the challenges explained above led to closing the recruitment process and progress to the next phase of the research process. My own epistemological and ontological position leads me to be particularly aware of Fricker's concept of testimonial injustice (2007, p 17) (rejection of the knower's experience due to prejudice about their identity). In relation to domestic abuse survivors, their voices and experiences are often occluded (Neale, 2018) or omitted from research. Their input has been identified as a gap in the literature (DeVault, 1999), and their inclusion is therefore crucial. Feminist researchers (Collins, 1990, Harding, 1987; Ringer, 1992) highlight the importance of honouring the voices of female survivors within domestic abuse research and advocate for a survivor-informed philosophy (Gilfus et al 1999). More generally, opportunities to share stories and experiences can also have a therapeutic and healing effect on survivors of violent crime if handled with care and attention (Pascual-Leone, Kim & Morrison, 2017).

Data Collection: Survivor Sample

This second phase of data collection with survivors was initially scheduled for early 2022 however, a deeper consideration of methodology and a suitable epistemological approach led to a revision of the survivor interview schedule (Appendix D). Through further consultation with my supervisory team, the final draft of the survivor interview schedule (Appendix D) was resubmitted for ethical approval in April 2022. On receiving ethical approval, I was able to carry out four research interviews with survivor participants from Service A and two survivors accessing Service B were interviewed in person.

Approach to Analysis

The data gathered through interviews was analysed using inductive thematic analysis (Braun & Clarke, 2006). Thematic analysis can form the basis for gathering core themes as well as metaphors used by survivors when describing their experiences. Tracking the use of embodied metaphors in the survivor interviews was of particular interest in accordance with my ontological and epistemological approach and helped me to understand the participant's frame of reference (Heracleous & Jacobs, 2008). Thematic analysis is suitable for inductive studies (Bryman, 2012) and offers an accessible and theoretically flexible approach to analysis (Braun & Clarke, 2006). In adherence to Braun & Clarke's guidance on reflexive thematic analysis, codes and themes were generated from the data sets with survivors and practitioners, through a careful process of 'systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set' (Braun and Clarke, 2012, p 57).

Initially I took a deductive or theory driven approach to producing the codes for practitioner interviews, which were relative to pre-specified conceptual framework, specifically the trauma-informed principles as listed by SAMHSA (2014). Byrne (2022) point out that this 'analyst driven' deductive approach often leads to a 'less rich description of the overall data set' (2022, p 1397) and is typically associated with positivistic or essentialist approaches (e.g. Boyatzis 1998).

The trauma-informed principles had informed the interview schedules with participants and through a closer reading of Braun and Clarke I started to realise that I had inadvertently gotten caught in the 'positivism creep' or as Marecek describes, 'swim unknowingly in the waters of positivism' (Marecek, 2003 cited in Braune and Clarke, 2023, p 1). I had made the common mistake of confusing meaningful unified interpretative stories (themes) with topic summaries and failed to acknowledge their own subjective perspective or position in relation to the study. I then revisited the theme generation process of the practitioner interviews using a more combined (deductive-inductive) approach to analysis with a stronger leaning to an inductive orientation to better align with my own reflection on the constructed and ever evolving conceptualisation of trauma and trauma-informed approaches. This meant revisiting and clearly differentiating between semantic and latent coding of the practitioner interviews; semantic meaning communicated by the respondent, and the latent meaning I interpreted (Patton 1990). This process demanded a re-familiarisation with

the data set, as part of a more recursive process of generating meaning from the data and paying close attention to any initial codes that might be useful in addressing the research aims and questions which related to the conceptualisation and utility of trauma-informed approaches in two specific domestic abuse services. From an initial six themes, I was able to refine and reduce the data set to four themes and ten sub-themes.

In preparing for the analysis phase of the survivor interviews, I sought support from my supervisory team and attended post graduate training workshops in order to deepen my understanding and ability to adopt a more data driven approach to coding and analysis. A member of the supervisory team was able to assist me in cross checking and discussing potential codes from a section of one research interview. This process felt more data driven in that I felt less beholden to a prescribed conceptual framework (the trauma-informed principles) in the generation of the codes. The interview schedule for survivors was more orientated towards survivor experiences and subjective interpretation, they were not being tested or evaluated on their knowledge and application of a trauma-informed approach but instead being asked to share their experiences of receiving support which felt like a more reflective starting point. Analysis of the survivor data set was organised under three themes and seven subthemes.

My own practice experience as well as theoretical leaning led to a decision to map themes across the various layers of Bronfenbrenner's ecological systems model (1979) (see Chapter 3: Ecological Model) to inform the structure of the discussion chapter. As a novice researcher, this led to some challenging and complex structural issues in ordering and mapping themes which sit at multiple levels of the ecological framework and have a bi-directional influence on one another. I sought advice from their supervisory team who helped me to re-focus on the initial research aims and questions, allowing me think about how trauma-informed approaches were being conceptualised, harnessed, and challenged at each level of the ecological framework.

Limitations of the Study

While this study does include the voices of domestic abuse survivors, the sample is much more heavily weighted in favour of practitioner participants. The reasons for the low recruitment level of domestic abuse survivors in this study are discussed throughout the methodology chapter (above). While there was some diversity within

the small sample of survivors (different ages, different ethnicities, different religious backgrounds, different life experiences, accessing different aspects of service provisions, different parenting status) a larger and more diverse sample would have strengthened the practical significance of the research findings.

The research would also have benefited from documentary analysis, including organisational policies, outcome measures, and demographic data about practitioners and survivors accessing the services. In my initial contact with Women's Aid the business development lead (who left WA in 2021) was very helpful in providing the VOICES documentation (VOICES reflection tool & VOICES planner) and inviting me to VOICES training sessions on reflective practice and vicarious trauma at two of the research sites included within the 'Change that Lasts' programme. I was able to make some notes during the training sessions, but I became aware that this was not the full training package, some of which had already been delivered to the practitioners across multiple sites. If I were to undertake this research again, I would ensure that I would be able to have full access to the training materials and training schedule, to compare training material content and delivery with the views shared by practitioners about the training. This would have been particularly helpful in comparing the VOICES training with the TIME training. Had I known from the outset that this research would include the views of practitioners and survivors from Service B who had completed TIME training as well as VOICES training, I would have tried to negotiate access to the training materials and training schedule.

However, it should be noted that the services might still have been uncomfortable about sharing learning materials with me as an independent researcher, through fear of their material being stolen or plagiarised. The third sector increasingly positions itself as a specialist training provider as a means of generating income to ensure the continuation of services. The precarious nature of the funding context for specialist domestic abuse service provision is likely to increase the wariness of these organisations sharing their training materials with third parties. There is an additional risk that any comments provided on the training content could be taken out of context if the commentator has not attended the training programme themselves.

Summary

This chapter has explored the theoretical underpinnings to this research study, bringing together key elements of feminist theory and embodied realism within an interpretivist epistemological position in advocating for a 'both and' approach to psychological and cultural enquiry on domestic abuse and trauma. These values influenced the research process, my ethical position as a researcher, methods adopted and the reflexive nature of the research. The methods enabled practitioners and survivors to engage with this research, however there were restrictions placed on the research through COVID-19 lockdown measures which prohibited face to face contact and increased the demands of day-to-day service delivery for practitioners. The case study nature of the research enabled me to understand the dichotomy between theory and practice, to generate context dependent knowledge and offer practical significance. This chapter has also highlighted the difficulties of negotiating access to survivors when relying on practitioner gatekeepers as well as the challenges of conducting reflexive thematic analysis.

The next chapter will report findings from semi-structured interviews carried out with domestic abuse practitioners from Services A and B, organised under themes I generated.

CHAPTER 6: PRACTITIONER FINDINGS

Introduction

Practitioner responses to Trauma-informed Service delivery from two sister domestic violence and abuse support services with multiple service provisions within the Northeast of England were obtained through individual interviews over the phone or video call software with fifteen staff members. The sample included 14 practitioners from Service A and one practitioner from Service B. There were no significant thematic differences identified between the responses of practitioners from service A and those of the practitioner from service B with one exception. This concerned the sub-theme of coaching raised by the worker from service B in relation to guiding the choices made by survivors she worked with, particularly around how the survivor processes and communicates emotion (see more on p 199). There was a stronger correlation between the experience level of practitioners and the level and their ability to reflect on broader systemic issues impacting upon their work with domestic abuse survivors.

Practitioners who took part in research interviews represent a wide cross- section in terms of positions within the organisations and levels of experience prior to joining the organisation. The interview schedules were designed to illuminate practitioners' experiences and reflections on adopting a TIA to their work with domestic abuse survivors, including strengths and challenges of TIA working.

Staff demographics table:

Table 4 (below) features demographic information about the practitioner sample. It purposefully omits certain demographic information including the practitioners age, ethnicity, and specific job role, to protect the practitioner's anonymity.

NAME	GENDER	YEARS OF EXPERIENCE	NUMBER
Service A: leadership role	Female	Over 10 years' experience in domestic abuse sector	(P-01)
Service A: leadership role	Female	Over 10 years' experience in domestic abuse sector	(P-02)

Service A: leadership role	Female	Over 10 years' experience in domestic abuse sector	(P-03)
Service A: leadership role	Female	Between 5-10 years' experience in domestic abuse sector	(P-04)
Service A: Practitioner	Female	Under 5 year experience in domestic abuse sector	(P-05)
Service A: leadership role	Female	Over 10 years' experience in domestic abuse sector	(P-06)
Service A: Practitioner	Female	Under 5 years' experience in domestic abuse sector	(P-07)
Service A: Practitioner	Female	Over 10 years' experience in domestic abuse sector	(P-08)
Service A: Practitioner	Female	Under 5 years' experience in domestic abuse sector	(P-09)
Service A: Practitioner	Female	Over 10 years' experience in domestic abuse sector	(P-10)
Service A: Practitioner	Female	Under 5 years' experience in domestic abuse sector	(P-11)
Service A: Practitioner	Female	Under 5 years' experience in domestic abuse sector	(P-12)
Service A: Practitioner	Female	Between 5-10 years' experience in domestic abuse sector	(P-13)
Service A: Practitioner	Female	Under 5 years' experience in domestic abuse sector	(P-14)
SERVICE B: Practitioner	Female	Over 10 years' experience in domestic abuse sector	(P-15)

Table 4: Practitioner sample demographics

Research Questions (Practitioners)

1. How do domestic abuse practitioners and survivors understand the links between trauma and domestic abuse?
2. How is a Trauma-informed Approach (TIA) being harnessed and utilised in the context of two specific domestic abuse service provisions?
4. What are the key barriers and facilitating factors to implementing a TIA within DVA service provision?

The analysed findings presented below are organised under themes, some of which are unique to this research and identified through inductive analysis, such as legitimacy and harm while other identified themes build on existing literature such as gender, training, and intervention.

THEMES	SUB-THEMES	CODES (LATENT)	CODES (SEMANTIC)
Theme 1: Trauma 'the reason that people can't argue with, its accepted now'	Institutional advocacy	Legitimacy Meso-system	Trauma is accepted now, People now link trauma with domestic abuse, We use trauma theory to combat victim blaming
	'Credentialising' the domestic abuse sector	Upskilling the workforce	Giving an additional voice to advocates People can't argue with trauma We've always worked with trauma but now we can spot the signs and name it
Theme 2: Why does she put up with this versus Why did he act like that?	Domestic abuse is traumatising	The impacts of domestic abuse are serious, pervasive, and normal response to abnormal treatment	Domestic abuse can result in PTSD
	Trauma-informed explanations of survivor responses	Trauma can explain the unexplainable- i.e. why a survivor stays	Moving away from the narrative that survivor responses are abnormal- instead, we should see the abuse perpetration as abnormal.
	Domestic abuse is a gendered crime	Must place blame and scrutiny with perpetrators	Why don't we ask him why he acts like that? Why is it

THEMES	SUB-THEMES	CODES (LATENT)	CODES (SEMANTIC)
		of domestic abuse, not survivors	always about why she stayed/why doesn't she leave
Theme 3: Trauma-informed helps but it's not the only thing	Using T-I approach to develop a non-judgemental, objective stance to intellectually manage the stresses of the work?	Relational rupture with survivors: It's not me, it's not them, it's trauma.	Distance, don't take it personally Their response is because of trauma- not because of me (practitioner) Can we meet their needs? Being led by the survivor Being trusted as practitioners that we know the needs of our clients
	How is a T-I approach understood in relation to a needs-led approach?	Effective service provision hinges on the alignment between practitioner and survivor	Tell me what you need and want in the here and now and I'll tell you if and how I can help you
	Striking the Right Balance Between Needs & Risks	The limits to holistic and relational approach Clarity needed around how trauma-informed approaches fit with risk management/assessment	We don't need case notes about how many flowers they planted in their garden today We have a job to do, we must still assess risk, but the trauma stuff could confuse people about their role
Theme 4: Facilitators and Barriers in delivering Trauma-	Training	Increases practitioner compassion and understanding of domestic abuse survivors	Helps us better understand survivors and be more compassionate

THEMES	SUB-THEMES	CODES (LATENT)	CODES (SEMANTIC)
informed service provision			Trauma training is great for learning about the brain- everyone should know this! Helps us with our practice Lights bulb moments
	Impact of the work	The risk of over-identification with role or with survivors Role confusion	Wooded healers Need for separation- between them and their role, between work and home Are you tough enough to do this job? Too clinical, not enough change to embed the learning- we are not therapists we are advocates

Table 5: Practitioner themes

Theme 1: Trauma ‘The Reason That People Can’t Argue With, It’s Accepted Now’

The opportunities and promise presented by harnessing a ‘trauma informed’ knowledge base emerged as a strong theme within some of the staff interviews, particularly those with staff who had greater experience working within the domestic abuse field.

Institutional advocacy

In identifying potential benefits, this new knowledge could hold for the domestic abuse field specifically, the concept of institutional advocacy (Kelly and Coy, 2011) arose, with most workers asserting that trauma knowledge offers to advocate on behalf of domestic abuse survivors within multi agency contexts:

'I do MARAC [multi-agency risk assessment conference] so I can see the difference between the way we work and the way other services work - there is a lot of victim blaming - some can't identify what trauma is. We have to challenge professionals at times... ask why they [survivors] are the way they are, why they stay, why they are using substances?' (P-14, Service A).

'If you're having a conversation with a police officer, for example, that's saying she's a nightmare...we've gone round, he's assaulted her but she's refusing to leave...they've got absolute clear lack of understanding and then it's probably better to come from a trauma-informed angle...whenever you are doing advocacy, I think we'll probably use that more trauma-informed approach with professionals, because I think it is the buzzword, and people are wanting to use a trauma-informed approach.' (P-08 Service A)

'Because they [the police] say, "well, why doesn't she just leave or just block them" or whatever. Or if a woman's given a statement, and then she gives another statement, or if she changes her mind or something like that, they [the police] very judgmental. So, we say, 'have you thought about this? Have you thought what's going on for her? And, you know, she's had this major trauma. So that's your brain and just things.' (P-05 Service A)

These workers (P-14 & P-08 Service A) illuminate the potential benefits of adopting the language of trauma in their advocacy for domestic abuse survivors within multi agency contexts as a means to challenge victim blaming. The first practitioner (P-14) seems to identify a trauma-informed understanding of the behaviour of domestic abuse survivors as a key element that defines and differentiates their service provision from that of other agencies. In this sense, trauma knowledge could be seen as offering the domestic abuse field a legitimacy it had previously not been afforded.

The second practitioner (P-08 Service A) builds on this perspective and highlights the opportunity to capitalise on the current popularity of trauma-informed approaches. The notion of 'buzz words' within contemporary discourse and service provision also speaks to the ever-changing landscape of assumptions and priorities that underlie social policy agendas and consequent service provision. There is a sceptical edge to the notion of 'buzz words' which could denote a kind of meaninglessness or fickleness. While adopting the trauma informed approach wholesale is demonstrated by the less experienced practitioners, a more critical perspective is adopted by the more

experienced practitioner (P-08) who acknowledges the utility of 'trauma' whilst alluding to the ever-changing landscape of models and approaches adopted within the sector.

'Credentialising' The Domestic Abuse Sector

Another related subtheme was the idea that traumatology and trauma-informed practice offers the domestic abuse sector a chance to upskill, professionalise, and consequently strengthen its voice:

'It's about developing, education, upskilling training, building awareness and insight for clients. When I'm delivering training, I always talk about 'credentialising' the sector. Because what that's doing is it's giving us an additional voice, to advocate for clients, because predominantly, you know, domestic abuse survivors have not been seen as survivors of trauma historically, going back.' (P-02 Service A)

This practitioner (P-02) emphasises that domestic abuse survivors the identity of trauma survivor has not historically been extended to domestic abuse survivors and that viewing them in this way could afford them an additional avenue through which to access support. The implication for those who support domestic abuse survivors is to therefore acquire the understanding, skills and language to advocate and encourage this reframing of their victimisation and their support needs within the discourse of trauma.

Traumatology has undergone its own major paradigm shifts from the early studies focussing on veterans' experiences of shell shock and war neurosis (Crocq and Crocq, 2000) which were initially perceived as a 'character flaw' (SAMSHA, 2014) to the acknowledgement of post-traumatic stress disorder in the DSM-III, (1980) towards the conceptualisation of trauma as public health crisis and prioritisation of trauma-informed services within the 'consumer movement' (SAMSHA, 2014). The legitimacy afforded to traumatology and indeed trauma survivors can be linked to the biomedical origins of traumatology and the perceptions of an unassailable diagnosis framework:

'It almost gives us a real reason that people can't kind of argue with! Because trauma is accepted, now, it's become the thing that's acceptable. So now we can put the focus on survivors and tell others that they go through that. It fits that criteria'. (P-03 Service A)

The belief that the recognition of female domestic abuse survivors as trauma survivors could serve, prioritise and better meet their needs raises interesting questions about the potential benefits and risks of utilising the medical model. The Roadmap evaluation (Stanley et al., 2021) also found that a trauma-informed approach was being utilised by domestic abuse practitioners to defend their approach to other practitioners; 'Understanding more about trauma-informed practice has enabled us to challenge negative comments from other professionals who victim-blame and state that problems are due to drug and alcohol use and not trauma lived experiences.' (Survey Respondent, Stanley et al., 2021, p 43).

More experienced practitioners also alluded to change over time – at the layer of the Chronosystem - in their discussion about the early adoption of trauma language within domestic abuse contexts:

'When I started that back in 2003, there wasn't the recognition of trauma' (P-06 Service A)

'We have been working with women who have exhibited signs of trauma, but not always understood those signs ourselves really... I think it's taken quite a long time for the language of trauma to arrive... because predominantly, you know, domestic abuse survivors have not been seen as survivors of trauma historically, going back.' (P-02 Service A)

Both practitioner quotes above bring into focus issues around definition, language and changing perceptions around 'who' could experience trauma and the shifting understanding around what kind of experience could be understood as traumatic.

Theme 2: Why Does She Put Up with This versus Why Did He Act Like That?

Domestic Abuse is Traumatising

The notion that women could indeed be experiencing post-traumatic stress disorder as a consequence of domestic abuse was identified as an important shift by other practitioners:

'[In the past] there wasn't the recognition of trauma, certainly not in domestic violence cases, it was much more black and white, in terms of who gets PTSD, complex PTSD, and who doesn't. And I think the great thing about trauma work now is that there's that recognition now that, you know, that women are exposed to that.' (P-02 Service A).

'The impact of violence and abuse isn't just physical and it's not just immediate, but there is often long-term residual effects of those sort of experiences and behaviour on the individual. And that will present itself in a variety of ways. So you can have things like, nightmares, flashbacks, or often can be forgotten, at an unconscious level, still play out at an unconscious level, and affect people's health and well-being in numerous ways.' (P-06 Service A)

'Trauma absolutely impacts on every aspect of their life, and domestic abuse is a repetitive, traumatic event. And that will impact on their psychological wellbeing, their emotional wellbeing, and finances, everything, every aspect of their life, and just recognising that people will present in many, many different ways. And that we need to scratch beneath the surface to make sure we're not making judgments.' (P-08 Service A)

'I suppose it comes in various ways, but most of it is kind of the verbal emotional abuse that someone is subjected to. So when I think of psychological abuse, I think of name calling, and trying to make someone feel so that they're going crazy or losing their mental health, gaslighting. Putting somebody down and constantly criticising them, making them feel like they're a bad person, making them feel that they're to blame for everything, making them feel guilty, making them take responsibility for things that they haven't done... I would say most people who have been subjected to abuse have some form of PTSD or complex PTSD.' (P-10 Service A)

The practitioners above make reference to 'feelings' and residual effects such as flashbacks or nightmares, commonly referred to within a medicalised context as symptoms. All the practitioners quoted above seem to value the language of trauma in helping them to describe and conceptualise the myriads of psychological and emotional damage that is caused by domestic abuse, moving us away from an understanding of domestic abuse as being physical violence, towards an

acknowledgement of financial and emotional control and cruelty.

Harm is an amorphous or 'fuzzy' concept in terms of 'what exactly constitutes harm and to whom' (Riley and O'Hare, 2000, p 8). This is particularly pertinent when considering emotional harm and the difficulty practitioners have had in identifying and adequately supporting survivors on the basis of emotional harm or abuse within domestic abuse contexts (Robinson et al, 2018; Seff et al, 2008; Stark, 2007). Trauma could offer a way of conceptualising harm and a language to use about emotional harm across different groups and organisations.

Practitioners speak about the impacts of domestic abuse as long-term, repetitive, widespread, pervasive and all-encompassing. Perhaps the language of trauma is particularly valuable because its amorphousness is in some way validated through its association with the biomedical model and an emphasis on symptoms.

Trauma-informed explanations of survivor responses

Trauma appeared to offer the majority of practitioners a new language to justify ongoing support for women with nonphysical harm, as well supporting their position on standing alongside survivors even when they may be taking decisions that seem counter-intuitive:

'We talk a lot of our women making wise choices, or unsafe choices that are actually not really choices that they make at all, because they don't have a choice. She doesn't choose to go back to her abusive partner, because she doesn't choose to be abused, she might go back to her abusive partner, because actually, he still financially controls her, he's still using the children as a weapon, or she has a trauma bond with him and that can't be broken, and we have to recognise all of those things really, that come from trauma.' (P-03 Service A)

The practitioner above reflects on not only a survivor's limited choice but how they as domestic abuse workers/ domestic abuse service can justify their choice to continue their work with survivors. This raises an interesting question about how domestic abuse practitioners are conceptualising trauma, possibly as a means to justify continued involvement from a damage limitation stance.

Another practitioner commented on the importance of normalising how a survivor of domestic abuse may feel:

'So I think the language of trauma can actually, to a degree in the best possible way, kind of normalise how people feel, kind of, I think that's, that's really important.' (P-06 Service A)

The practitioner above refers to the need to legitimise the survivor response as a normal response to abnormal events (abuse). Positioning domestic abuse as abnormal and traumatic responses to domestic abuse as normal speaks to the wider goal of domestic abuse organisations to shift broader societal attitudes around domestic abuse, shifting blame and scrutiny from survivors to perpetrators.

Domestic Abuse is a Gendered Crime

While the SAMSHA (2014) definition of trauma-informed care specifies the consideration of gender (Culturally and Gender-Responsive Services) and feminist scholars have called for trauma exposure to be understood in a gendered context (see literature review; Herman, 1992; Humphreys & Thiara, 2003; Tseris, 2013), the language of trauma and indeed trauma survivors is predominantly gender neutral. A recent review (Mendlowicz, et al 2022) of the top 100 cited journal articles on post-traumatic stress disorder found that female victims of sexual or physical violence were examined in less than 8 percent of the most-cited publications.

Academics from the fields of psychiatry and traumatology such as Van Der Kolk (2014), Cozolino (2002) and Perry et al (2017) have all written seminal texts on trauma which largely focus on the intrapsychic and autonomic impacts of trauma with very little focus on the gendered context of trauma exposure or manifestation of trauma symptoms. The linguistic framing of harm caused by domestic abuse as 'trauma', could be indicative of the shift or what some have called the depoliticization of domestic abuse as a gendered form of abuse towards a more gender-neutral understanding of domestic abuse (Simmonds, 2019; Hirst & Rinne, 2012; Robinson & Rowland, 2006).

Meanwhile the practitioners interviewed were rooted in their understanding of domestic abuse as a gendered crime:

'We know that it's a gendered crime, and that females are generally the victims

of domestic abuse. That's what the statistics tell us. Women are victims of domestic abuse, and that is about male privilege. And the way that women are still seen within society, and what's acceptable and what's not acceptable within communities, and, yeah, all sorts of people's beliefs.' (P-08 Service A)

'It's gender specific. And that's where I like to be because I don't want to be lost in the middle of it 'happens to everybody' because it doesn't, look at the bigger picture. We might only make a small difference in what we do but it feeds into the bigger picture of what happens to women all over the world.' (P-03 Service A)

'Women experience much more gender-based violence. if we were looking at trauma from a gender perspective, in terms of the amount of people exposed to trauma, then I would say, yes, women are more exposed to traumatic events. We have to look at the gendered nature of violence and the huge impact that has, you know, on the clients we support.'
(P-07 Service A)

SAMSHA's trauma-informed principles highlight the importance of acknowledging gender and the way in which it intersects with the individual's experience of traumatic events. While not all practitioners made explicit links between trauma and gender, almost all described domestic abuse as a gendered crime. One practitioner summarised the potential benefits of adopting a more gendered approach to TIA in relation-to-relation domestic abuse, at both the Micro and Macro levels of the system:

'I wish we could start placing responsibility for abuse with the perpetrator, that would be a start. Because then all of the other things that we do to women would stop. Because then we stop asking, Why does she put up with it? Why does she do this? Why does she do that? And we would just go, Why did he act like that? Why? Why is he violent or abusive? Why is he allowed to do things? What are we doing in society that makes men think that they can just do whatever they want to do with women?' (P-03 Service A).

'I've got a child protection case, and the social worker will say oh I'm going to step it down, because there's not a lot more we can do and I said that you can't do that because you're saying to him that it's okay that you haven't actually been to the perpetrator programme and the reason we went into child

protection, the first instance was because of the domestic abuse .' (P-10 Service A)

Another practitioner reflected on how the invisibility of male abusers in her work with survivors helps to her bolster in not losing sight of the female survivor she is working with and prioritising her rights and needs:

'I quite often think, oh god, why don't the social workers see what a perpetrator he is? I think it's because they see that crying man. Of course they will feel more empathy, just like the survivors who go back to their abusive partners, they have that sympathy or that trauma bond. We [domestic abuse practitioners in Service B, a women's only service] are quite lucky that we only see the crime as such, we see what he's done to her, and how it's going to affect her the rest of her life and everything like that. Yeah, we don't see him. And once you do see him, your perspective changes.' (P-15 Service B)

One practitioner alluded to the tension between staying true to their gender-based organisational identity and priorities while competing for limited funding sources:

'We might be funded in part by social services, or the PCC but they're not the client. In this, in this world of complex funding, it's, it's important to remember who the client is, isn't it, and be a little bit brave, and make sure that you are still advocating for the right person.' (P-01 Service A)

Within this context of competitive tendering, and preference for gender-neutral services (Simmonds, 2019) there have been other linguistic reframing in how the impact of domestic abuse on victims is described. Throughout the years, numerous discussions have transpired regarding these matters, particularly concerning the interplay between the Women's Movement and governmental entities, as well as the potential appropriation of the former when the latter intervenes (see Hague and Mullender, 2006; Hague & Malos, 2005; Lovenduski, 1993).

Theme 3: Trauma-informed Helps but It's Not the Only Thing

The extent of the 'choices' available to domestic abuse survivors was something that many practitioners reflected on during their interviews. While trauma informed approaches promote providing survivors with choices wherever possible, a minority of practitioners expressed a tension in promoting choice when survivors seemingly make choices that are counter-intuitive to their own safety or wellbeing. While some were very clear that, within the context of abuse, survivors' choices were limited to non-existent, others spoke about an advocacy of damage limitation when faced with the stark reality of the 'choices' their clients seemingly made:

'I can't do anything about choices people make, all I can do is give them the options. This morning, a woman went to court to discharge a restraining order – a five-year restraining order against a man who was incredibly violent. All I did was say you've got choices at the court, the court might not discharge this, because he's a really violent man - he has just got out of prison, this five-year restraining order that protects you. But if you want that relationship to carry on, then what you can do is you can ask the judge to look at... to allow you both to have contact, but he can't harass or harm you.' (P-12 Service A)

Conversely, using a trauma-informed lens to increase understanding and compassion for survivors who are seemingly taking actions that are counterintuitive to achieving their own safety or recovery was something many workers spoke about when reflecting on their direct work with service users:

'I think it (trauma-informed approach) gives you, like, opens your eyes to sort of like thinking in a different way. So for somebody who is presenting with, like, a difficult behaviour, or, you know, like aggression, or something like that, it's about trying understand why, where before, you know, like, people think, oh I am not having anything, do with them, I don't want to support her, you know not that I think anybody from [my organisation] would say that, but I just think it gives you a little bit of understanding of why women act the way that they do, especially the women that are working with complex needs women' (P-05 Service A)

'I think being informed, it sort of gives you two strands: you can have the knowledge to explain to the woman how, why she's feeling the way that she's

feeling and why she might behave in the way that she behaved so that she can understand that nothing wrong with her – it's the product of everything that's happened to her, that has led to a maybe developing with a coping or surviving that are not helpful or that might frighten or [have] even more an impact on her life.' (P0-3 Service A)

An experienced practitioner spoke about working closely with a survivor to make them aware of how their behaviour was playing into the malicious allegations being made by her ex-partner and reinforcing the bias other services seemed to have towards her:

'Some survivors- like the one you [addressing the researcher] spoke to, don't quite understand quite what's happened to them [coercive control]. She's a perfect example because she basically she didn't quite understand what was happening to her. And from him, there was a lot of malicious allegations to professionals about her. And when she got really upset about that, it made the malicious allegations look real. So it was more about [saying to this survivor] stop doing that, take a breath and say, can I get back to you?' (P-15 Service B)

In the example cited above, the worker is not simply promoting the choices made by the survivor, she is using her own knowledge and experience to guide the choices made the survivor (in terms of how she communicated/responds with her ex-partner as well as professionals). This quote from the only practitioner from service B points towards a subtle difference in approach between the two services, which is captured in more detail in the survivor findings section (p 232-235).

Another worker talked about the importance of boundaries, and that while an entire staff team might be 'trauma-informed', it does not in itself guarantee a consistency of approach in relation to things such as professional boundaries. Individual workers might manage their caseloads and their work very differently and some differences in working practices could lead to strained staff dynamics. The worker gave a particular example of boundaries:

'It's about boundary and as well. So even though you're trauma informed, it doesn't mean you have to open everything and go to the ends of the earth. That's not what it's about. But some people would make it like that, and that that could cause tension in the team.' (P-08 Agency A)

This practitioner is emphasising one of the common misunderstandings around 'trauma-informed' approaches. Well intentioned practitioners may interpret the relational and flexible stance embedded within 'trauma-informed' approaches as so holistic that it loses focus (open everything up) or so responsive that it falls into the doing 'for' instead of doing 'with' relational dynamic (McCold & Wachtel cited in Stang, & Braithwaite, 2001).

Using T-I approach to develop a non-judgemental, objective stance to intellectually manage the stresses of the work?

Many workers spoke about not taking challenging or conflictual presentation behaviour from survivors personally and related this to having an understanding of trauma presentations as both beneficial for their relationship with a survivor as well as when advocating on their behalf to other professionals:

'So when they come in and they're angry, or they're frustrated or screaming, or they're aggressive, and when you feel it like in a threatening way, I suppose you can take that very personally or somebody becomes angry. when you break it down, and you work from a more trauma-informed perspective, you think very differently. So to think about how trauma impacts and how that can make people reactive. So it can either make them very subdued, it can make them very angry, and not to take that personally.' (P-06 Service A)

'And I think when you're working with domestic abuse, it can be quite complex. And it can be really difficult. And you can take things personally. So, if somebody is ringing up shouting and screaming, or they're not getting what they want, or getting their needs met at that point, you can't take that personally. But what the trauma-informed training did was helped you to remove yourself from that and look at it from a trauma-informed perspective about how that person is reacting, why they're reacting in that way, and not to take it personally.' (P-08 Service A).

'I guess it's important when you're working, I guess, from a frontline in a support perspective, that you understand that, because if practitioners don't, then we can get very personal in terms of our interpretation or reactions and interactions

with people that are impacted by trauma. Once people, once practitioners have an understanding of that, there's much more of an ability to be more objective in the level of support.' (P-02 Service A)

'Having an understanding of how that trauma may impact that person may impact their ability to engage and be involved in services. So how can we help them in that either by first addressing the trauma or making the support you offer them more flexible to fit with that?' (P-09, Service A).

'I think I genuinely sort of think about, what would I say to my friend, so I treat them like I would treat my friend. But if they are really aggressive or telling me to F off, it's more about just about seeing if I can manage their behaviour myself to at least getting them to trust me. Yeah, so yeah, that's what I'm doing with that the trauma, it's about getting them to trust me.' (P-15 Service B).

The quotes above could be understood in the context of 'emotional labour' (Hochschild, 1983, 2019) in that practitioners' understanding of a correct interactional response has been shaped by their organisational ethos, specifically the trauma-informed approach. Practitioners offer a selection of characteristics or virtues that TI helps them align to and express, such as being non-reactive, curious, objective and flexible in the way they support and meet the needs of the women they work with. The trauma-informed approach could be seen as helping to ameliorate or at least provide guidance and structure to the emotional labour that is required of them in their professional role. The notion that TI assists individual workers to reframe their understanding of survivors' behaviour and adapt their response accordingly speaks to a wealth of pre-existing literature around concepts such as emotional neutrality, emotional labour and emotional regulation in service or public facing professional roles (see Chapter 8: Don't take it personally: Psychological distancing).

One of the service managers spoke about the importance of experience in dealing with difficult interactions with survivors:

'I think, perhaps, the other aspect of it for me is, more so in a refuge environment than in an outreach environment, you are working alongside women whose trauma will play out in various ways. And you need to understand that that's what that is, you know, for example, I had a recent sort of experience in one of the refuges where there was a woman who was seen

as really sort of challenging, she was quite aggressive in in the way that she reacted sort of interacted with staff, she was very critical towards staff, she was verbally quite aggressive in terms of calling them all sorts of names at different times. For an experienced member of staff, you can deal with that and not take that on board, you know, that that's not personal, but for a new member of staff, that can be really difficult.' (P-06 Service A)

This manager highlights the importance of trauma knowledge to increase a practitioner 'understanding of how survivors may present and emphasises the need for the experience and ability to reframe this behaviour and create some emotional distance between themselves and the survivor in order to 'not take it on board' and deal with it appropriately.

How is a T-I approach understood in relation to a needs-led approach?

In many senses a trauma-informed approach can comfortably incorporate a needs-led approach in that trauma-informed practice acknowledges the need to 'see beyond an individual's presenting behaviours and to ask, 'What does this person need?' rather than 'What is wrong with this person?'" (OHID, 2022). While the workers interviewed had some differing ideas about what constituted a trauma-informed approach, a needs-led approach seemed to be well understood and utilised by most:

'This woman may seem really angry - but it's just an expression- then she would be fine. People get their needs met through this presentation.' (P-08 Service A)

'You don't have to tell me your story if you don't want to, just tell me what you need' (P-14 Service A)

'I had a conversation with one woman I worked with about trauma, and she understood but other times it isn't appropriate - it was more about meeting her needs there and then' (P-08 Service A)

'It's about what they need and want, it's not about what we want from them to do well. But if we do it more around their needs and wants and how they want to see.' (P-07 Service A)

'We refuse a lot of women at recovery (complex needs refuge provision)

because we could not meet their needs.' (P-13 Service A)

'We don't use the trauma symptoms checklist, but we use chaos index which is a more of a needs approach.' (P-02 Service A)

A practitioner from Service B highlighted the importance of professional judgement and knowledge of survivor needs in relation to managing their own case load, reinforced by the trust in their professional judgement they receive from managers or supervisors:

'So, I find in [Service B], it's more about [supervisor asks] is that need still ongoing for that client? Yes. Okay. And it's, and it's very much up to me as the professional, [to decide] whether to keep it open or not.' (P-15 Service B)

The emphasis in all the quotes above is on the importance of learning and understanding what the survivor needs and being sure about whether the practitioner or the service can meet their needs. The practitioners also spoke about the importance of the survivor being at the centre, echoing the long-standing feminist empowerment approach to domestic abuse advocacy work - described as a survivor-centred approach - which aims to increase survivor autonomy and empowerment (Davies & Lyon, 2014; Nnawulezi et al., 2018).

The worker from Service B also reflected on the importance of adopting different strategic approaches with different professionals working with a survivor to ensure that the survivor's needs are seen and that their status as a domestic abuse survivor is fully acknowledged:

'But you've got to engage through the working with as well to understand them. And that first social worker that basically said, I don't believe there's any domestic abuse, I think it's tit for tat. So, once I knew that, I thought, right, okay, you've got to show her what he's doing.' (P-15 Service B)

The practitioner went on to discuss the notion of the perfect victim and the injustice and necessity for survivors to 'present' in a certain way to ensure that they are listened to and not dismissed by other professionals. This phenomenon was also highlighted in some survivor testimonies (see 'Don't let them use your trauma against you' section).

Striking the Right Balance Between Needs & Risks

While the VOICES framework and service model aims to centralise survivor voices as the experts of their own experience and move away from a risk-based approach and towards a need-based approach, one practitioner voiced concern about the way in which the framework was being interpreted and utilised by practitioners;

'It's about getting that balance where you don't come too much like a statutory service and end up ticking boxes for the benefit of the service rather than the client. But it is about that risk. And it is about managing risk. I think sometimes that things can get lost in trauma informed and I think the VOICES sort of shows that. I've seen notes about how the survivor was 'in the garden planting bulbs, and they've been shopping with their mother', and while we need to get to know that person, actually, what I need to know is when I'm following up on that case, what's going on now, where's the perpetrator around, you know... It doesn't mean you can't be trauma informed, but you're also managing risk at the same time. And I think sometimes with a trauma-informed approach, and certainly with the VOICES, it becomes a bit wishy washy on getting that balance...' (P0-8 Service A).

This practitioner went on to offer a suggestion about how a needs led, survivor-centred approach could be utilised alongside the prioritisation of survivor safety and risk assessment;

'I think the risk is outside influencing factors but also understanding what that survivor or victim sees as a risk. So, risk isn't just about risk assessment is it's about coming from that person, what their needs are, how they see risk, and what they feel they're at risk of, and then incorporating those obvious risk factors that they may not be aware of. So it's a balance between that needs led and understanding who that person is, but also still being able to assess risk and manage risk because we are still working in a multi-agency context, we still have MARAC meetings, we still work with the police, you know, risk, there's risk management everywhere' (P0-8 Service A).

This interpretation of a trauma-informed framework such as VOICES as being needs led instead of risk-based throws up important questions about how to prioritise survivor safety in domestic abuse advocacy. Proponents of the VOICES framework would

argue that this more relational and holistic approach enables survivors to disclose more about their emotional needs and explore avenues for healing and independence, leading to improved engagement from survivors with services (Women's Aid, 2018 pp 23-24).

Theme 4: Facilitators And Barriers in Delivering Trauma-informed Service Provision

Training

The majority of practitioners had found any trauma training they had undertaken very useful and relevant to their work with domestic abuse survivors;

'We would also deliver training on trauma-informed practice, generally sort of within the sort of probationary period for somebody working for us. So in that first sort of 26 weeks, we would be sort of delivering sort of that formal training and push. And that would address vicarious trauma' (P-06)

'There are different levels to it... it really helped me in terms of practice, and how I then responded to clients' (P-08 Service A),

'If only everyone could see just that example of how your brain works- You know, and the actual visual, you know, example of it- which parts of your brain and how your brain responds to trauma. I don't think people understand how someone's decision making is impacted by trauma.' (P-11 Service A).

'I found it really useful because it was so practical, it makes you consider different things like where you're sitting in the room with a survivor and how you respond to things' (P-09 Service A)

'What I took from it is you cannot judge people, and you've got to remember, there's always a reason, a reason why, you know, what's going on inside for them' (P-05 Service A).

'And I think across the sector, certainly the feedback I've had when I've delivered sort of trauma training is there's always almost these light bulb

moments in the sector where practitioners have, or they've kind of known there was something else, but they haven't really known what, and a lot of them have felt quite restricted in terms of how they advocate for clients, or how they react to clients. Without that knowledge, so there's something about learning about trauma that really kind of opens up a practitioner's practice.' (P-02 Service A)

Within the complex needs unit, there seemed to be a commitment to ongoing monitoring of staff training needs:

'So we look at what staff have been trained on what and what staff need to continue to do the other things to bring them up to speed, because it's about self-development as well. And you would hope that staff will feed into that development because we have appraisal, so there's a structure around appraisals and supervision' (P-03 Service A).

Some of the practitioners suggest that trauma training helped them to enhance their communication skills and empathy in their work with survivors. Given the stated importance of harnessing a trauma-informed knowledge base, it is worth noting that the level of awareness and knowledge of individual workers of the ways in which trauma could impact upon an individual varied greatly, which largely seemed to correlate with level of experience working within the domestic abuse field. More experienced workers distinguished between physical, psychological and behavioural impacts of trauma as well as recognition of immediate as well as long-term effects.

The majority of practitioners in this study highlighted a need for an increase in supervised/led learning opportunities following formal trauma training to help embed their theoretical learning within their practice. Practitioner interviews also highlighted some challenges encountered within the shift towards trauma-informed practice in their specific context, including: COVID-19 lockdowns and social distancing restrictions (P-01, P-02, P-04, P-012), a reluctance by some practitioners to utilise clinical supervision, inconsistencies in support provisions for practitioners across the organisation (P-01, P-02, P-04, P-07, overly 'clinical' language often associated with trauma (P-02, P-07, P-08) and turbulence or frequent changes in organisational structures:

'I think where the training comes from is from our - so the counselling therapeutic background. It was developed, and it (TIME training) was devised

by our clinical lead here and at the service I used to work for before. And I think that, as a therapist, you have that constant knowledge in terms around symptoms. While I have some of that knowledge- I'm not a therapist, if that makes sense. Sometimes I struggle to retain all of that information.' (P-08 Service A)

'Sometimes it (trauma training) can get too psychology. And I just want to say, just give it to me in layman's terms... what I need to know and how I should maybe deal with that or react to it or what my options are?' (P-07 Service A).

The practitioners equate trauma knowledge with clinical or therapeutic roles, clearly seeing their role as advocates as something distinct and separate from this.

A range of practitioners with varying levels of experience described the gap between initial training events and further opportunities to embed and really grasp what has been presented and how they might apply that learning:

'You can have training on trauma-informed practice, but actually, you need day to day coaching on that as well and support to deliver that...training is seen as something that you do once and then that's enough...but it's about actually challenging yourself and your own practice challenging the practice of others on an ongoing basis.' (P-02 Service A)

'I feel like I have so much to learn...I just want to say. Just tell me at my level, because I don't do that clinical side of it..' (P-07 Service A)

The four practitioners quoted above are all making statements about their felt lack of confidence, clinical expertise or knowledge. The sense that trauma theory comes from a discipline or a background they are not familiar with, and the expectation placed upon them to know what to do in terms of embedding a trauma-informed approach into their practice seems daunting or overwhelming for these practitioners. This seems to point to varying levels of training, knowledge, expertise and confidence amongst the staff team. Is trauma-informed training offering way to address this, an attempt to upskill all workers and close the variability gap in skills and knowledge within the domestic abuse sector? This raises more questions around fidelity and practice, as trauma-informed approaches are not a unified model of practice, it could present a challenge for services wishing to evaluate the levels of competence or confidence in a varied workforce

(varied in skill level and confidence) and attempts to implement TIA in frontline service delivery.

Impact of the work

In addition to upskilling the workforce, a trauma-informed ethos should involve raising knowledge and awareness within an organisation around the potential impacts on staff of working with traumatised populations, as stated by this practitioner:

'Trauma-informed care has two strands: the knowledge to educate survivors about their feelings and behaviours being based on their past experiences and the knowledge about vicarious trauma in terms of staff' (P-03 Service A).

A few of the practitioners spoke about the importance of considering how the practitioner's own past experiences could be impacting on their work with survivors;

'I think within our sector, historically, we have a lot of lived experience practitioners working in the sector, I think, and that brings a lot of sort of, you know, advantages but, but equally, you know, when we consider something like the wounded healer kind of concept, and being unaware of some of how your own experiences can affect you individually or affect your role, I think it's absolutely critical that there's some awareness around that.' (P0-2 Service A and B)

'You know, because we have all come from different life experiences and we have all got things that have happened to us in the past that might have a bearing on how we deal with something that where we sit similarly, and will think, Oh, God, I can't revisit that same problem, I can't revisit that. And you either have to muddle through with or ask somebody else to do it.' (P-13 Service A)

'The worker may think I can't get any getting closer or go any further because actually, it's triggering it on something that might have happened with me' (P-03, Service A)

'With trauma-informed practice, it's not about what's 'wrong with you?' it's about being curious about 'what happened to you?'. Now, it's about even practitioners, you've got to ask what's happened, what's happening, and really understand practitioners holistically, just as much as you do your clients because that, that interplay between the two of them can be significantly affected by trauma on both sides.' (P0-2 Service A and B)

The practitioner quotes above all acknowledge the potentially 'triggering' impact of working with domestic abuse survivors, particularly if the practitioner has experienced similar experiences in their own life. The last quote emphasises the importance of trauma-informed organisations implementing trauma-informed principles in a duty of care towards their staff, as well as their client base.

All practitioners were asked about their level of awareness about burnout, secondary traumatic stress, and vicarious trauma, including any training they had been given around the concepts, how they would characterise them in their own words and if they or their colleagues had ever experienced any of the associated symptoms:

'I personally find that quite difficult to recognise in myself. And I think I have cases where I'm definitely still thinking about them over the weekend, or I'm like lying in bed thinking, oh, gosh, I hope that person's okay. But I don't think I'd necessarily be able to come up and be like, oh, that that was secondary trauma. I think I'd find it hard personally, myself, to recognise it because I feel like I don't necessarily know that much about it. Like, I know where it is, but don't really know what it looks like.' (P0-9 Service A)

The quote is from a less experienced practitioner who conveys a lack of confidence in being able to adequately identify secondary traumatic stress or differentiate it from burnout or workplace stress.

'I think I probably have seen it with staff, you know, that you can see an inability perhaps, to walk away at the end of the day, people working longer hours than you might perhaps want them to do, you know, because they're ceasing to sort of separate themselves from what's going on in the project, perhaps sort of overly involved with individuals service users not able to, to kind of, you know, kind of, again, gain some distance from that.' (P0-6 Service A)

The second quote is from an experienced practitioner with a middle-leadership position who is reflecting on what she has noticed in her staff team, particularly over-identification with clients or an inability to achieve a work/life balance.

'What we noticed with staff during lockdown is because when we sent outreach staff home, to work from home, I could see in them there was what I would term a sort of those vicarious response, because they were just really struggling to have those stories coming into their own homes, when they were on their own, there isn't anybody else to bounce that off.' (P-01 Service A)

The final quote is from a member of the senior leadership team who is comparing different aspects of service provision and associated staff teams, stating that the outreach team, who were asked to work from home in accordance with Covid-19 lock down restrictions, seemed to exhibit vicarious traumatisation responses due to a lack of separation between their home and work environments.

The three practitioners quoted above are each at different experience levels and hold different professional roles within the organisation, which is somewhat reflected in their answers.

Impact of Covid-19

The organisation responded to this staff need by inviting outreach workers back into the office as soon as restrictions allowed:

'We brought people back in sooner than most people would have done where a lot of services was still working from home. but we put to staff and said, if you're struggling at all, we're open in the office and come in work part time work at home, if you want to come in the office, if you want to. Most opted to come back in the office, I think that's about getting that level of support to keep their own sort of homeostasis if you like.' (P-01Service A)

The impact of Covid 19 was also discussed in relation to the generic refuge staff team:

'The second lockdown has been much harder; I think particularly for refuge mainly because I think the residents have had enough. they flaunt the rules.

And that's really difficult for staff because, you know, the staff say we're putting ourselves at risk by coming in here every day when there's been issues with child contact, and all that sort of thing that goes on. In our social services [they] think it's absolutely fine for, for the children to have contacts to different fathers and then come back into the refuge.' (P-01 Service A)

The pressures of the wider context are alluded to in the quote above, with the expectation to uphold child contact requirements inadvertently placing refuge staff at greater risk and jeopardizing their sense of safety at work.

Partitioner attitudes towards help seeking

Practitioners were all asked about their willingness to seek support if the stress associated with their work becomes unmanageable and any potential barriers to seeking support:

'Historically, there's been that kind of approach that you see in a lot of other very, you know, services that are dealing with extreme trauma, there's almost a kind of, well, are you tough enough kind of approach?' (P0-2 Service A and B)

There is a universal expectation somehow that, you know, will just carry on. And the emotional price of the work isn't always addressed. (P0-6 Service A)

'You know, sometimes it is hard to open up, even if you do have secondary trauma, because you don't want to be seen as not being able to cope. It depends on what type of personality you are, if I need help I'll ask for it but some of my colleagues might just struggle through.' (P-13 Service A)

'I'd say I definitely see people getting weary, I think that is really hard and, and can be, can be, like, tiring them out emotionally, you think about it, you carry it into the next day, then I think sometimes you do always feel like behind. But I think that's just the nature of the job. Like, there's always going to be more incidents, there's always going to be things behind the support plan that you don't have chance to do, because there's just so so much.' (P0-9 Service A)

Practitioners talked about the 'historical' and 'universal' expectation of domestic abuse

advocates to keep going and the emotional impact being seen as part of the job. The third practitioner alludes to individual differences (personality types) as the primary variable in whether a practitioner will seek support.

Formal and Informal Support Structures

Practitioners from each aspect of service provision within Service A were asked about the support structures and mechanisms within their organisation, there was a notable variation in the support infrastructure offered to workers in different aspects of service provision.

The practitioner from complex needs unit listed a range of workplace support structure and mechanisms which support them in their work;

'The clinical supervisor is here every week- we have a staff meeting on a Wednesday and a group case discussion meeting on a Friday'. (P0-5)

We have regular weekly team meetings, and we have weekly case meetings. There's lots of opportunity there through clinical supervision, line management supervision, there's a lot of resource there and chances to reflect. We seem to pick up on issues like that much quicker, because the focus [of complex needs unit] is very sort of trauma. trauma based. (P-03, Service A)

'For the complex need's unit, for example, we are dealing with some really challenging issues. So, there's a there's a weekly meeting of staff and they go through some cases, they talk about the impacts of that, how to manage that. How are we managing that as a team? Is the team okay? Are we all on the same page? And they get individual clinical supervision. And that's something we're wanting to extend to the other refuge.' (P-01 Service A)

The practitioners all cite clinical supervision and staff team case discussions as primary sources of support. At the time of conducting these interviews, the complex needs unit was the only staff team that had scheduled access to clinical supervision. Staff from the outreach team commented on a range of more informal support structures such as helping one another with workload, peer support and having a supportive manager:

'Quite often we like chip in and we'll, we'll like fill in forms for each other or, and yeah, I think when you have like up-to-date case notes, it's easier for people to like chip in and take on a bit of the workload.' (P0-9 Service A)

'The peer support around us is really good. And we have a good team. It's one of the best teams I've ever worked with, in my life.' (P-14 Service A)

'I've seen a couple of colleagues where I thought have witnessed them maybe put their heads in the hands and look very frazzled. In fact, I saw someone do it yesterday. So I messaged her this morning, just privately and just said, How are you doing? Are you okay? We when we do look out for each other in that way.' (P-11 Service A)

The outreach service staff in particular talked about the importance of having strong leadership, particularly the importance of leadership having an open-door policy so that staff could seek ad hoc support. Two practitioners recalled occasions where their team manager had supported them with their workload:

'And I think you know that our caseloads always monitored very closely. And [outreach service manager] is very good at making sure who can cope with a high caseload and who can't, the referrals are very much allocated on a skills basis but also it's about the level of risk associated with each of the cases, so our manager is really good at monitoring that and trusting us that we know the women on our caseload and what they need.' (P-11 Service A)

'And yeah, so I mean, [outreach service manager] has like written reports for me, helping me when I feel overwhelmed or behind with my work, so it's nice.' (P0-9 Service A)

The generic refuge service provision seemed to have fewer formal mechanisms or structures to ensure practitioner wellbeing;

'Where we've been less supportive, is the refuge. Because it's sort of been business as usual, and yet not business as usual. It's more difficult when you've got people with shifts to sort of do that. The refugee environment is slightly different in that it's quite constant contact all day with very with residents coming and going.' (P-01 Service A)

The refuge staff in service A did not have scheduled access to clinical supervision, but one member of the leadership team spoke about her efforts to source supervision training to try and ensure that case management/ line manager discussions could be more restorative and reflective:

'One way to support staff well is through is through supervision. But that requires a particular approach to supervision that is not your traditional kind of organisational manager or managerial type of supervision, it is about actually offering opportunities to talk about particular service users and to reflect on what's happened and to explore how that's left the member of staff feeling, and what else they might do differently in the future.' (P0-6 Service A)

However, this participant highlighted a gap in supervision training provision for line managers who have a supervisory role:

'I was looking for training courses on supervision because we had a couple of new supervisors, we could really have done with it. We didn't have anything to deliver internally at that time. So it was about looking to see what was out there externally and it's hard to find that kind of training. You can get your normal sort of traditional managerial types of supervision and then there's your clinical supervision delivered by a psychologically trained individual. But nothing in that middle ground, for experienced practitioners, who are now supervisors and want to support the staff members to reflect on what they do and what impact is having on them. But I, I haven't really found that. we really do need to find training that that kind of that can reassure us that we are giving our managers the skills that are needed to undertake supervision effectively.' (P0-6 Service A)

As this practitioner reflected on the lack of clinical or reflective supervision available for practitioners in the main refuge and outreach services, she suggested that perhaps the VOICES reflective tools were an attempt to help practitioners become more reflective, however, this has its limitations:

'And I can see that's where obviously, like the reflective tool came in from the voice or VOICES work to try and get people to do that. But I think you need to, you need a second person to help you with that often, to challenge your thinking, to reflect on its own won't necessarily produce that. And it's difficult, you know, in busy outreach, refugee environments, it's really difficult to address that. And I think you know that it's probably true to say that, that we don't address it enough.' (P0-6 Service A)

To alleviate some of the workplace stress experienced by the refuge staff team, a member of the senior leadership team described efforts such as increasing staffing levels, shortening shifts and encouraging staff to reach out to the inhouse counselling team for emotional support:

'We have just put another manager over at the refuge and said, we need, we need to support people better. We need to shorten their shifts. We brought some bank staff in to make sure that you know, full time staff, and not doing those really long shifts, just give them the space and time and yeah, just trying to give some bonuses if you like and a bit of relief.' (P-01 Service A)

'But what I've said was we have a counselling team, go and if you're worried about anything, go talk to them about it - they are in that office, you know and it is an open door policy and staff are picking up on that beginning to do it and I think see the benefits. So, we want to spread more of that, so that we get that therapeutic approach and therapeutic thinking if you like, into not only what we do but self-care as well.' (P-01, Service A)

Other provisions include emotional wellbeing training for managers and the employee support scheme helpline;

'MIND put out a mental health sort of first aid check during COVID. So the managers went through that with, with each member of staff about, you know, how are you coping? You okay, what do you need? How do you, how are you

looking after yourself? So that that went through the organisation that everyone did that.' (P-01 Service A)

'We have we have an employee support scheme that they can ring: nobody uses it. I'm not surprised that they don't use it, because it's external. I'm not sure I would go external either, you would only go external, I think if you had a really unsupportive team, that's the only way that you would have to look outside. I think it quite heartens me that people don't use it, because I think they don't use because it's safe enough inside to raise whatever they need to raise.' (P-01 Service A)

The participant quotes above both place emphasis on strengthening the internal channels of support available to staff to create an emotionally safe working environment, so lessening the need to use external support mechanisms such as the employee support helpline. However, it could be argued that if certain staff are reluctant to seek support within the organisation through fear of being perceived as not being able to cope with their job, despite the apparent efforts made by the organisation to reassure staff, it is unlikely that they will use an external helpline. An external service could provide a useful mechanism of support for practitioners who have less supportive supervisors or managers. While the aspiration of the service leadership team was for all practitioners and supervisors to be psychologically aware and trauma informed, system change at every level of the system can take time and, as alluded to by mid-level project supervisors and managers, there were still unmet training and support needs that they were struggling to meet internally.

Summary

The practitioner findings chapter begins by outlining the research questions pertinent to the practitioner sample and detailing practitioner demographic information in addition the themes, subthemes, and codes generated by the researcher in organising and interpreting the findings. There are four main themes, including 'Trauma the reason people can't argue with', 'Why does she put up with that versus why did he act like that?', 'Trauma-informed helps but it's not the only thing' and 'Facilitators and barriers in delivering trauma informed service provision'. The practitioner findings offer insight into the way in which they think that a trauma-informed approach has been

useful in their practice, highlighting particular benefits such as offering a language for non-physical abuse, legitimising the concerns and needs of survivors, as well as upskilling the domestic abuse sector.

Interestingly, many practitioners cited one of the primary benefits of adopting a trauma informed approach as enabling them to psychologically distance themselves during their interactions with survivors; this was a way of protecting themselves and adopting a more understanding and survivor-centred interpretation of challenging behaviour exhibited by women. While previous research suggests that psychological distancing could be an indicator of risk of secondary traumatic stress, vicarious trauma or burnout, some practitioners in this study conceptualised it as an antidote to workplace stress and a protective barrier enabling them to engage more effectively with domestic abuse survivors. It should be noted that most practitioners stated that their level of awareness of secondary traumatic stress and vicarious trauma were limited, and none could cite resources about these topics shared within the organisation, beyond a brief exploration in their initial trauma training.

Most practitioners were very positive about the utility and alignment of a trauma informed approach within a feminist domestic abuse service, particularly when it was coupled with a needs-led approach, focusing on here and now concerns articulated by survivors. There were some practitioners who voiced caution and the possibility of role confusion between advocacy and therapeutic practice and others who reiterated the need for domestic abuse advocates to not lose their purpose, which they understood as assessing and managing risk.

CHAPTER 7: SURVIVOR FINDINGS

Introduction

Survivor responses to Trauma-informed Service delivery were captured through interviews with six domestic abuse survivors, conducted over the phone or video call software or in person. The trauma-informed services included within the study were two distinct services operating under the same federation, both in the north-east of England and both with multiple service provisions such as outreach, counselling and or refuge services. The semi-structured interview schedules were designed to explore the research questions (see methods chapter). Many of the themes (and therefore a lot of the quotes below) did not specifically address the experience of trauma informed service delivery, but their reflections on the concept of trauma serve to illustrate the nature of the work undertaken with them by the services. Survivors also spoke more broadly about their involvement with other services; their experiences of abuse and provided reflections on responses to domestic abuse more broadly (including societal views, stigma, community responses, etc).

It is worth highlighting that the survivors had all received various forms of intervention from Services A and B and some of their perceptions were likely to have been influenced by their experiences of domestic abuse counselling and/or advocacy.

All the survivors listed (apart from S0-2) had engaged with outreach, IDVA and or counselling services offered by the domestic abuse services. Only one (S0-2) had engaged with the refuge service provision. While one interviewee was under 20, the other five women were between 30 – 55 years in age.

While survivors within this study rarely used the word trauma, they do highlight the ways in which non-physical domestic abuse had been emotionally damaging for them and two survivors make links between sexual abuse/assault and feelings of powerlessness and avoidance. Physical abuse is most widely acknowledged by the survivors in this study as potentially traumatic however most survivors appear to minimise its occurrence or impact upon them personally. Most survivors do however use anatomical language when describing the impact of psychological abuse. Almost all survivors use imagery of violence when describing the impact of engaging with services (not including domestic abuse support services). Most of the survivors describe the recovery process as an incremental and slow process of returning to

themselves in some way, and the challenges of learning to live in the 'new normal', the post abuse reality.

Survivor Demographics

SERVICE	Survivors coded by NUMBER	Age, ethnicity, and parenting status	Length of exposure to DVA	WORKER/provision	DURATION OF SERVICE
Service A	(S-01)	White British No children	Less than a year	Outreach	A few months and now being referred to counselling
Service A	(S-02)	White British Has children	Around 3 years	Refuge	Less than a year
Service A	(S-03)	White British Has children	28 year relationship, control increasing over time	Outreach and counselling service	6 sessions with counsellor
Service B	(S-04)	Pakistani British Has children	20-year relationship	IDVA service and counselling	A few years with Service B About a year with current IDVA About to start counselling
Service B	(S-05)	White British Has Children	Around 14 years- control increasing over time	Counselling service previous involvement from IDVA service	This time- 2.5, 3 years
Service A	(S-06)	White British Has children	Stalking and coercive control over an 8 week period	IDVA	6 Months

Table 6: Survivor sample demographics

Reflexive thematic analysis (Braun & Clarke, 2006) was used to generate themes through an iterative process of ‘creating, distilling and refining’ codes (Gregory et al, 2019, p 605). The analysed findings presented below are organised under themes, some of which are unique to this research and identified through inductive analysis, such as the survivors’ conceptualisations of the impacts of domestic abuse, the transformational impacts of trauma, and learning how to ‘play the game’ of service involvement by utilising the tools of the system. Meanwhile, other identified themes were dictated by certain components within the interview schedule, which were shaped by research questions (see methods chapter) such as questions focussing on the ideological principles of trauma-informed care in relation to recovery and support as highlighted within the existing literature.

Research questions (survivors)

3. How do domestic abuse survivors understand and experience a trauma-informed approach in relation to domestic abuse?
4. What are the key barriers and facilitating factors to implementing a TIA within DVA service provision?

THEMES	SUB-THEMES	CODES (LATENT)	CODES (SEMANTIC)
How The Impacts of Domestic Abuse are Acknowledged and Conceptualised by Survivors.	Psychological abuse- too familiar to notice.	Realisation that Abuse doesn't need to be physical, psychological abuse is harmful but hard to identify- even for survivors	Forms of domestic abuse Acknowledgement of psychological harm as abuse- and can have long lasting effects
	Body Talk: Figurative Language	Emphasis of how physical/anatomical abuse is prioritised- given a language in our culture- impact of mental abuse is less easy to describe, identify- or even acknowledge	Psychological and social impacts of domestic abuse Impact of Mental abuse described in physical/anatomical terms
	Coping with post abuse reality	It's still not safe and secure, outside or within- must take certain steps measures to get through each day This is how I keep me safe	Closing the blinds, not going out, not taking the bus, bracketing tasks - I have to do things in a certain way now (coping strategies- crutches)
	Trauma is transformative	Trauma changed how I view the world Trauma changed how I behave. Trauma changed how I feel	I've neem through a process, I am a new person now I'm like this now...it's like this now
Retraumatizing oppressive systems: Bombs, Executioners and Guns	Don't Let 'Them' Use Your Trauma Against You- Navigating the System- Resistance – Winning the Game	Strategies of resistance Fighting talk Similarities between original abuse and the system response	Build a case, play the game Bring it on, stick it out, defensive On my knees, in a corner, nowhere to turn

THEMES	SUB-THEMES	CODES (LATENT)	CODES (SEMANTIC)
	Domestic Abuse Only Stops When Perpetrators of Domestic Abuse Are Stopped.	Domestic abuse perpetrators will not stop of their own accord. The perpetrator to be the focus, to be made visible and accountable in the system	They won't quite People need to realise This is how he is to women, he even bullied my social worker
Factors That Can Facilitate Recovery from Trauma for Survivors of Domestic Abuse	Recovery: The Long and Winding Road: A New Self, Adapting to A New Normal	Gaining power and agency, more like who I used to be Wish to regain what has been lost New identity, forever changed in some way	Stepping stones, realisations, payback, building confidence. In limbo, want to regain trust and confidence I've changed, that was the old me, I am more resilient now
	Small Victories	Freedom and autonomy- Doing things I like Moving at my own pace Returning to self, a sense of achievement	Chuckling about the pots not being done I love walking, like I am on a mission I respect myself; I can look in the mirror and say that now

Table 7: Survivor themes

Theme 1: How The Impacts of Domestic Abuse are Acknowledged and Conceptualised by Survivors.

Most survivors within this small sample did not identify as survivors of physical abuse, almost all cited other forms of domestic abuse as their primary concern, including emotional/psychological abuse (S0-1, S0-3 S0-4, S05), coercive control (S0-2, S0-3, S0-5) and stalking (S-06). Closer refinement of codes in relation to types of abuse and types of harm generated a shared meaning/theme relating to the delayed realisation experienced by most of the survivors that the non-physical harm they endured could be categorised as domestic abuse. All the survivors listed (apart from S0-2) had engaged with outreach, IDVA and or counselling services offered by the domestic abuse services. Only one (S0-2) had engaged with the refuge service provision.

Psychological Abuse; Too Familiar to Notice/ You Can't See It- Neither Can I

Many researchers have highlighted the dangers of overlooking emotional or psychological abuse in relation to domestic abuse (Kirkwood, 1993; Harne & Radford, 2008; Sharp-Jeffs et al, 2018) and this remains difficult to identify for survivors and professionals alike, perhaps due to the amorphous nature of psychological harm. The survivors quoted below each provide a unique insight into how this had influenced their views about themselves and their experience of non-physical abuse, including not seeing themselves as someone who could access support from a domestic abuse support service (06), not seeing the link between manipulation or control and psychological harm (03), and not seeing that anything was wrong (05).

'I used to think of domestic violence I used to think of somebody who like was getting physically hurt not mentally. So I just didn't view that they [abuse service] would be able to ever help us because I just thought they dealt with like battered women or men, obviously I wasn't aware of that.' (06, Service A)

'So I would always view, even the domestic abuse side I would always say, well if it's physical I completely get it [the idea of abuse as traumatic], but as it happens, I feel at the minute that the mental side is probably worse than that. Because there was only ever one physical incident between myself and my ex-partner, the rest has all been sort of mind like manipulation and control and stuff like that.' (S0-3, Service A)

'He wasn't violent, it was rare that things would be physical. So, it would just be, I think a lot of years I went through it and didn't even realise anything was wrong because it was just my life, that was just how it was.' (S0-5, Service B)

There seems to be a paradoxical relationship between the ubiquitous occurrence of psychological abuse and the lack of acknowledgement in the wider culture. Survivors could easily internalise societal blindness or silence about mental or emotional abuse, normalising or minimising their experience, with insufficient language or frameworks to understand or identify psychological harm.

Sexual abuse or assault was also alluded to by two of the survivors but not elaborated upon:

‘The sexual side to me is massively traumatising because it does get to a point where you give up. You give up trying, you just think, if I just allow this to happen then it’s going to be better tomorrow’ (S0-3, Service A)

There are various theoretical or ideological frameworks available to conceptualise or understand the idea of ‘giving up’ spoken about by this survivor, including (but not limited to) characterological self-blame (Janoff-Bulman 1979), learned helplessness (Seligman, 1967) or a fawn (Walker, 2013)/ appease response (Treisman, 2004; Porges, 2011).

Another survivor referred to something happening in bed, that she did not specify. In selecting this quote to illustrate sexual assault in the context of domestic abuse, I note the ambiguity surrounding the account: the survivor did not specify, and I did not ask for clarification. The details around what actually happened to this survivor in this instance remain ‘unvoiced’ (Burnham, 2012, p1460) between survivor and researcher, the survivor describes how ‘it’ [the event] has impacted her:

‘Yes, it still, sometimes I feel like I can’t go to sleep in my own bed because knowing it happened in this bed is what kind of freaks us out, so I need to get a new bed. I feel like getting a new bed will kind of like get rid of that entirely.’ (S0-1, Service A).

The ‘unvoiced’ narrative in this survivor’s quote raises important questions for relational and epistemological reflexivity (reflection about how relationships and knowledge are constructed and culturally bound) (Patridge, 2019). A reflexive and systemic lens would encourage qualitative researchers to think about the nature of their relationship with the participant. Particularly the ways in which the researcher-subject dynamic is understood by each person and the impact this could have on their ideas. It would also encourage the researcher to consider what can or cannot be uttered *to* or asked *of* the other, and what implications this could have for the construction of knowledge on any given topic area. A relational or systemic approach might situate the ‘unvoiced’ within the dynamic or the context of any given interaction. Consequently, it seems important to emphasise that in this research interview the research questions did not pertain to the instances of abuse, but rather the impact *of* and recovery *from* such events (fully explained in methods chapter). A more individualised approach might point to an

unconscious or conscious avoidance or reluctance on the part of the participant or researcher to discuss particularly personal or difficult topics like physical or sexual assault, lessons we may have internalised from a culture that renders such things 'unspeakable'.

In relation to what S0-1 does say about how what happened in the bed has impacted her, trauma theory would support an interpretation that 'the bed' has become a kind of 'trigger': a constant reminder of the past trauma. Removing or replacing the bed could be categorised as avoidant coping (Krause et al, 2008), the belief being that the removal of the trigger will remove the traumatic memory and its impact (not being able to sleep, feeling 'freaked out'). The survivor talks about the bed as the site of trauma (not the body). This could also be understood as the survivor's attempt to externalise the 'psychophysical' experience of trauma (Rothschild, 2000, p 5).

Body Talk: Figurative Language Showing the Link Between Emotional Experience of Domestic Abuse, Trauma and Physiological State.

Survivor conceptualisations of the psychological harm they endured within their relationships were varied. While all survivors spoke about changes to their perspective, many used anatomical or physical language, alluding to an embodied sense of confusion or oppression:

'I don't really know in my heart of hearts how an ordinary relationship would work. Like what the dynamics are in that relationship, like how, when should you approach and ask for permission. Should you ask for permission for things? It's all very, it's all very confusing if I'm honest.' (S0-3, Service A)

'I was absolutely broken...he just tried to push me into a corner every which way...And I was literally at that point on my knees.' (S0-5, Service B)

'That's why I let him tell me what to do and let him take control of my financials...because I trust him from the heart.' (S0-4, Service B)

The image of the heart is used in one survivor's description of confusion (S0-3), and in another's description of an abuse of trust (S0-4). The phrase 'on my knees' is used to oppression and powerlessness (S0-5). While the body and physicality are linguistically prominent in each description relating to the impact of their abusive

relationships, none of the survivors above characterised their relationships as physically abusive. Trauma theorists provide a lens through which the psycho-physical experience of non-bodily harm (Rothschild, 2000) can be acknowledged and understood as having detrimental impacts on the survivor's 'physiological and biological systems' (Williams, 2006, p322). The amorphous nature of psychological harm is concretised through physiological and anatomical language. Returning to the prevailing notion that trauma is held inside the individual (Levine, 2010) who experiences emotional or physical pain that overwhelms the central (brain) and autonomic (body) nervous system in a way that 'leaves a mark on us as we move forward' (Conti, 2022, video), the survivor quotes can be further distilled, and new meanings can be generated.

In addition to describing the impacts of psychological harm, survivors identified and described strategies they employed for dealing and coping with the emotional impacts of domestic abuse such as 'people pleasing' (S0-2), keeping it all inside (S0-3 & S0-4), being careful not to 'burden' their friends and family (S0-1), pushing themselves (S0-2 & S0-5), blocking the emotion (all survivors), 'bracketing things' - breaking overwhelming tasks down and prioritising (S0-2) and 'pretending to be invisible' (S0-4). Understood through the lens of relational trauma and attachment theory, many of these strategies could be categorised as dismissive (of self, of one's own distress, of one's own need for care, prioritising others) (Crittenden & Heller, 2017).

In contrast, feminist scholars have long called for the acknowledgement of Macro-cultural and structural arrangements as the cause of victimisation and highlight the importance of moving beyond a victim's individual developmental history (difficult childhood, learned response, etc) to explain their response behaviour (Courpasson & Valles, 2016; Lilja & Vinthagen, 2018). Much of this feminist literature on intimate partner violence reframes victims as 'survivors', who are 'angry, resourceful' and agentic (Mahoney, 1994) and would categorise some of the coping mechanisms quoted above as 'strategies of resistance' (Rajah and Osborn, 2020).

Coping With Post-Abuse Reality

When discussing how they were coping currently with their new (post-abuse) realities, most of the women talked about home security measures or new habits at home which helped them feel safe (S-01, S-02, S-03) and free from intrusion (S-03, S-05). One survivor explained that she had experienced numerous incidents of physical abuse in

her relationship (S0-2) and consequently sought out physical safety through moving into the refuge provision offered by Service A. Security measures at the refuge such as the secret location, locked doors, constant staffing and security cameras all helped her to feel safe there. However, she explained that she still preferred to sleep in the same bed as her child leaving a small night light on to further increase her sense of security and decrease anxiety (S-02).

Another spoke about keeping the blinds at home shut at all times so that no one could see in through the window (S0-5). In addition to changing their habits or adopting new protective measures, all women spoke about their experiences in seeking support from services that would help them to feel physically and psychologically protected, such as the engagement with the criminal justice system to ensure convictions of perpetrators, court orders, risk alerts to trigger faster response rates (S0-1, S0-3, S0-6) or having home security devices fitted (S0-1, S0-3, S0-6). While most survivors stated that home security measures did increase their sense of physical safety in their current accommodation (all post separation), none of the women felt completely safe, with feelings of anxiety (S0-1, 2, 3, 4, 6) or paranoia (S0-5) quickly resurfacing in the face of any perceived threat. When referring to a conversation her son had with her after he had been at his father's house at the weekend this survivor commented:

'My son said to me, "Dad's friend saw you, so he followed you, took a picture of your car on the drive, sent it to dad". I don't believe it was his friend I think it was him. So, then it just made me paranoid that like someone was like watching me and driving. It's not the sort of house that you would drive past, it's a brand-new estate. So, you wouldn't drive past it accidentally, you drive to this estate. So, I just, it just didn't make me feel safe. And it's just about having my own privacy, so from then on I just kept my blinds shut. And I like that fact that no one knows what I'm doing in my house, it's my house. I constantly like the chain on the front door. That makes me feel safe.' (S05, Service B)

Trauma is transformative.

The idea that people are forever changed or transformed by the traumatising impacts of abuse was acknowledged by almost all survivors which echoes much of the existing literature on PTSD and C-PTSD. Williams (2006) refers to subjective, negative 'life-relearning' events when discussing complex trauma. Survivors spoke about withdrawing from social life and activities (S0-6, S0-2), taking different routes to work

or appointments (S0-1, S0-4) and feeling reluctant to enter new romantic relationships (S0-1, S0-3, S0-5). One survivor described the impact of coercive control of her jealous ex-partner on her decision making about the places she went socially:

'If he thinks, not that I have, if he thinks that I am with somebody else, if he has an inkling, he then goes mad. So like what will he do to keep us? That's my worry. Like what will he do if he seen me out in the street? And I stopped going [to a pub she used to go to] because he would go all the time thinking I would be there. So I stopped going.' (S0-6, Service A)

When considering Kelly's work on 'space for action' (2003), which was inspired by Lundgren's concept of 'Women's life space' (1998), this survivor's account could be understood as a result of coercive control, a 'liberty crime' (Stark, 2007), resulting in the victim's freedom being restricted, both while in the relationship and post separation though restricting her behaviour.

Many academics have noted that increasing levels of knowledge and around coercive control awareness have not led to coercive control being accurately assessed or substantiated in a way that facilitates adequate protection or equality for women (Pitman, 2017; Laing et al., 2013). This point is particularly pertinent when viewed in light of the full gambit of tactics employed within coercive control used to deprive victims of their rights, including constant monitoring of their movement, restricting access to financial resources, threatening their economic security, restricting access to education, employment, medical care and reproductive coercion (Pitman, 2017; Stark, 2007, 2013; Stark & Hester, 2019; Postmus et al., 2020).

Theme 2: Retraumatizing oppressive systems: Bombs, Executioners and Guns

Most survivors acknowledged that they had been fundamentally changed by not only their traumatising experiences of domestic abuse but also by the traumatising effects of engaging with services such as children's social care, health care professionals, the criminal justice system and the police, which often echoed components of the original abuse including minimizing, dismissing, blaming, taking away control and abuses of power. The survivor below described her experience of reporting stalking to the police:

'I think that's the thing with the police, I think they don't always think before they

...speak to be honest. I think, because I haven't been physically hurt, I feel like they don't take it as serious some of them. Some of them do but some I feel like I'm just like a hindrance to them.' (S0-6, Service A)

Survivors were urged to report coercive control and stalking to the police after coercive and controlling behaviour in an intimate relationship had become a criminal offence (S 76, Serious Crime Act, 2015), but police forces promptly reported being 'overwhelmed' by the increase in reporting which saw domestic abuse harassment related reports in England and Wales increase by 52% over two years; (HMIC, 2015). Stark (2016) points out that while police are encouraged to identify stalking and other coercive controlling behaviours associated with DVA, they consistently fail to identify, remove, or convict perpetrators, instead relying on referrals to domestic abuse services to keep victims safe.

The survivor (S0-6) quoted above describes a thoughtless response from the police, who are seemingly at once underwhelmed (physical abuse is taken more seriously) and overwhelmed (hindrance, increased levels of reporting) by the prospect of responding appropriately to non-physical abuse. A recent report from the BBC (Kendall, 2024) highlighted the fact that professionals often feel underprepared and lack confidence when dealing with non-physical abuse such as coercive control. In many cases, training programmes focus too heavily on physical violence. This concern has also been raised by Haliwell et al., (2021), who point out that these gaps in training leave victims vulnerable and unable to escape non-physical forms of abuse.

Four out of the six participants spoke at length about their experiences of powerlessness in the face of interactions with services that felt oppressive. The quotes listed below also conjure images of closed, historic, and patriarchal male dominated systems:

'One day everything was okay, you know, everyone was at home, yes, it was difficult, but they (the police) came and essentially blew my world apart when they came and picked him up [after she reported the abuse to the police]. I felt like they were kind of on his side a little bit just because of the job that he did [he was in the police]. They were all full of, 'hi mate, how are you doing? Are you alright, are you keeping, okay?' And I felt like they were completely on his side then, so that was difficult. So that was quite hard to trust them because it was like they're from his team essentially.' (S0-3, Service A)

'I said, so between you and him you'll take my career and it's game, set and match, he's took everything. So, we went into the meeting, and I just said I needed some clarity as to exactly what the local authority's involvement was. I said, is that your job to be judge, jury and executioner? Even when we went to court, the judge threw my advocate out of court because she emailed him on his break, I was just on my own... and I was like just get me out of here.' (S0-5, Service B)

'So, the first ever social worker that I had, I didn't like him from the minute I met him. I didn't like him, and he was very much in that meeting, 'This child needs a protection plan'. He was gunning, gunning, and I was like, you don't even know me, like you don't know me. And it was like, hang on a second, wow, like what on earth, like this is madness. So, I did feel I was further persecuted...And because he was a male I was like, oh here we go, here we go, you're an abuser as well. Like that's all that was running through my head.' (S0-2, Service A)

Some of the language used in the quotes above evoke violent images (blew my world apart, threw, execution, persecution, gunning for me), images of competitive games (sides, teams) competition ('gunning for') and winning or losing ('game, set and match'). Survivors used more emotionally evocative language expressing pain, anguish and outrage in relation to their engagement with oppressive services than when talking about their abusive ex-partners. Viewing this through the lens of traumatology, the relational response to the (potentially traumatic) harmful event is seen as just as important and potentially damaging and destabilizing as the original harm, particularly if the original harm was relational (Perry, 2017; Van der Kolk, 2014; Treisman, 2016).

The trauma-informed mantra 'relational harm requires relational repair' (Treisman, 2016) means that if a victim is dismissed, shamed, not believed, silenced, or stigmatised when they seek support, the original harm is much more likely to result in symptoms associated with PTSD/C-PTSD (Courtois & Ford, 2012). The survivor quotes above could be categorised as descriptions of symbolic acts of violence enacted by a system that is at best ill-informed about the nature of domestic abuse and ill-equipped to meet the needs of survivors.

Another survivor describes how a hospital receptionist responded to her when she tried to seek medical attention after being physically assaulted by her ex-partner:

'I said to the receptionist, I've been assaulted, and I think I've got broken ribs. And her response was, we don't do anything for broken ribs, just go home and try some breathing techniques and that was it. That was my visit to hospital. So completely let down by professionals. And I just looked at her and I was like, but I've been assaulted. And again, it was we don't do anything for broken ribs, there's nothing we can do, try breathing techniques.' (S0-2, Service A)

The receptionist seems to focus on the physical symptom of broken ribs, without showing any legitimate professional curiosity about how the survivor acquired such an injury, even after she states she was assaulted. There is a legal and ethical duty placed on all professionals working in the health service to ensure the safety and wellbeing of their adult patients and raise safeguarding concerns if they suspect abuse or neglect (Care Act, 2014). The survivor identifies a missed opportunity by health services, who are often the first point of contact after an incident of physical abuse and ideally placed to identify victims of domestic abuse, with 56% of victims accessing Accident and Emergency services in the year before getting help from any other agency (SafeLives, 2016).

The National Institute of Clinical Excellence (NICE) issued guidance in 2014 requiring all sectors of healthcare to recognise support and manage survivors of domestic violence and abuse. Hinsliff-Smith and McGarry (2017) carried out a systematic review of studies concerned with the prevalence, management and support for survivors of domestic violence and abuse who present at emergency departments and concluded that 'knowledgeable and supportive emergency department staff can have a positive benefit for the longer-term health of the domestic violence and abuse survivor who seeks help' (2017, abstract). Interestingly the survivor above (S0-2) states twice that she has been assaulted, seemingly hoping that sharing this information would bring about a protective response. The survivor is not just seeking medical attention; she is disclosing an assault. While the advice given in relation to the physical injury she had sustained may be in accordance with medical guidance, the disappointment experienced by the survivor (feeling 'let down') seems to relate to the failure of the hospital to provide not only care, but protection.

While survivors spoke about instances where their most clearly articulated pleas for

help and support were dismissed, they also spoke about instances in which their ability to advocate for themselves in professional contexts served them well:

‘The manager in the meeting was typing to my new social worker and she’d put a message across saying, she is fab. Because I just went in and I was like, bang, bang, bang, because I was in like lioness mode and I was like, you are not, you are not doing this to my child and you are certainly not making me feel even more shitter than what I do. And I think that’s where, because that fight came from us, I turned it around.’ (S0-2, Service A)

‘I was like, I’ve got nothing to say to you (the social worker) via telephone, I need a paper trail of everything. I wrote a complaint that was as long as my dissertation for uni and within a week she was gone.’ (S0-5, Service B)

Interestingly, both survivors quoted above had completed professional training in mental health related disciplines. Both women described the benefit of being able to articulate and consequently advocate for themselves within child protection meetings/contexts. Understood in contrast to the previous descriptions of oppressive system responses experienced by survivors, the quotes above could be categorised as examples of resistance: these women were determined to not be beaten by an unjust or inadequate professional response, with both acting in response to the threat of their children being removed from or not being returned to their care. It is important to point out that some women may not have the ability, opportunity or support to advocate from themselves as they would wish to.

Don’t Let ‘Them’ Use Your Trauma Against You- Navigating the System-Resistance – Winning the Game

Many researchers have highlighted the tendency of children’s services to blame mothers for exposing their children to domestic abuse (Holt, 2017; Stanley et al, 2011), and the ways in which domestic abuse survivors resist such forms of structural oppression (Rajah et al, 2020). Rajah et al’s (2020) systematic review grouped resistance into three broad categories; ‘defining resistance in the context of power relations, conceptualizing resistance as a form of agency, and understanding resistance as a mechanism of physical, economic, and existential survival’ (Rajah et al, 2020, p 1377).

Within this particular theme, some subtle and nuanced differences were generated in conceptualising survivor responses about how they were supported by service A and service B respectively in relation to ‘coaching’ (see more on this below).

The following excerpts from survivor interviews could be understood through the domains of defining resistance in the context of power relations and conceptualizing resistance as a form of agency. Specifically, the survivors talk about the ways in which they took action (harnessing their own agency) to successfully navigate the child protection system in the UK and retain or regain custody of their children. Three survivors (S0-2, S0-4 & S0-5) with children under eighteen described their experiences of doing so:

‘Making sure like when they [the children] come back [from contact/family time] they are not talking about parents, so I just ask them, did they enjoy themselves? What did they talk about? And I have to note down if they have been talking about me or their dad because it’s just about sibling contacts.’ (S0-4, Service B)

‘I had to stick out the process [child protection process], I had to stick out, after all of them allegations she [the social worker] said and then said that I didn’t need to see my children supervised [social worker recommended unsupervised contact between mother and her children while survivor wanted supervision in order that no false allegations could be made against her] and I was like “absolutely not”. I was like “anything could be said” ...I said, “absolutely not, I want to see them supervised”. And she [social worker] was like, “I’ll supervise it”. And I was like, “no, I wouldn’t let you supervise me with a hamster”. I said, “you tell more lies than Pinocchio”. I said, “absolutely not”, because I wanted someone completely independent.’ (S-05, Service B)

‘But he [the social worker] was gunning and I felt further persecuted by him and I was furious. And that’s when I was like, okay if this is the road we’re going down bring it on. And I went into that meeting and I had my file and I had the report from the social worker and I had highlighted all the bits that I did not like. All the bits that were false because there was a lot of false things in there, a lot. And I was like, ‘hang on a second, no, you [social worker] are not putting that forward because that’s wrong’. I highlighted it all and they came to me and they were like, “have you got anything?” I went actually, “yes, I have”, and I

just opened the book up and I went, “so on page one you’ve put in”... and I read and I went through it like that and I had all my bits highlighted.’ (S0-2, Service A)

All three women make reference to record keeping and the importance of gaining some control over the words ‘on file’, the words used describe their character, their conduct and their experiences, that ultimately form the basis of the local authority’s assessment of their parenting capacity. The quotes above demonstrate the ways in which each woman borrowed from the language, protocols (note taking/record keeping) and mechanisms (child contact) employed by service providers in order to combat the injustice (such as false allegations) they had experienced in their interactions with these service providers. Two of the survivors quoted above (S05 and S02) were fighting to regain or maintain (respectively) custody of their children and both women give some insight into their mindset or their approach to this felt sense of conflict; ‘stick it out’ (S0-5) and ‘Bring it on’ (S0-2). Resistance of any kind requires endurance, strength, and even a kind of defiance. The language they use generates images of winners and losers in a high stakes game or battle. The idea that the truth will reveal itself through the building of a case also seems pertinent to what each survivor is describing, steadily gathering evidence to counter the allegations or assumptions made about them.

The notion of ‘building a case’ against a perpetrator of domestic abuse to seek a just outcome for victims is familiar to many front-line domestic abuse practitioners. Furthermore, the idea that domestic abuse practitioners are well placed to help survivors build a defence against a perpetrator who is manipulating or weaponizing the child protection process is evidenced throughout the survivor interviews included in this study. Survivors S0-1, S0-3, S0-6 all refer to conversations with their worker about logging complaints and keeping a record of what has happened:

‘She says, and if anything happens just make sure you’ve got a log of it and then it means that with regards to any safeguarding that you need then there’ll be a note of it on the system. So they’ll be able to look back on that and say, well this happened, this happened then, she says, so just keep it that way.’ (S0-3, Service A)

Other survivors spoke about how their worker (S0-4 & S0-5 had the same domestic abuse support worker) helped them with emotional regulation, teaching them how to

stay calm in their communication with other professionals. In contrast to the strength and resistance the survivors demonstrated throughout their accounts, all the survivors spoke about feelings of rage and powerlessness, not only in relation to the original abuse, but in relation to dealing with the professionals who were consequently involved in their lives. Survivors S0-4 & 5 spoke in detail about how these feelings impacted the way in which they engaged with professionals (such as social workers) who they felt were not treating them fairly. While rage and powerlessness could be experienced by anyone facing injustice, powerlessness speaks to the complex neurobiological impacts of trauma, over which the survivor's consciousness and language have little control. When encountering new situations reminiscent of the original events that rendered them powerless (traumatising effect) survivors are often fated to re-live or re-play the fear and rage associated with the original trauma (Liotti, 2014). It becomes easy to see the ways in which trauma survivors could be misunderstood when acknowledging that, 'trauma decontextualised in a person could look like personality' (Menakem, 2020). As one of the survivors stated:

'I constantly was on the defence because I constantly felt like I had to defend myself. So (my worker) sort of taught me how not to react and how to sort of approach it a different way. And when I stopped screaming and shouting back that's when people started to listen to me, so it did work.' (S-05, Service B)

The worker was able to reflect with the survivor in a kind of parallel process, on the way in which the oppressor and the oppressive system seemed to be requiring her to provide justification of her position and on the way in which these demands evoked feelings of defensiveness and powerlessness in the survivor. When asked more about the strategy she developed with her domestic abuse worker to deal with the child protection process, she said:

'You feel like, at the start you feel like the need to scream and shout back to defend yourself. It's a natural thing to want to do is to defend yourself and I never did this, and I never did that. But in the end, it's about you don't really need to defend yourself, you don't. I don't have to justify everything that I've done and it just, I think it comes from years of having to justify everything you've done and explain everything you've done and why you've done it. And it's about, these sort of taught me like you don't need to do that, you don't need to answer him, so I had that control.' (S0-5, Service B)

The description of this domestic abuse support worker helping this survivor to self-regulate, gain control, and recontextualise and adapt her coping behaviours in a way that would enable her to better navigate the child protection system and get her children back, goes beyond advocacy. It is an example of what becomes possible when the truly circular or bi-directional relationship between the layers of influence surrounding each individual (their nested system) is acknowledged.

It is noteworthy that S0-4 and S0-5 - who both engaged with service B - each described the way in which their worker not only gave advice but took a more directive and active process in helping them to conceptualise their own responses differently and learn new communication strategies. While survivors accessing service A did describe ways in which they were able to mirror the system through observing it (S0-2) or being advised the 'log' any incidents (S0-3), none of them described the same level of therapeutic advocacy as described by survivors accessing service B.

The interview with this particular worker (P0-15), made it clear that her practice was rooted in a feminist and humanistic ideology and she was acutely aware of the paradoxical impact of her intervention, which she described coaching survivors to become perfect victims in order to get their needs met (see 'How is a T-I approach understood in relation to a needs-led approach?' section in previous chapter). This idea of victimhood and how it is perceived by others is further contextualised in the survivor's account of how a social worker described her:

'She [the social worker] said *she* [S0-5] *does not present as a typical victim...* then said that she didn't believe there was any domestic abuse . I [S0-5] don't present like a victim, I'm as tough as old boots.' (S0-5, Service B)

The idea that a survivor does not present 'like a victim' emanates from and further perpetuates simplistic stereotypes about abuse, reinforcing a false dichotomy between female defendants who 'deserve' sympathy versus those who do not (Lazar, 2008). The domestic abuse worker (P0-15) expressed her frustration with this attitude taken by some of some child protection social workers but also described a strategic approach she takes in order to counter such stigmatizing and demoralising narratives. The worker acknowledged the unfairness and power of the 'perfect victim' persona.

While P0-15 resents this notion, she describes herself as a kind of coach, helping women to stay calm, polite and diligent, in essence coaching them to present like a

'perfect victim' in order to get their needs met by the system. The worker described the paradoxical effect of this intervention focus; in her effort to help domestic abuse survivors have their voices heard and access the support they are entitled to, she is perpetuating the continuation of the very system/ideology which renders certain victims as believable and worthy of support, while others are too troublesome to be helped, or even fully believed. Lazar (2008) notes that this need to present as 'victim', worthy of resources and support further obscures agentic or resistant acts taken by survivors and perpetuates 'superficial distinctions between victimization and service and between oppression and resistance' (2008, p. 5).

domestic abuse practitioners can also inhabit this complex position of 'both/and' in relation to their power/powerlessness in different contexts, as alluded to in this account from S0-5:

'My advocate that I had before... they actually threw her out of the court. They said, the judge was a male and he just said that he didn't want her there because she'd emailed him on the break, said he didn't want her there.' (S0-5, Service A).

While domestic abuse advocates may seek to utilise their professional role, organisational affiliation, skills and knowledge to share power 'with' (Domenelli, 1998, 2017) survivors, they too are subject to patriarchal and sexist ideologies and practices. The quote above evokes ideas of male violence (thrown out), in describing the volition of the male judge and the helplessness of the female domestic abuse advocate. While it would be reductive to attribute the action taken by the male judge solely to sexism or patriarchal attitudes, gender can be considered alongside the varying aspects of an individual's identity (Burnham, 2012) and the way in which these aspects of a person's identity can coalesce or intersect in any given contextual interaction rendering that individual more powerful or powerless.

The most important aspect of domestic abuse service support for survivors without children (S0-1) or with older children (S0-3) was about reconnecting with themselves, with skills such as boundary setting, confidence, assertiveness and independence being central to their recovery journeys and their work with services. Women with older children or no children did not have to worry about the looming threat of children's services and the confidential nature of the support they were able to receive could be trusted:

‘Because she knew I was going to be sharing and she knew I was going to be sharing some really difficult stuff and again that confidentiality is key, 100%. I knew if there was a safeguarding issue that had cropped up she would have needed to share that with the authorities but at the same time everything that had happened was more of a past tense [children are grown up now] and moving forward it wasn’t so much that there would be a safeguarding issue there.’ (S0-3, Service A)

Domestic Abuse Only Stops When Perpetrators of Domestic Abuse Are Stopped.

The idea that perpetrators of abuse will ‘quit’, ‘give up’, ‘stop’ or ‘step forward’ or keep their ‘promises’ of their own accord (survivors attributed these views to the police, court system and social services) was not reflected in their lived experiences as domestic abuse survivors:

‘They (the police) need to know about this, like they need to know that he’s not giving up.’ (S0-6, Service A)

‘He just doesn’t quit ever. That’s what I said to [worker’s name], I was like he’s never going to stop. And she was like, he will, I promise he will. When we went to court to get a non-molestation order... the judge was like basically just got him to agree to an undertaking - so he just told him it’s not enforceable by law. So basically, you can do what you want, it’s just a promise to me.’ (S0-5, Service B)

‘But it’s because unfortunately there is abusive men and women out there and they won’t stop, they don’t come forward...this person is never going to change ever.’ (S0-2, Service A)

The first two survivors quoted above both make reference to conversations they had with professionals about how domestic abuse can be ended. S-06 recalls a conversation she had with her domestic abuse support worker about reporting her ex-partner’s continued stalking behaviour to the police after he broke a non-molestation order, and S0-5 recalls a conversation with her domestic abuse support

worker about the way in which her ex-partner bullied a young female social worker. She goes on to describe how a judge failed to enforce a legally binding non-molestation order. The last survivor seems to make a more general point about the lack of visibility of perpetrators of domestic abuse, perhaps inferring that if they do not 'come forward' and identify themselves, they will never be subject to any form of intervention that could facilitate change. The survivor testimonies invoke a wealth of literature on the invisibility of domestic abuse perpetrators (Stanley, 1997; Holt, 2016; Humphreys & Diemer, 2019).

Seen through an ecological lens, the shared meaning generated from these themes can be understood as survivors' call to action aimed at the wider system that seems to sustain domestic abuse through passivity, lack of awareness or a lack of understanding. Neale (2018) points out that, if occlusion of perpetrators from child protection assessments is accepted or normalised, this sends a message to perpetrators that their behaviour could continue unchecked (Neale, 2018 pp 5-7).

Theme 3: Factors That Can Facilitate Recovery from Trauma for Survivors of Domestic Abuse

All the survivors (apart from S0-2) had engaged with outreach, IDVA and or counselling services offered by the domestic abuse services included in this research. Only one (S0-2) had engaged with the refuge service provision. Survivors were asked about presence and impact of each TIA principle (safety, trust, collaboration, choice, empowerment, consideration of history or gender) in their work with their domestic abuse support worker. They were also asked to speak more generally about what they found most helpful or valued most about the support, prompting survivors to talk in more detail about the specific virtues or qualities of their worker and other relational components that they felt facilitated connection, recovery and healing.

When survivors were asked if their worker made them feel safe and built trust (SAMHSA TIA principles, 2014) with them (and if so, how), most survivors spoke not just about the traits associated with professionalism such as reliability and confidentiality (S0-3, S0-6) but also about relational virtues such as approachability, authenticity, and care:

'She's so like friendly and just like acts like a friend it makes it a lot easier to

talk to her. (S0-1, Service A)

'They [staff in refuge] speak to me like a friend, they get to know you, your ups and downs - they check in with you, they get to know what you need.' (S0-2, Service A)

'She's [the domestic abuse worker] really calming, she doesn't judge me, she sometimes gives advice but sometimes just listens.' (S0-3, Service A)

'She smiles at me and hugs me. I know she is proud of me and that motivates me.' (S0-4, Service B)

'She's in my corner... she's got my back. She answers her emails after hours- I know she shouldn't, but I do that with work as well, I can tell she cares.' (S0-5, Service B)

Here the survivors emphasise how their worker made them feel (supported, listened to, accepted, the recipient of compassion, calm), particularly the idea that their worker genuinely cares about them, 'like a friend' would. A feeling of friendship (or something like it) may best correspond to the safety and trust principles of a trauma-informed approach but perhaps corresponds more closely with concepts of relationship-based practice (MacLeod, 2008; Beresford et al, 2008).

Another relational component valued by the youngest survivor included within the sample was problem free or phatic talk (talk aimed at maintaining social relationships) which often included an element of self-disclosure from the domestic abuse worker. S0-1 describes how this helped to put her at ease and build trust;

'We talk about like everything, like rather than just talk about everything that's like bad. We'll talk about my sister; we'll talk about what I'm going to do for the next week or something. We'll talk about my dog, what I'm doing at uni. We'll just talk about everything and then we're like getting like some of the other stuff. I just feel more like secure just like talking about everything else and then like kind of getting into other stuff.' (S0-1, Service A)

The survivor identifies that talking about everything that's 'not bad' affords her a sense of relational safety or 'security' which seems to scaffold or prepare her to be able to

discuss the 'other (bad) stuff'. The problem free or social focus of the initial stages of interaction could again be likened to a more typical conversation between equals or friends as opposed to practitioner-client. This survivor was significantly younger than the other survivors in the sample which could suggest that young people (adolescents/young adults) interpret the required relational components of safety and trust differently from older adults accessing services. While the older survivors in the study all highlighted the importance of relationship-based practice (see above), S0-1 was the only survivor participant who expressed a preference for problem free talk. From a trauma informed perspective, this preference could also be indicative of an avoidant coping mechanism, a way to delay or avoid conversations which might trigger more focussed discussion about the abuse itself.

Meanwhile, some survivors placed value on the expertise and knowledge of their domestic abuse support workers, who seem to offer new ways of understanding as well as practical guidance and support within the support seeking process:

'She helps me to identify and deal with things.' (S0-3, Service A)

'She gives me advice; she helps me to actually see what is happening and understand what he [abusive ex-partner] is doing.' (S0-4, Service B)

'She's taught me how to manage services and she has helped me with so many other things like housing and legal advice.' (S0-5, Service B)

All survivors confirmed that their domestic abuse workers gave them choices, or at least they did not insist upon anything that they were not happy with. A couple of the survivors said they could not imagine disagreeing with their domestic abuse worker (about how they should schedule or structure their support sessions or experiencing a difference of opinion) and one reported feeling awkward when her domestic abuse support worker focused all of attention on her. This felt like being 'under a Microscope' and made her feel 'stressed out' (S0-1). When asked if she would feel comfortable talking about this form of self-consciousness she experienced sometimes with her worker, she responded with 'no...because saying it would feel too awkward'. This survivor was the youngest in the sample (18 years old) and had spoken about other 'awkward' or 'uncomfortable' experiences of counselling she had received when she was younger. Age and previous experiences could be contributing factors to the level

of discomfort this survivor was experiencing.

Recovery: The Long and Winding Road: A New Self, Adapting to A New Normal

When talking about recovery, survivors spoke about moments of realisation (S0-3), 'stepping stones' (S0-2), 'payback' (S0-5), 'hope' (S0-4) and regaining 'confidence' (S0-1). All survivors (aside from S0-6 who was awaiting a court verdict) spoke about reconnecting with themselves, making choices to do what they wanted and spending time with loved ones. Almost all the survivors talked about recovery as a kind of liminal space, a form of temporal space in which they experienced high levels of distress and uncertainty before any kind of reintegration (with self, with society) was able to take place:

'For the first few weeks after he [abusive ex-partner] was taken away [removed from the home by police], I initially I kind of buried my head in the sand a little bit. It was like my world had blown up. I didn't quite know which direction I wanted to go, I didn't know what was up and what was down. I was all over the place, I cried so much of the time. But then this realisation hit that you know what, I can start to make my decisions. But I was kind of still in limbo, I'm still kind of in limbo a little bit because it's like, it's essentially going back to when I was 18 [becoming an adult, having independence for the first time] and reliving everything but in a slightly different way.' (S0-3, Service A)

Thoughts about the journey ahead, outlining an uncertain but optimistic future were also evident in the survivor interviews:

'And I remember walking through the doors of the refuge, and I closed the door, and I was like, it was like a sigh of relief. I was like, right I'm safe. And I came up to the flat and I was like we're okay. Like we are okay, and we are going to get through this. Like this is just a stepping stone, this is just part of the story. It's not the full chapter, like the chapter isn't even finished yet. Like it's just part of the story.' (S0-2, Service A)

Other women spoke about becoming themselves or returning to an old (pre-trauma) self:

‘Before I gave it (trust) really easily but now, now I kind of hold back. I mainly wanted to like try and get my confidence back that I’d lost because of the relationship and just like working on like becoming myself again.’ (S-01, Service A)

Other survivors referred to a new self. When asked about recovery, one survivor conjures images of a manufactured new self, stronger and more resilient as a result of being ‘processed’:

‘Yes, so it’s sort of like processing it to work through it. I suppose in some ways it builds sort of resilience. I feel like a lot stronger as a person now I’m out the other side, So now I feel like I’m out the other side, but I feel like a completely different person to the one when I started.’ (S0-5, Service B)

Another survivor talked about the old self and the new self, even referring to the old self in third person:

‘Because before [name] would have kicked off and gone... whereas the support with [worker] I said, okay, thank you for your help and have a nice day... Oh she [old self] would have gone off, she would have lost the plot.’ (S04, Service B)

As well as the idea of returning to an old identity or constructing a new one, the concept of the ‘new normal’ emerged in some survivor interviews:

‘So, I’m becoming so much more comfortable now with just like getting up and getting dressed and walking out the house without having to worry about it. That’s not something I’ve ever had to deal with before. So, it’s always been like I’m going here, or can I go here, I’ll be this long, I’ll be back around about an hour. And when I get back, who have I spoken to? I don’t have to do that anymore and that’s really, that is quite overwhelming, So I guess it is kind of like seeking permission essentially, but I know I don’t have to do that now. I know I don’t have to justify my actions.’ (S0-3, Service B)

Small Victories

Survivors spoke about the sense of satisfaction or enjoyment they experienced in moments of peace and autonomy; the small victories that had been afforded in their lives post separation from their abusive partners:

‘Sometimes I have a chuckle because I said to [worker’s name], sometimes I leave the pots on purpose because I know that, and I know he doesn’t know that they’re there but I think, god if he knew them pots were there he would be absolutely off it. Like a little payback.’ (S-05, Service B)

‘I love to walk. It completely distracts my mind. I get into, I’ll walk past trees and I’ll notice them and sort of like grounding techniques if you like. I’m always getting in trouble off the girls for walking too fast because I do tend to get on a mission and I’m like, right okay, we’re going here.’ (S0-3, Service A)

‘I think the biggest change is me, giving myself respect which I haven’t been for years and years. Looking in the mirror and going, I’m proud of myself where I am as a single mum now. Things may be hard like, you know, financially, but being alone I’m better off and I can actually accept that now.’ (S0-4, Service B)

Regaining a sense of control, and self-esteem are all described in the survivor testimonies listed above. The detrimental impact of domestic abuse on these aspects of self is well documented within the literature. Recovery for almost all the survivors interviewed in this study could be characterised as a tentative journey towards regaining aspects of a ‘pre-trauma self’ to cope with their post trauma future. Herman (1992) outlines three stages of trauma recovery: safety, remembrance and mourning and reconnection, insisting that the while safety stage is primary and foundational, the other stages are often not linear. In order to fully inhabit their life post domestic abuse, survivors seem to experience an iterative and sometimes recursive process in which the new sense of joy, control, relaxation, or freedom is an immediate reminder of their previous lack of these sensations and the time they have lost, living with the absence of these feelings. Through this lens, mourning and reconnection are not seen as disparate points of experience but as interdependent processes that characterise the undulating journey of recovery.

Summary

This chapter began by outlining the research questions pertinent to the survivor sample and detailing survivor demographic information in addition to the themes, subthemes, and codes generated by the researcher in organising and interpreting the findings. Three main themes from the survivor interviews were explored, including 'How the impacts of domestic abuse are acknowledged and conceptualised by survivors', 'Re-traumatising oppressive systems: bombs, executioners and guns' and 'Factors that can facilitate recovery from trauma for survivors of domestic abuse'.

The survivors in this study were asked about the SAMHSA principles of trauma informed care (safety, trust, choice, peer support, collaboration, empowerment and gender) in relation to their work with their domestic abuse advocate practitioner. The questions were designed to gain a richer and more nuanced understanding of how domestic abuse survivors understand and experience a trauma-informed approach (research question 3).

The survivors placed a great emphasis on psychological safety and trust. They talked about the importance of soft skills: the implicit aspects of communication with their domestic abuse practitioner that allowed them to feel understood and cared for. All survivors focussed on how they were treated by their practitioners and the relational aspects of the work. In some cases, the strength and quality of this working relationship bolstered their resilience in their continued engagement with other services or professionals who demonstrated less understanding or compassion. Two of the six survivors spoke explicitly about how a domestic abuse practitioner helped them to emotionally regulate themselves in difficult or conflictual communication with other professionals or their ex-partner. This level of honesty and transparency within the communication between survivors and domestic abuse practitioners is not only born from a trusting relationship but in turn can strengthen it.

The principle of peer support or mutuality was also alluded to in numerous different ways by survivors. Most survivors spoke about their domestic abuse practitioners as the first or only people who really believed them, understood them and sided with them. The importance of gender in terms of having other women who understood the signs and tactics used by perpetrators of domestic abuse was valued by survivors. The principle of gender also intersected with the principle of peer support or mutuality.

There was a feeling of solidarity between the female practitioners and female survivors that was apparent in the way survivors described witnessing their practitioners facing some of the same adversities they had, such as an ex-partner trying to intimidate them, a social worker not listening or a judge throwing them out of court. The sense of mutuality between survivor and practitioner was also evident through the way in which survivors discussed a kind of mutual care, showing concern for their practitioner and knowing their practitioner cared about them. The survivors gave a sense of themselves and their practitioners standing together, navigating a complicated and sometimes oppressive web of services.

Survivors used highly emotive and anatomical language to illustrate the distress and harm they had experienced, not only in their abusive relationships but particularly in relation to their interaction with statutory services such as the police, children's social services, the criminal justice system and health care providers. All survivors spoke about these negative experiences of services as being just as hurtful and damaging as the original abuse that had led to their engagement with those services. A trauma-informed perspective and literature base would support the notion that services and professionals can re-traumatise survivors accessing their services and highlight the need for all professionals to be aware of and mitigate the risk of re-traumatisation within front-line service provision.

CHAPTER 8: DISCUSSION

Introduction

This discussion chapter critically examines the complex relationship between trauma-informed approaches and domestic abuse service provision and the potential benefits and limitations of framing domestic abuse through the lens of trauma, considering the implications for service delivery, survivor experiences, and broader societal perceptions of gender and victimhood. The chapter begins by re-introducing the ecological framework which will be used to organise the discussion of findings. The chapter then discusses the importance of language in naming harm associated with domestic abuse, and the appropriateness of trauma as a conceptual lens and a means of framing of non-physical abuse. The discussion then examines findings and themes relating to the Micro, Meso, Exo and Macro-systems in accordance with Bronfenbrenner's ecological framework (1979).

Ecological Model

Themes from interviews with domestic abuse practitioners and survivors relevant for understanding and engaging in trauma-informed approaches are synthesised and mapped across four levels of Bronfenbrenner's (1979) socio-ecological model: the interpersonal layer (Micro-system), the professional layer (Meso-system), and wider organisational and community (Exo-system) and socio-political layers (Macro-systems).

ECOLOGICAL SYSTEMS FRAMEWORK FOR MAPPING SERVICE USER- SERVICE PROVISION INTERACTION:

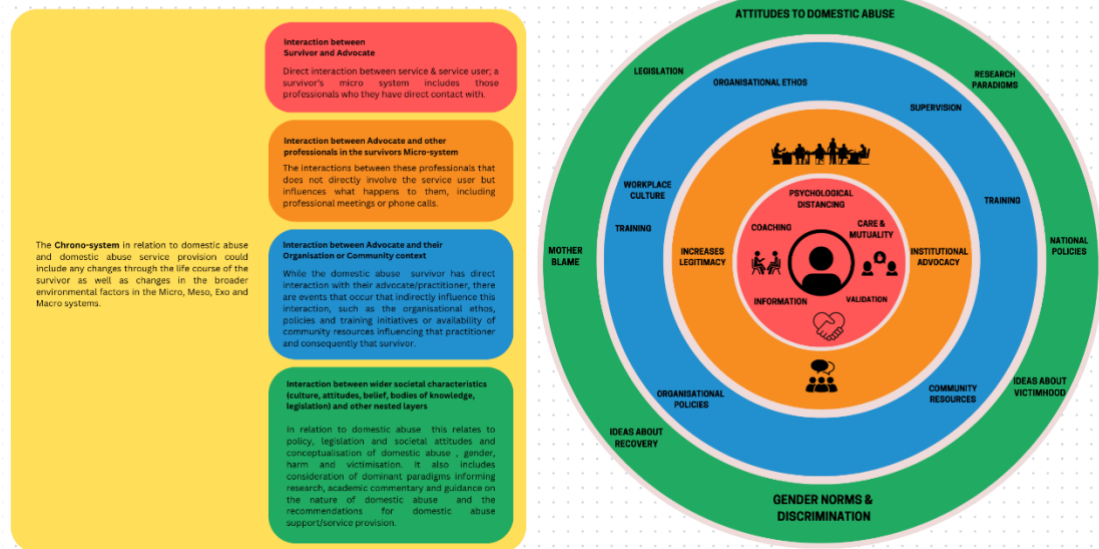


Figure 13: Bronfenbrenner's Model (1979) adapted to show Key Findings from this Study

Through examining the bi-directional influence of the multiple systems within which each survivor is enveloped and in turn influences, the aim is to provide a more holistic view of the impact of trauma-informed service delivery and what it means for practitioners and survivors of domestic abuse. Interpretation of these themes is also supported through an understanding of feminist critiques of medicalised intervention models as well as exploration of the conflicts between the value systems of the feminist grassroots domestic abuse movement and clinical practice models. However, first we will consider how the language of trauma is used in relation to domestic abuse.

Language: Naming Harm in the Context of Domestic Abuse

The way in which harm is defined and framed in relation to experiences of victims/survivors of domestic abuse has a significant impact on the way in which society and systems respond to and support these individuals (Swan & Snow, 2006; Meyer & Stambe, 2022). Increasingly, harms consequent to domestic abuse are framed in academic discourse through a trauma lens, with domestic abuse survivors seen as trauma survivors. Language in policy and legislation also evidences this shift towards a trauma-informed view of domestic abuse, highlighting the need for services

to recognize and address the impacts of trauma on domestic abuse survivors (Home Office, 2022; The Domestic Abuse Commissioner's Office, 2023; National Institute for Health and Care Excellence (NG116) Guidelines, 2018). Language is extremely powerful in shaping the understanding and response to social problems like domestic abuse with political and pragmatic implications (Bostock et al., 2009; Nixon, 2009).

Language was a recurrent theme generated from the research interviews with practitioners and survivors cutting across various layers of the ecological framework, shaping discourse, policy, service provision and interpersonal relationships. Questions about the utility, benefits and risks of viewing domestic abuse through a trauma lens or at least borrowing the language of trauma to describe it were brought into focus. Questions for analysis included: can trauma help to equalize the conceptual hierarchy between physical and nonphysical forms of domestic abuse? Are there any risks for the domestic abuse sector in borrowing language from the medical model of trauma? Does the language of trauma depoliticize domestic abuse, shifting focus and resources away from the structural causes towards the individual recovery? And is trauma language being used to embolden professionals, survivors, both or neither?

Is Trauma the Right Conceptual Lens? According To Who?

Both domestic abuse agencies included within this study are part of the larger Women's Aid Federation. In the definition of trauma offered by Women's Aid, taken from the working definition used by the charity Mind, trauma refers to 'very stressful, frightening or distressing events [that] we find traumatic' (McCarthy, 2022, p 22). While survivors in this study came to the realisation that emotional harm is a form of domestic abuse, it was less clear whether they would conceptualise the impact that this had on them as traumatic. This finding mirrors the ongoing debate cited in other literature that places emphasis on ever changing, ambiguous or porous delineations between trauma, adversity, and harm (Hacking, 1995; Haslam, 2016; Chatterjee & Park, 2024).

While there is no intention for this research to make claims for or against diagnoses of either PTSD or C-PTSD in participants, the survivors interviewed in this study did describe experiencing many of the symptoms associated with complex post-traumatic stress disorder as defined by the International Classification of Diseases (11th ed.; [ICD-11], WHO, 2019). C-PTSD is defined as re-experiencing, avoidance, hyper-

arousal and reactivity relating to 'exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible' (WHO, 2019, 6B41). The emphasis within this definition is on a sense of ongoing threat (not just enactment of physical violence) that is difficult to escape.

Some survivors spoke about this in relation to their abusive ex-partner and some extended this to their interactions with other services or professionals, particularly children's social care. Others spoke about this sense of impending threat within their community relating to being followed, attacked or shamed by the abuser or the abuser's friends. This 'constant looming' threat of physical or sexual violence (which may never actually be enacted) (Pence & Paymer, 1993 cited in Chavis & Hill, 2008, p 134) can strengthen the power and control tactics employed by abusers as well as being transmitted via wider community systems. It demonstrates the way in which oppression can manifest at various levels of a survivor's ecological context and 'impact various aspects of women's lives' (Carr, 2024, p 12).

Most participants reported significant physical reactions, demonstrating that the psychological violence and emotional abuse had direct physical consequences, in the same way that physical violence carries psychological effects, echoing the findings in Penttinen's (2023) study. Some of the physical experiences that they attributed to the non-physical domestic abuse included: not being able to swallow, shaking, headaches and nausea. Beyond the language of physical 'symptoms', survivors also used figurative anatomical language to describe their psychological experiences of domestic abuse, such as the image of the heart being used to describe certainty/uncertainty as well as trust/mistrust and confusion, another woman described being 'on her knees' to denote feelings of oppression and powerlessness.

Interestingly, traumatology is partly responsible for bringing physiology back into the broader discussion around mental health, but it is often referred to within psychometric testing as a list of symptoms. Trauma theorists provide a lens through which the psycho-physical experience of non-bodily harm (Rothschild, 2000) can be acknowledged and understood as having detrimental impacts on the survivor's 'physiological and biological systems' (Williams, 2006, p322). The amorphous nature of psychological harm is concretised through physiological and anatomical language. This returns us to the prevailing notion that trauma is held inside the individual (Levine, 2010) who experiences emotional or physical pain that overwhelms the central (brain)

and autonomic (body) nervous system in a way that 'leaves a mark on us as we move forward' (Conti, 2021, video). Baird et al. (2021) found something similar in that domestic abuse survivors' narratives illustrated how the emotional pain of trauma was felt within their bodies (2021, p 8128).

Baird et al. (2021) found that survivors' shifting perspectives in relation to trauma and their experiences of abuse were attributed to gaining new information about trauma, either through media (documentary films) or through working with a counsellor (Baird et al, 2021, p 8127). This was evidenced in one of the survivor interviews (S-04) when I offered her a short description of psychological trauma at the start of the research interview, to which she responded, 'that's definitely had an effect on me then'. Survivors made clear links between the original abuse they had endured and their subsequent thoughts, feelings, and behaviour such as being constantly put down by their partner causing them to lose confidence and feel anxious. While only one survivor explicitly mentioned the word trauma (S-02) without being directly asked about it, all the survivors gave detailed accounts of the various ways in which they felt their experiences of abuse had changed them.

While the language of trauma (deriving from psychodynamic theory and traumatology) may have once been confined to academic reflection and inquiry, the widespread information sharing around ACEs and the prioritisation of mental health and wellbeing (both nationally and globally) has led to an acceptance and prevalence of 'trauma speak' (Carr, 2023) which has become ubiquitous in the western culture and professional discourse. The confluence of this with awareness raising efforts about the impacts of psychological abuse seem to have afforded a new language to not only domestic abuse practitioners but also to domestic abuse survivors. The findings from Bliss et al. (2014) relating to the use of formal strategies in domestic abuse victims who report PTSD could be due to the increased likelihood to access mental health support to mitigate 'psychiatric symptoms' (Bliss et al., 2014, p 110), and these are relevant here in considering how PTSD acknowledgement are more likely to prompt women to access services rather than acknowledging domestic abuse. This finding supports the notion that adopting labels recognised in medical discourse give victims as well as staff credibility and thence access to support and services.

Some survivors referred to other adverse experiences they had endured in their childhood or in life before their abusive relationship. One survivor (S-02) used the term 'traumatic' when describing her experiences, citing childhood sexual abuse and

bereavement. In contrast, another survivor (S-05) voiced her frustration at her childhood being (mis)characterised by a social worker as 'traumatic'. This assertion was not only verbalised by the social worker in a multiagency safeguarding meeting but was recorded within the assessment regarding the survivor's capacity to adequately care for her own children. This account illuminates the wider epistemic complexity around who 'decides' whether or not an experience was traumatic.

Baird et al. (2021) found that multiple adverse experiences correlated with a struggle for acceptance and a greater risk of being blamed and shamed by professionals (Baird et al, 2021, p 8135). In the second example stated above, it would appear that trauma can indeed be weaponised and used against survivors. Tseris (2013) emphasises that an overly simplistic or reductive understanding of trauma when describing a woman's psychological experience and her choices can: 'carry hidden assumptions that constrain the possibilities for how a woman's identity can be constructed and understood...such as a presumption of lifelong difficulties, which can actually obstruct social justice and discredit the validity of a woman's telling of her own experience' (2013, p 7).

This question about who gets to define or name an experience as traumatic (i.e. professional or survivor) relates to Fricker's concept of epistemic injustice, which explores how a person's knowledge can be discredited, both *testimonially* and *hermeneutically*. Testimonial injustice refers to a rejection of the knower's experience or knowledge due to prejudice based on their identity (e.g., because they are a woman or a survivor of abuse or because they are a person of colour) leading to a perceived 'credibility deficit' (2007, p 17). Hermeneutical injustice refers to someone not having access to the conceptual and structural resources needed to understand their experiences.

The social worker's insistence that S0-5 'must' have had a traumatic childhood because her mother used drugs, even after the survivor tried to correct her could be seen a testimonial injustice. It raises an important question about the possible reasons why the survivor's own experience or characterisation of her experience would be rejected by the social worker in this interaction. The child and family social worker wrote this following a single child and family assessment and verbalised this in a child protection conference meeting during which a period when the survivor's parenting capacity was being investigated.

The practitioner's thought process and rationale for their characterisation of the survivor's childhood clearly cannot be verified. However, it is possible that the context of the interaction and the social worker's formal role as assumed 'expert' within that context may be relevant. It is also possible that their intention was to demonstrate empathy for the survivor's experience, but the social worker made their statement based on what they themselves would deem traumatic if part of their own life history. The social worker may have been trying to offer a lens or conceptual framework to the survivor, a new way of describing or validating her experiences. This is a common and widely appreciated skill employed by domestic abuse practitioners, cited within this study and others (Bradbury et al., 2014; Penttinen, 2023) whereby practitioners help survivors to identify, name and characterise their experiences of harm within the context of domestic abuse. If a domestic abuse survivor does not always know they are being abused, then does a traumatised person always know they are traumatised and what is the utility in pointing this out?

While some domestic abuse survivors in other studies have described feeling validated by the concept of trauma (Doolabh et al., 2022, p 868; Baird, 2018) or the diagnosis of PTSD (Women's Aid, 2022, p 9), others have pointed to feeling pathologised or dismissed (Doolabh et al., 2021, p 872). Allen (2008, p 21) asserts that trauma is 'in the eye of the beholder' (2008, p 21), pointing to the importance of subjectivity in defining what is or is not traumatic. Boals (2018) examined the correspondence between objective trauma exposure and the subjective experience of traumatisation and found evidence that strongly supports the need for 'inclusion of subjective experience in the classification of PTSD' (2018, p 86).

Instead of solely relying on medical or 'professional' classifications of trauma as the standard against which all other accounts are judged as true or valid (or not), it seems that a more carefully co-constructed meaning making process must take place between the service user and service provider in order to close the gaps between objective and subjective, between practitioner and survivor and between language and experience. Fricker's concept of hermeneutical injustice helps to identify how these gaps can manifest on an both an intrapersonal and interpersonal level; the gap between the experience and having the language to adequately or credibly describe that experience or the gap between the two parties that lack enough shared experiences to understand one other. In practice, these gaps could become evident when a person is engaging with services who are not making links (or at least showing professional curiosity) about the relationship between symptoms and life experiences

(such as abuse); or conversely when practitioners make assumptions about a person's life experiences without having a shared understanding of those experiences.

Non-Physical Abuse: Too Big to Tackle, Too Familiar to Recognize

The small sample of survivors included within this study seemed echo the paradox around non-physical abuse illustrated by survivors cited in other studies in that it is commonly experienced but rarely recognised as domestic abuse. Kaukinen (2004) found that survivors who have experienced both physical and non-physical forms of abuse are much more likely to report features of psychological abuse than those who have exclusively experienced psychological abuse. Stark posits that this is because psychological abuse does not fit the stereotype of intimate partner violence, so survivors are less likely to characterise their relationships as abusive. Penttinen (2023) calls this the 'hierarchical distinction between real physical violence and 'mere' emotional abuse' (2023, p 2).

All but one survivor included in the current study spoke about non-physical harm as the main issue in their relationship and explained that they did not initially characterise this as domestic abuse. Most survivors described their initial reluctance to characterise emotional harm as abuse and demonstrated a reluctance to talk about other forms of harm they had experienced in their relationship, such as physical or sexual assault. For some survivors in this study, there was cognitive dissonance between the rarer instances of physical or sexual assault and the pervasive, chronic nature of the emotional abuse they were being subjected to. A reflexive point about the interpersonal layer of this interaction would be to consider the possibility that perhaps physical or sexual abuse was more difficult to discuss with a researcher, someone they had never met before. Only one survivor spoke directly about sexual abuse, another alluded to it without naming it.

One survivor spoke directly about physical abuse, but another three survivors alluded to occasional or singular instances of physical assault. While most survivors stated that they thought domestic abuse meant physical harm, they simultaneously discounted their own experiences of physical harm, stating that they only realised they were victims of domestic abuse when the emotional harm they had endured had been validated as domestic abuse. It is important to note that women who had experienced emotional abuse as well as less frequent instances of physical or sexual abuse did not

immediately characterise their relationships as abusive, seemingly discounting the instances of physical or sexual assault entirely and citing emotional harm as something they regarded as conceptually separate to domestic abuse.

In this sense, the 'normalisation' (Evans & Feder, 2016, p 67) of verbal aggression or psychological oppression of women by men could render this kind of harm as a commonly 'invisible' but 'voiced' (Burnham, 2012, p1460) phenomena. Meanwhile, the rare or less frequent instances of sexual or physical harm they had endured was not problematised and remained 'unvoiced' (Burnham, 2012, p1460). A Macro-level framework of analysis for these findings is offered by Kitzinger (1994), who refers to society's tendency to minimise the seriousness of violence against women as 'the frequency game'. She claims that a 'taken for granted' understanding dictates that 'if it's rare, it's not a problem; if it's common, then it is normal rather than problematic.'

The question of how a survivor can acknowledge the impacts of abuse if they do not classify what happened to them as abuse remains. If what they are experiencing is framed in the wider cultural discourse as a 'relationship problem' or a 'mental health issue' (Doolabh et al., 2021, P 872) there is a risk that the impact of non-physical harm will not be traced back to the cause of nature of that harm, what Neale (2018) calls occlusion; occlusion of the abuse itself or occlusion of the perpetrator (2018, p 5-6). Could framing the impact of non-physical abuse as traumatic help to mitigate the risk of occlusion? Perhaps trauma help to equalise the conceptual 'hierarchy between physical violence and 'mere' emotional abuse' (Pentinnen, 2023, p 2).

Other studies have concluded that emotional harm is unlikely to be identified as domestic abuse by professionals if it is not accompanied by reports of physical or sexual abuse (Neale, 2018; Fagerlund et al, 2020; Doolabh et al, 2022). The domestic abuse practitioner participants demonstrated a resounding consensus around their understanding of emotional harm as a pernicious and chronic form of domestic abuse and most made strong conceptual links between emotional harm and trauma, sometimes using the terms interchangeably, with some saying that the impacts of emotional abuse can be the most damaging. The domestic abuse practitioners' views on emotional abuse reinforce the substantial body of evidence that shows the effects of psychological violence are similar to those resulting from physical violence, including stress-related illnesses such as PTSD, anxiety and depression (Karakurt and Silver, 2013; Teitelman et al, 2011; Pico Alfonso, 2005; Humphreys and Thiara, 2003).

The insidious nature of non-physical abuse, often designed to dismantle the target's sense of self, can lead to more protracted recovery compared to instances of physical abuse as it profoundly impacts the individual's self-worth and identity, leaving lasting psychological and emotional scars. (Reyes, 2007; Siltala et al, 2014; Penttinen, 2023). In this current study, it was only when survivors sought support from services that many of them started to fully acknowledge or give voice to the chronic and oppressive nature of the non-physical abuse they had experienced and the long-lasting impact this had had on them. In this sense, one could argue that the acknowledgment of abuse in any of its forms is the primary and essential component to the naming of - and recovery from - its potentially traumatic impacts on the survivor.

Having considered some themes that cut across the different levels of the eco-system, the themes identified at the four different levels of the eco-system will now be explored, starting with the Micro-system.

Micro Level: How Trauma Theory and Trauma-Informed Practice Were Manifested in Staff-Survivor Interactions

The Micro-system is the pattern of 'activities, social roles and interpersonal relations experienced by the person' (Bronfenbrenner, 1994, p 40). The Micro-system of a domestic abuse survivor accessing domestic abuse service provision includes their relationship with their domestic abuse practitioner, any other interactions they have directly with professionals as well as their family and friends. In this study, the examination of the Micro-system includes how practitioners and survivor characterised their communication and interactions.

Components and Principles of Trauma-informed Care

Some practitioners seemed to identify with the concept of trauma-informed practice more than others, while all practitioners strongly emphasised the importance of being needs led and survivor-centred. Difference experience levels, training experiences, workforce development opportunities and roles within the service provision could partly account for this variation.

In accordance with Hanson and Lang's (2016) components of trauma-informed care,

some of the components that were considered least unique to TIC including a strengths-based approach to promote positive development and having a positive, safe physical environment (Hanson and Lang, 2016 p 96-97) were the most commonly discussed by practitioners in this study. One other component identified by Hanson and Lang (2016) as being more unique to trauma-informed care was the mitigating the risk of traumatisation which was also consistently referred to by practitioners in this study when discussing their work with survivors.

In accordance with the principles of trauma-informed services for women identified by Elliott et al. (2005) all practitioners included within this study showed an awareness and recognition of the 'impact of violence and victimization on development and coping strategies' (Principle one; Elliot et al., 2005 p 465), the employment of an empowerment approach (Principle three Elliot et al., 2005 p 465) and working to maximize woman's choices and control over her recovery (Principle four Elliot et al., 2005 p 465)

In relation to principle two, 'Identify trauma recovery as the primary goal' (Elliot et al, 2005 p 465), there seemed to be some variation in the way in which domestic abuse practitioners in service A conceptualised and prioritised trauma recovery, with some expressing a degree of trepidation about moving away from a prisonisation of physical safety as the primary goal in cases of physical domestic abuse .

Principles six and seven identified by Elliot at al. (2005) mirror the important but not unique components of TIC outlined by Hanson and Lang including creating a positive safe environment for survivors and using a strengths-based approach and were commonly cited by practitioners in this current study. Practitioners also demonstrated a commitment to minimising the possibility of re-traumatisation (principle eight, Elliot at al., 2005) and relational collaboration (principle four; Elliot at al., 2005) with survivors, skills which they felt were enhanced by the trauma training they had undertaken. Principle nine, 'Strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background' seemed to be something that the VOICES framework had been designed to address. While some practitioners spoke about the helpfulness of the VOICES planner and framework in prompting them to get to know the survivor more holistically, others described some limitations of how this was interpreted and utilised. Some practitioners were confused about the focus of VOICES and others described limitations in how the framework was being utilised, echoing the long-standing debate in the domestic abuse field about the

potential benefits and limitations of needs-led approaches versus risk-based approaches.

While survivors absolutely acknowledged the raft of physiological symptoms they were experiencing as a result of psychological abuse, very few had done any work with professionals to address their physiological symptoms. Interestingly, the two organisations involved in this small study did not routinely screen for trauma, instead opting to use scales such as the chaos index scale (used in Service A, complex case refuge), the CORE-34 (used in Services A & B, counselling services) or general wellbeing scales such as the Warwick Edinburgh Wellbeing scale (Service A, outreach service), none of which look specifically at the physiological symptoms of traumatic stress. Practitioners explained that they preferred a more conversational approach to tracking traumatic experiences and symptoms without adding more 'ticky box' (P0-2) forms, which can sometimes act as a barrier to relationship-based practice. A recent scoping review by Clark et al. (2023) found that out of 163 assessment tools used in domestic abuse practice, the Warwick Edinburgh Wellbeing scale was the 'only one tool that was recommended by both the practitioner advisory and the [survivor] steering advisory groups' (2023, p5). The authors note that this tool was not developed specifically for domestic abuse, and therefore was 'more likely to use language, or to be designed, in a way that could cause participants to relive their trauma' (2023, p 5). The survivor advisory group contributing to Clark et al.'s (2023) review highlighted the need to develop more trauma-informed outcome measurements to use with domestic abuse survivors.

While many of the practitioners found the language of trauma helpful in speaking with other professionals and felt that traumatology was a useful theory base to inform their work with survivors, most felt that the explicit language of trauma had limited utility in their interpersonal working relationships with survivors. Practitioners did seem to really value trauma knowledge in the way it reframed their understanding of behaviour exhibited by survivors. For example, many of the practitioners understood non-engagement or any resistance to support services as a manifestation of trauma, with some making specific reference to 'avoidance' (DSM 5, Criterion C).

Many practitioners reflected on the notion of 'choice' in relation to domestic abuse survivors and the importance of constrained or seemingly counterintuitive choices or actions (such as hostility towards workers) being viewed through a trauma lens. A non-pathologizing, non-medicalised understanding of trauma might view these behaviours

in survivors not as symptoms but as adaptive survival strategies in the face of adversity (Johnstone, 2018). In relation to domestic abuse specifically, these survival strategies could be understood as strategic responses to domestic abuse (Goodman et al., 2003; Bliss et al., 2014) or strategies of resistance (Rajah and Osborn, 2020) within an ever decreasing 'space for action' (Kelly, 2003). Only one practitioner included within this study explicitly used the language of resistance or strategy to linguistically frame the behaviour of survivors they had worked with. Some practitioners did allude to the idea of survival strategies through talking about the ways in which survivors try to get their needs met.

The next section explores some of the ways in which a trauma-informed approach was conceptualised and utilised by domestic abuse practitioners in their interactions with survivors, including distancing, coaching and care.

Don't Take It Personally: Psychological Distancing

Perhaps the strongest point of consensus identified within the trauma literature was around the importance of a trauma-informed approach ensuring the preventing Re-traumatisation (R4) principle which prioritises an understanding of how services can replicate power-over or oppressive relationships and trigger distress in trauma survivors (Wilton & Williams, 2019; Hopper et al., 2010; SAMHSA, 2014; McCarthy et al., 2020). On the interpersonal level, many practitioners in this study felt that their own training and knowledge around trauma helped them to adopt a calmer, more compassionate approach with survivors and create a sense of psychological safety for themselves when working with survivors who behaved aggressively towards them.

Practitioners described a kind of psychological distancing which helped them not to 'take it personally'. This aligns with existing literature (Van der Kolk, 2014; Perry & Szalavitz, 2017; Seigel, 2015) on the ways in which a trauma-informed perspective can help practitioners reframe presenting problems or problematic behaviours as coping strategies that were 'once adaptive in the traumagenic environment but which can become self-destructive or harmful across different domains of human functioning' (Levenson, 2017, p 107). The intersection between trauma theory, attachment theory and interpersonal neurobiology is relevant here, as these have all pointed to the importance of the practitioner's ability to emotionally regulate the distance between them and their client, to avoid becoming activated and replaying familiar relational

dynamics and expectations of the client (Meyer & Pilkonis, 2001).

Two studies highlighted within the literature review (Chapter 4: Stress, Vicarious Traumatization & Burnout in Domestic Abuse Organisations) by Brown and O'Brien, (1998) and Glenn and Goodman (2015) highlight another potential use of psychological distancing for domestic abuse practitioners. They suggest that psychological distancing could be used to prevent further exposure to distress and as a coping mechanism to prevent or mitigate the impacts of secondary traumatic stress or burnout. This protective aspect of distancing was highlighted by practitioners in this study, when discussing the possible ramifications (STS or burnout) of becoming overly involved with survivors or struggling to switch off after work.

Aggression displayed by domestic abuse survivors could also be viewed through the lens of shame sensitivity, with some researchers pointing to the link between PTSD symptoms such as aggression or irritability and manifestations of shame (Taylor, 2015) such as 'attacking others' as a means of masking shame (Nathanson, 1992, pp. 305–377) which can damage oneself and social bonds (Taylor, 2015).

The notion that trauma-informed approaches assists individual workers to reframe their understanding of survivors' behaviour and adapt their response accordingly speaks to a wealth of pre-existing literature around concepts such as emotional neutrality (Ward & McMurray, 2011), emotional labour (Hochschild, 1983) and emotional regulation in service or public facing professional roles (Chapter 6: Using TI approach to develop a non-judgemental, objective stance to intellectually manage the stresses of the work). Burman et al (2023) emphasise the significance of emotional labour in relational gender-responsive work with women, which 'requires the adoption of specific forms of self-presentation, demeanour, and emotional states on behalf of service providers...which can not only be exhausting but also take a toll on service providers' (2023, p 14).

Coaching

Some practitioners seemed to try and model this 'distancing' ('it's not personal') technique for survivors to take on in their interactions with other professionals, by encouraging them to sublimate their defensive impulses into the work of building a

case (i.e. don't fight on the phone, make a log of everything and we will present it at the next Child Protection meeting). Survivors seemed to appreciate this co-working/coaching aspect of support and could tolerate feedback from their domestic abuse support workers about how they could amend their communication style in multi-agency meetings for example, with the aim of having their needs met or reaching their goals.

The perfect victim

One of the practitioners reflected on her conflictual feelings about 'coaching' survivors to become/appear as 'the perfect victim' in preparation for multi-agency meetings or correspondence with their ex-partner. In this sense, the practitioner could be seen as acting as a 'role model' (Voronka, 2017), modelling the behaviour and expression that best align with the social rules that 'govern what are expected, desired, or accepted emotional responses within a given situation' (Maclean, 2023, p 1269). 'Feeling rules' (Hochschild 1983, p 56) facilitate understanding of emotional experiences as structurally informed by the social order. Feminist scholars have critiqued how services have historically positioned service users who openly display psychological distress as the irrational, the emotional, the 'other' (LeBlanc & Kinsella, 2016; Voronka, 2017). While many of the practitioners in this study spoke about their effort to fight against this notion of survivors, they also acknowledged that other services and institutions such as social services, the police and the courts still seemed to express these views. Consequently, domestic abuse workers are caught between their own organisation's prevailing attitudes and goals versus those of the wider culture. Service users face a similar fate, with their responses 'rooted in the unconstructed raw ontology of painful experience and past traumas' (Brosnan, 2019 p 3), being met by organisational and institutional cultures that are 'dry, officious procedures that espouse overt power [which] inhibits passionate expression and manages it via business-as-usual' (Ibid, 2019 p 3).

Church (1996, 2009) identified the ways in which passionate or politicised displays of emotion by survivors 'unsettled' bureaucratic processes in psychiatric survivor participation involvement in a community mental health steering committee in Canada in the 1980s (Church, 1996, 2009; Church & Reville, 1988). Professionals or officials were often found to perceive survivors' engagement style as challenging or bad mannered. The survivors included in this study provide evidence that this sentiment is

still being expressed today, with professionals questioning their victimhood, their honesty and their intentions. Barret (2019) asserts that a trauma-informed approach recognizes that typical emotional, psychological, and social aftereffects of trauma hinder an individual's ability to seek and engage with services designed to help them.

The subthemes 'perfect victims' and 'playing the game' were both generated in relation to practitioner and survivor interviews. These themes can also be understood in relation to the philosophical concept of 'epistemic injustice' (Fricker, 2007): the forms of domestic abuse advocacy described above could be seen as affording survivors testimonial justice (they hear, believe and bear witness to their experience of domestic abuse) as well as hermeneutical justice through providing them the conceptual resources to understand their experience of domestic abuse and their trauma symptoms. For example, when a practitioner says to a survivor, 'you don't have to respond to that email, you don't have to justify yourself anymore', they are contextualising the survivor's defensive strategy in relation to their lived experience, through the implicit understanding that this coping mechanism was once essential or 'adaptive' in their previously 'traumagenic environment' (Levenson, 2017). Furthermore, a kind of strategic justice is offered when the practitioner encourages the survivor to harness and channel that 'agentic resistance' (Mahoney, 1994,2013; Rajah and Osborn, 2020) into building a case against their abuser in a strategic manner and gain access to resources.

Practitioners coaching survivors in 'perfect victim' presentation inadvertently reinforce a system that deems certain victims as credible and deserving of help while marginalizing others. Lazar (2008) highlights that a focus on presenting as a worthy victim obscures the resistance of survivors, creating a false dichotomy between victimization and agency. Despite advocates' intentions to empower survivors, their Micro-level interactions and decisions are of course impacted by Macro-level influences such as patriarchal ideas about victimhood and deservedness.

The discourse surrounding trauma and domestic abuse raises critical questions about what support is genuinely available to survivors and what has been lacking historically. Discussion of 'deserving' versus 'undeserving' victims reveals a hierarchy that often leaves many domestic abuse victims without adequate support, compounded by funding cuts, stigma, and low conviction rates.

Friends, 'Experts', Women

Three survivors included in this study were engaging with independent domestic violence advocates (IDVAs), two were engaging with outreach support workers, two were receiving counselling support and one was currently receiving support within a refuge setting. Survivors identified two key components of building a positive working relationship with their domestic abuse support worker: being treated like a friend rather than a service user and being assisted by a professional they trusted who had their best interests at heart.

The priorities of survivors in terms of topics and approaches to conversations with their domestic abuse support workers varied. While some stated a preference for problem-free talk (George, Iveson, and Ratner, 1990, 1999) or phatic talk (Makice, 2009; Miller, 2015) with an emphasis on survivor and worker getting to know one another, others highlighted the importance of more pragmatic and problem focussed conversations. This had some (but not complete) correlation with the aspect of service provision the survivor was engaging with, i.e. women engaging with an IDVA while going through the criminal justice process spoke about the importance of being kept up to date with information pertaining to their case.

Caring

While a sense of internal and external safety felt fragile and precarious for all survivors included within this study, a sense of relational safety and trust between them and their domestic abuse support worker was cited and prioritised by all survivors. Survivors specifically commented on the importance of one or more of the following: [the practitioner] being 'like a friend', being 'calming', 'non-judgemental', 'warm' and even 'physically affectionate'. This sense of kinship or solidarity was echoed by some survivors who expressed concern about their domestic abuse support workers answering emails after work, having to interact with their abusive ex- partners or being unfairly treated by other professionals.

Practitioners spoke about the importance of gender and a sense of solidarity with the women they were supporting. While practitioners had varying levels of confidence in the notion of themselves as 'experts' in relation to trauma, many attributed their sense of 'knowing' to a kind of lived experience wisdom, acquired through both their personal experiences (as women, and sometimes as survivors of domestic abuse) and their

professional experience (years spent supporting survivors of domestic abuse). These findings echo Fuller's (2023) study in which domestic abuse survivors identified the importance of domestic abuse workers being validating, connected, knowledgeable, needs led and accepting.

While many studies have highlighted the importance of advocacy (Ogbe, et al., 2020) or intervention model efficacy (Paphitis et al., 2022), a smaller number of studies focussing on trauma-informed approaches (with domestic abuse survivors or other client groups) have highlighted the relational qualities (Kulkarni et al., 2012; Paphitis et al, 2022), supportive actions and perceived strengths of the practitioner as experienced by the client/service user. Qualitative research focusing specifically on domestic abuse service provision has offered some insight into the attributes and qualities survivors value in their workers such as authenticity and availability (Stanley, et al 2021, p 47) or the power of a 'warm relationship' between client and worker (Chandhok & Anand, 2020). However, the notion of worker as 'friend' or equal within the domestic abuse literature is largely limited to older feminist grassroots advocacy literature, when the personal was (seen as) political and the focus of intervention was seeking to 'raise consciousness amongst female survivors and their allies to challenge gender inequalities' (Campbell, 2021, p 3).

Whilst some research has highlighted the fact that engagement with female survivors using services can sometimes be hard to establish (Lightbody 2017; Batchelor 2005), a body of feminist work on effective practice has highlighted the necessity for gender-responsive relational interventions in working with women in order to enable the development of consistent, positive and trusting relationships (see for example, Batchelor & Burman 2004; Rumgay 2004; Gelsthorpe & Hedderman 2012; Brown & Gelsthorpe 2022).

Ethics Of Care

Examining the Micro level of staff survivor interactions has unearthed some principles and structures of relational practice that one would expect from trauma-informed approaches from a practitioner perspective, such as staying calm and being non-judgemental, but survivors' accounts also indicated the importance of something else, specifically care.

Practitioners spoke about the importance of supporting and understanding survivors and most felt that the trauma-informed approach aligned particularly well in helping them to draw links between survivor experiences and their presentation or behaviour. Meanwhile, survivors spoke about the importance of feeling cared for and feeling that the domestic abuse practitioner was in their corner or on their side. None of the practitioners mentioned the word 'care' outside of the concept of self-care, relating to safeguarding themselves against burnout, secondary trauma or vicarious traumatisation. So, while practitioners had no reluctance in acknowledging the inevitability of being moved or impacted by the work with survivors, presumably rooted in their care for the women they are supporting, they did not use the language of care in their description of their work. Why then is the language of care privileged by survivors but not practitioners?

It could be that the language of care risks being confused with personal relationships, indicating a wariness from practitioners about upholding professional boundaries, part of the turn towards professionalism in the domestic abuse sector (Duithe, 2012; Wiles, 2008, Hague & Mullender, 2006; Ishkanian, 2014; Dewy & Germain, 2014; Mehrotra et al., 2016). Steckley and Smith posit that the 'woolly notions of care and relationship is likely to be a bridge too far for the modernist mind with its need for checks and balance' (2011, p 192). Dewy and Germain point out that the domestic abuse sector has undergone a 'transformation from the peer-to-peer model of the first shelters that opened in the United States and United Kingdom in the 1970s to the federally funded and professionally staffed organizations that exist today' (2014, p 391).

Wiles (2008) found that some domestic abuse advocates have expressed the view that being seen as professional legitimizes domestic abuse services through the 'credentialing of advocacy' as more credible, high quality, and deserving in the eyes of funders and other human service partners (Wies, 2008 p 227). Meanwhile, others have expressed concern about the impact of these changes on the feminist foundations of domestic abuse services in 'moving away from community-based, feminist, grassroots structures and analysis' (Mehrotra et al., 2016, p 155). Wies (2008) explains that professionalization helps the advocate to establish a distinct or distant professional identity from the woman (Wies, 2008, p 230). The adoption of trauma-informed approaches could be seen as a way in which professionalization of the domestic abuse sector is being reinforced, especially when considering the importance of distancing (as discussed above) in both trauma-informed practice and professionalization.

Meanwhile, caring relationships offered by domestic abuse practitioners were really valued by survivors. Practitioners' descriptions of 'needs-led' or women focussed support were translated by survivors as a kind of unwavering positive regard and care. Women felt accompanied by their domestic abuse practitioners, even extending care and concern for their wellbeing such as worrying about their practitioner working late or being treated badly by their ex-partner or other professionals (see Chapter 7, theme three).

Survivor descriptions of domestic abuse practitioners and their relationship with their practitioners was more closely aligned with the principles of Care Ethics than the principles of trauma-informed practice. Care Ethics or Ethics of Care (EoC) (1982) was devised by Carol Gilligan (1982) in critique of Kohlberg's model of moral development which tended to deduce boys and men as more morally mature than girls and women (Walker, 2014). In keeping with the long held feminist critique of the 'view from nowhere' (Harding, 1991; Allen, 1996; Collins, 1990; Hartsock, 1983; Prilleltensky, 1989, 1994; Sarason, 1981), Gilligan argued that Kohlberg's model of moral development was not objective but based on a traditionally masculine view of morality which prioritises justice and rights. Gilligan (1982) claimed that women often placed more emphasis on more 'feminine virtues' such as empathy and compassion. Meanwhile some feminist scholars have criticised EoC for further compounding gender stereotypes and argued that it risks being viewed solely through the lens of biological essentialism that sees care as a 'natural' feminine virtue (Bartky, 2015; Tronto, 2005).

While many institutions such as social services, the police or legal entities may prioritise rule or duty based ethical approaches and may see 'care as being outside of their moral scope' (Vidale-Plaza, 2023, p3), domestic abuse services could find a natural congruence with the tenets of Ethics of Care (Gilligan, 1982) given their feminist ideological roots. The four components of EoC outlined by Tronto are 'attentiveness, responsibility, competence, responsiveness' (2005). Tronto later added 'plurality, communication, trust and respect; solidarity or caring with' (2013). Perhaps practitioners chose instead to talk about support, education, and advocacy as they adhere more closely to rights-based or needs-led models of practice, which frame survivors as agents of change or as beneficiaries of support (Vidale-Plaza, 2023 p 2).

Almost all practitioners in this current study understood domestic abuse as a gender-based form of oppression, and acknowledged the importance of their gender, their first-hand experiences (some had personal experience of domestic abuse) and their

concern about the amount of women impact by domestic abuse as sources of motivation for their work in a domestic abuse service. As Vidale-Plaza (2023) states, ethics of care is as much about caring through their 'situated understanding of relationality, interdependency, and vulnerability' as it is about the 'practical work of care' (2023, p 4). The positionality of the domestic abuse practitioners as women from the same local area, or as women who have had some similar experiences to the survivors they are supporting, allowed for this 'situated understanding'.

Gilligan (1982, 2013) described the importance of helping women and girls to 'know what they know' and re-engage them with their own intuition and their own authentic voices. Much of the work described by the practitioners and survivors in this study could be seen through this lens, for example, practitioners helping survivors to acknowledge and name the abuse they have endured, responding to survivor needs, accompanying survivors to meetings, showing warmth and even physical affection. The value placed on acts of care and connection between survivors and practitioners in this study echoes findings from some studies looking at trauma-informed approaches in domestic abuse service provision. For example, Wilson, Fauci and Goodman's (2015) analysis of trauma-informed approaches in domestic abuse service provision found that facilitating connection, intimacy and meaningful relationships between staff and domestic abuse survivors were common themes in the publications included in their document analysis sample. Kim (2010, p 4) referred to 'intimacy and care' in a kind of 'family' relational model to working with survivors. Burman and colleagues (2023) highlight the emphasis placed by female workers supporting women on kindness, empathy and trauma-informed care as key 'requirements to do their work well' (2023, p 44). Burman et al. translate this into a kind of ethics of care, rooted in relationship-based practice and social justice.

The next section focuses on how trauma-informed approaches were utilised at the level of the Meso-system, legitimising the role of the domestic abuse advocate and in turn the experiences of the domestic abuse survivor.

Meso-Level: How Trauma Theory and Trauma-informed Practice Were Manifested in Professional Interactions

The Meso-system is 'a system of Micro-systems' (Bronfenbrenner, 1994, p 40). A survivor's Meso-system includes the interactions between professionals who they work

with, interactions that directly involve the service user but influences what happens to them, including professional meetings or phone calls.

Practitioner stated that adopting a trauma-lens helped them better advocate for survivors in multi-agency/inter-disciplinary discussions (Meso-system). In a broad sense, this aligns with the assertion made by Warshaw (2014) that trauma-informed work is social justice driven and closely linked with advocacy, in that a trauma-informed approach can be utilised to transform the conditions that allow for violence in our world' (Warshaw, 2014, p. 15).

How A Trauma-informed Approach Can Help To 'Legitimise' Domestic Abuse Practitioners

Practitioners who placed emphasis on TIAs as an opportunity to legitimise domestic abuse service providers believed that this would give them more influence within multi-agency contexts to advocate on behalf of survivors: 'they can't argue with it' (P-06). The concept of legitimacy relates to ideas about worthiness or perhaps even 'deservedness' in terms of societal perceptions (Macro-system) about domestic abuse advocates, specifically how other professionals assess the legitimacy, professional status and knowledge base of domestic abuse advocates.

This question has been reflected on within some of the 'professionalization' literature, which cites professionalization of the domestic abuse sector as being 'instrumental in enabling once marginal feminist voices to be heard in established centres of political power (Markowitz and Tice 2002, p 954) and has substantiated that domestic abuse is a 'serious social problem that needs to be given visibility and skilled attention' (Eizikovits and Buchbinder 1996, p186 cited in Wies, 2008, p 223). A key benefit of a trauma-informed approach according to practitioners in this study is the idea that using the discourse of trauma in relation to domestic abuse survivors helps to validate the survivor experiences in the eyes of other professionals as well as professional judgement of the advocate.

When understood through an ecological systemic framework, Hester's frequently cited three planets model (2011) focuses on three possible domains of the Meso-system or three 'planets': the domestic violence planet, the child protection planet, and the child contact planet. Hester's model is valuable in highlighting the gaps and very different

conceptions of both the problem and the intervention between the planets. While the domestic abuse planet does not have statutory powers, Hester (2011) emphasises the efforts made by those working in the independent domestic violence sector to position domestic abuse as a criminal matter, not a private matter but as an issue worthy of public concern, promoting a criminal justice approach. Practitioners and survivors both noticed agencies' differing stances towards domestic abuse and domestic abuse survivors and it was apparent that the domestic abuse worker was often the person tasked with re-educating misconceptions about domestic abuse among other professionals: many practitioners said they found the language of trauma useful in their efforts towards institutional advocacy (Kelly and Coy, 2011) in this regard.

The Knock-on Effect of Legitimising Survivors

It was felt that the upskilling and 'credentialising' of the domestic abuse workforce afforded practitioners and the women they advocated for a kind of legitimacy within the wider professional and societal context that had previously seemed unobtainable. The notion that a victim has been traumatised provided the basis on which they felt they could challenge victim blaming, rationalise revictimization, challenge other professionals and advocate for more appropriate service provision for survivors. In multi-agency contexts, the practitioners felt that their knowledge on trauma in relation to domestic abuse enabled them to reframe seemingly counterintuitive behaviour of domestic abuse survivors ('why doesn't she leave') and shift the discourse around a survivor's behaviour, leading to more of a needs-led approach to service provision. Practitioners saw it as something that made them different, or able to offer a 'different voice' or perspective that could shift the multiagency response; the 'difference that makes the difference' (Bateson, 1978 cited in Cárdenas-García et al 2020). Practitioners included within this study highlighted the importance of seeing the survivor's behaviour in the context of the abuse they have endured and the subsequent trauma they have experienced. They conceptualised themselves as distinct from other service practitioners, while also being a bridge between the survivor and the wider (often less understanding) system, with some even coaching and modelling effective communication strategies for survivors to adopt when engaging with other professionals.

Exo Level: Indirect Influence of Organisation and Community Networks

The Exo-system is comprised of 'linkages and processes taking place between two or more settings, at least one of which does not contain the person in question' (Bronfenbrenner, 1994, p 40). In relation to domestic abuse survivors, their Exo-system includes any organisational factors or community factors that could be influencing the advocates practice such as organisational ethos, policies and training initiatives. While these events and contexts do directly impact the survivor they their impact on the advocate influences the survivor-practitioner interaction. It can also include wider community factors environmental factors influencing the practitioner and consequently the survivor.

Practitioners spoke about the opportunity for TIAs to leverage better protection for survivors at the national level through influencing policy and legislative frameworks (the Exo-system). Practitioners seemed to be acknowledging the multiplicity of layers impacting upon the domestic abuse survivor's experience. Furthermore, the mention of policies, legislation and resource allocation pertains to the socio-political context in which domestic abuse survivors-practitioner interactions are situated and influenced by.

Barriers And Facilitators to Trauma-Informed Approaches Across Various Aspects of Service Provision

Organisational factors

In accordance with Hanson and Lang's (2016) components of trauma-informed care, some of the components deemed to be the most unique to trauma-informed care such as written policies that include trauma, use of standardised trauma screening/assessment measures, measuring staff proficiency using defined criteria, had not been implemented across any aspect of the service provision at the time of data collection. Some other important and unique components of trauma-informed care (according to Hanson and Lang, 2016) were being implemented within certain aspects of service provision, such as addressing secondary traumatic stress, availability of clinical providers of trauma focussed evidence-based practices and

defined leadership positions for trauma services and awareness.

Practitioners in this study cited a range of different facilitators in their work with domestic abuse survivors, including trauma training, strong leadership, and supervision. All practitioners (except one) were from service A, which has a range of different projects or service provisions within it, including the complex needs unit, the generic refuge, a community outreach service and a counselling service. The facilitators and barriers to delivering trauma-informed support varied across different aspects of the service provision as not all had the same workforce development or support infrastructure.

Staff at the complex needs unit all receive weekly support through staff team case discussion meetings and clinical supervision. The more specific focus on trauma within this aspect of service provision meant that staff felt that were well equipped and supported to pick up on any signs of workplace stress (including STS and VT) in themselves and their colleagues, however some of the less experienced staff in the complex needs unit did identify training needs in this area.

Meanwhile, in the absence of clinical supervision, the outreach team emphasised the importance of having strong and supportive leadership from their manager as well as a strong peer support network, with colleagues checking in with one another and helping each other with paperwork. The outreach practitioners had previously requested access to clinical supervision, but the opening of the new complex needs unit as well as the Covid-19 pandemic and associated restrictions had halted progress towards this goal at the time of data collection. The outreach workers emphasised the importance of availability of their manager, often citing an open-door policy, in the creation of emotional safety. They also emphasised the importance of ensuring physical safety through their lone working policy and regular check-ins with one another.

The generic refuge service was identified by multiple members of the leadership/management team as having the least formal support mechanisms in place for staff. Attempts are being made to improve working standards within the refuge such as shortening shifts, increasing staff recruitment, signposting to the internal counselling service and seeking out more appropriate and restorative supervision training for supervisors. An interesting point was made about the need for refuge staff to have more opportunities to 'reflect with' (Maclean, Finch & Tadam, 2018) an experienced

and reflective supervisor instead of reflecting alone. It was also suggested that perhaps the VOICES reflection tool had been introduced in an attempt to compensate for the limited availability of clinical or reflective supervision, encouraging practitioners to become more reflective through individual paper-based reflection, however it was deemed to be ineffective in this regard at the time of data collection.

Staff all seemed to agree that the main information given to staff about secondary and vicarious trauma is shared within their initial trauma training which should be undertaken within a practitioner's probation period. Practitioners had a vague sense that burnout, secondary traumatic stress and vicarious traumatisation all pertain to the impact their work has on their wellbeing but none of the research participants included within this sample demonstrated any ability to discern or differentiate between these concepts or clearly define them.

Workforce Development

New Knowledge Base, New Expectations

Practitioners involved in providing trauma training to their colleagues described the potential promise of trauma-informed practice and trauma theory as a way of upskilling and 'credentialising' the sector. Calls for better training on domestic abuse have come from various sectors of front line and public services in the UK - particularly in relation to better training around non-physical forms of domestic abuse (BBC, 2024; Westwood et al., 2023; Chang, 2003), and to assist practitioners in handling the emotional impact of the work (Taylor et al, 2019). Domestic abuse practitioners felt that trauma training afforded them a specialist knowledge of the impact of domestic abuse on their clients, as well as how to identify or prevent secondary trauma or burnout within themselves. A more critical view posited by Helminen (2019) identifies the challenge faced by traditional victim support organisations who are tasked with retaining their ownership through proving their distinctiveness in the way they treat victimisation in the context of 'austerity and mixed welfare economies... in the eyes of funders' (2019, p 159).

'Are we therapists now?'

There was some variation in training afforded to practitioners working across the two agencies. Most staff from service A had undergone VOICES training, which focused on need-led, holistic and trauma-informed assessment and intervention. Most of the trauma related content in this training programme related to identifying burnout,

vicarious trauma and secondary traumatic stress in the workforce. Meanwhile, service B staff had undergone the TIME training programme which focuses more on creating a holistic and therapeutic trauma-informed service provision, delivering both trauma-informed and trauma specific responses to domestic abuse survivors as well as considering the impact on staff working with a potentially traumatised client base. Most practitioners found the trauma specific training interesting and relevant to their work, but some felt that it was difficult to apply this theoretical knowledge in day-to-day practice with survivors. Three practitioners commented that some of the information seemed too complicated and perhaps better suited to practitioners doing trauma specific work such as therapists (see Chapter 6: theme 4). Managers commented on the over-application of trauma theory by some practitioners and expressed a wish to offer more embedded learning opportunities through mechanisms like supervision or reflective practice sessions to help practitioners to properly discern and operationalize this new knowledge base.

Survivor Experiences of Public Sector Services

Survivors in this study pointed to the stark contrast between various agency responses to them. While all survivors spoke positively about their interaction with specialist domestic abuse services, many had very strained or conflictual interactions with social workers, health professionals and police officers. Problems which require 'multiple agency involvement and elicit different understandings and disagreement about how they should be addressed' have been characterised as 'wicked problems' (see Devaney and Spratt, 2009 and Stanley & Humphreys 2013). Stanley and Humphreys (2014) cite Hester (2006) in their description of domestic violence as a 'complex phenomenon... evoking different agency models of response' (2013, p 1).

Survivors spoke about the importance of being believed and the retraumatising impact of being disbelieved, particularly in relation to the lack of understanding and compassion they had experienced when engaging with a range of other services. Survivors shared their experiences of abuse not being seen as serious or even not being believed at all, leading to conflictual and seemingly punitive responses to them. In such circumstances it could be attributed to the professionals misreading their attempts at 'agentic resistance' (Mahoney, 1994, 2013; Rajah and Osborn, 2020) as defiance or non-compliance, further compounding the notion that this person does not 'present' as a victim. Some survivors felt that any attempt they made to justify their

behaviour or correct misinformation (said or recorded) was interpreted by professionals as overly defensive, which lead to conflict between them and that professional.

At the Exo-system layer, public sector professionals can become desensitised to pervasive societal problems (Macro-layer) as a defence against feelings of powerlessness brought about by limited resource power. This has been found to apply to social problems such as poverty (Backwhith, 2015, Morris et al 2008). Many of the survivors in this study felt that they had been blamed, dismissed or damaged through their interactions with public sector workers such as social workers, health professionals, judges and police officers.

In relation to domestic abuse , some academics have built upon Lipsky's (1990, 2010) conceptualisation of the 'Cognitive Shield' (1980 p 153), the manifestation of cognitive dissonance employed by public sector workers to protect themselves by reducing their 'responsibility or sense of accountability' (1980, 153) to their clients, which could serve to justify instances of client blaming or rationing service provision.. An alternative and more nuanced view is offered by Ash (2013) who interrogates Lipsky's concept of the cognitive shield in relation to social work interventions related to protecting older people from abuse. She posits that rather than a 'crude client blaming' cognitive shield (denial, in other words), small actions or inactions accreted not into a shield (with imagery of solidity and impermeability), but masks that occluded clear vision' (2013 p 111). Ash (2013) goes on to conclude that 'cognitive masks do not fall fully formed straight out of managerialism, care management or any of the other bad guys said to bedevil contemporary social work' but are instead derived from 'the interplay of Macro, Meso and Micro levels, within a context of time, place and history' (2013 p 112).

Building on the work of Lipsky (1980) and Ash (2013), Neale (2018) examined the responses from agencies that frustrated women's attempts to leave an abusive male partner and concluded that practitioners sometimes ignore or occlude important factors relating to domestic abuse. Specifically, Neale (2018) identified occlusion of abuse itself; (lack of professional curiosity about possibility of domestic abuse), occlusion of the perpetrator (focus shifted away from the perpetrator's behaviour) or occlusion of the victim (survivors not kept up to date about case developments). The women in this study all cited experiences of occlusion, in particular the women who had children (under 18) described multiple experiences of occlusion of the perpetrator and occlusion of the abuse itself. Occlusion of the victim was less common, which could be

attributed to the fact that they were all working with a specialist domestic abuse agency that took on the role of keeping the survivors updated, particularly in relation to criminal justice or child protection processes.

Macro Level: Society And Culture

The Macro-system describes overarching 'characteristics of the culture, belief systems, bodies of knowledge, customs, opportunities and structures' in the societal context within which the other nested systems exist (Bronfenbrenner, 1994, p 40).

In relation to domestic abuse this relates to policy, legislation and societal attitudes and conceptualisation of domestic abuse, gender, harm, and victimisation. It also includes consideration of dominant paradigms informing research and academic commentary on the nature of domestic abuse and the recommendations for domestic abuse support/service provision.

Gender & Victim Status

The intersection between trauma, vulnerability and gender seems particularly pertinent when discussing female victims of domestic abuse. Feminist scholars such as Herman (1992) emphasise the need to fully acknowledge the extent to which women and girls are disproportionately exposed to violent and potentially traumatic experiences. Some practitioners spoke explicitly about domestic abuse as a gendered crime, and the sense of solidarity they as female practitioners felt with the women they supported. Survivors spoke about gender in relation to their own experience of domestic abuse but also about gender in relation to their interaction with other professional agencies (social services, court, police) and wider societal responses to survivors of domestic abuse. Survivors emphasised in their interviews that perpetrators of domestic abuse will only stop when the system of involved professionals force them to stop. Survivors made nuanced points about the false expectation harboured within the wider culture that perpetrators of domestic abuse will stop of their own accord, unprompted. The survivors seemed to issue a kind of call to action, with some holding out hope that if the professionals knew that perpetrators did not intend to stop, they would act in a way that was conducive with bringing an end to the abusive behaviour; however, others

were more pessimistic about the commitment from services or institutions to work towards this goal.

Domestic Abuse is Gendered Crime

The SAMSHA (2014) definition of trauma-informed care specifies the consideration of gender (emphasising the need for culturally and gender-responsive services) and feminist scholars have called for trauma exposure to be understood in a gendered context (see Literature Review part two; theoretical models for understanding domestic abuse) (Herman, 1992; Humphreys & Thiara, 2003; Tseris, 2013). However, the language of trauma is predominantly gender neutral. Very few studies, less than 8 percent of the most commonly cited journal papers on PTSD according to Mendlowicz, et al (2022), focus on female victims of gender-based violence. This indicates that the language of trauma is not being extended to accommodate harm inflicted upon women. The linguistic framing of harm caused by conceptualising domestic abuse as 'trauma', could be indicative of the shift or what some have called the depoliticization of domestic abuse as a gendered form of abuse towards a more gender-neutral understanding of domestic abuse (Simmonds, 2019; Hirst & Rinne, 2012; Robinson & Rowland, 2006). Meanwhile, the practitioners interviewed were rooted in their understanding of domestic abuse as a gendered crime.

Moving away from a structural gendered lens towards an individualised gender-neutral lens may be recognised as a useful tactic by women's services who hope to receive funding through a competitive tender application process (Simmonds, 2018). For individuals or indeed services to be 'rewarded' with funding hinges upon the notion that you are deserving of this money, and that the distribution is 'fair'. What could the utilisation of trauma theory by domestic abuse services be telling us about the way in which female survivors of domestic abuse and the services supporting those female survivors are viewed by society? Practitioners in this current study seem to indicate that framing domestic abuse as traumatic and survivors as traumatised could assist in the effort to validate domestic abuse survivors as worthy or deserving recipients of resources.

Some practitioners in the current study highlighted the importance of maintaining a gendered focus on domestic abuse, they spoke about concepts such as male privilege,

global inequalities between men and women and the societal structures that enable men to abuse women, and society's propensity to scrutinise the actions and motivations of the victims and ignore the perpetrators. Practitioners argued that there was a continued need to build awareness through education campaigns and resources on the gendered socio-political context of domestic abuse as well as raise awareness about how trauma impacts women. Bates and Douglas (2020, p. 20) highlight the discontent expressed by certain advocates regarding the shift from an emphasis on structural transformation (Finley, 2010) to a concentration on individual empowerment (Wood, 2015).

Mother Blame

Professional viewpoints regarding the intersection between gender, vulnerability and risk vary greatly, with children's social workers focussing on the risks posed to the child where domestic abuse has been reported, while domestic abuse support workers are often focussed on advocating for the rights of the survivor (usually the mother). For some survivors in this study, 'winning the game' meant regaining or maintaining custody of their children. Two of the women had already managed to leave their abusive partners but were still facing scrutiny from children's social care about their ability to provide adequate care for their children, something that had never been called into question before either woman had sought support in relation to domestic abuse. Neale (2018) concluded that professionals tend to prioritise work with the domestic abuse victim (usually the mother) who is more visible, available and 'willing' to engage with services than the perpetrator, who is effectively ignored' (Neale 2018). The author warns that this sends a message to perpetrators that their behaviour could continue unchecked (Neale 2018), further reinforcing the 'they won't stop' theme generated in this current study (see Chapter 7 above).

Research on children's social care interventions in families living with domestic abuse has shown that the father's violence is often invisible (Stanley et al., 2011). Humphreys and Diemer (2018) note that violence perpetrated by fathers is frequently overlooked while the ability of mothers to keep their children safe remains the central inquiry of most child protection investigations in cases concerning domestic abuse.

Women & Victimhood

One domestic abuse practitioner reflected on her own efforts to help survivors stay calm, polite, and diligent, in essence coaching them to present like a 'perfect victim' to get their needs met by the system. The worker described the paradoxical effect of this intervention: in her efforts to help domestic abuse survivors have their voices heard and access the support they are entitled to, she is perpetuating the continuation of the very system/ideology which renders certain victims as believable and worthy of support, while others are too troublesome to be helped, or even fully believed. Lazar (2008) notes that this needs to present as 'victim', worthy of resources and support, further obscures agentic or resistant acts taken by survivors and perpetuates 'superficial distinctions between victimization and between oppression and resistance' (2008, p. 5). While domestic abuse advocates may seek to utilise their professional role, organisational affiliation, skills and knowledge to share power 'with' (French, 1985; Dominelli, 2002) survivors, they too are subject to patriarchal and sexist ideologies and practices, as highlighted in one survivor's testimony about her domestic abuse advocate being thrown out of court.

Considering the ways that contemporary discourse around trauma survivors could help to legitimise and strengthen the voices of domestic abuse survivors and those who support them, one of the key questions is: what is trauma discourse really offering victims of domestic abuse within the current context and what was missing before? Much has been written about the notion of 'deserving' and 'undeserving' victims in relation to domestic abuse (Russell & Light, 2006; Lloyd & Ramon, 2017) and subsequent victim hierarchies (Fohring, 2018) with those at the top being afforded 'ideal' victim status (Christie, 1986) and thus identified as worthy recipients of legal, social, economic and psychological support. Academics, campaigners and advocacy groups have long argued that victims of domestic abuse are rarely afforded such status (Bows et al., 2024), resulting in inadequate multi-agency responses and service provision (cuts to funding of domestic abuse services, low conviction rates, stigma and victim blaming).

Is Recovery a Better Goal Than System Change?

Historically, the primary role of domestic abuse support services has been to aid the

escape from and prosecution of perpetrators of domestic abuse. Considering the wider context within which domestic abuse services are operating, such as cuts to local authority funding, reductions in availability of refuge services for women (Office of Domestic Abuse Commissioner, 2021, p 41) and the failure to secure (adequate or any) convictions for perpetrators of domestic abuse (Hester, 2006; McPhee et al., 2022; Brennan & Myhill, 2022) the domestic abuse sector clearly faces significant structural challenges. A valid concern considering these structural challenges is around whether the new emphasis on the survivor's 'recovery' from the psychological impacts of domestic abuse (such as symptom reduction) is being prioritised over, instead of addressed alongside, more structural interventions. For instance, ensuring the physical safety of the victim can sometimes be more effective than any therapeutic intervention in reducing the fear and anxiety the survivor is experiencing. Meanwhile, the Office of the Domestic Abuse Commissioner (2021) found that counselling and therapeutic support were the most sought-after forms of support by survivors of domestic abuse in England and Wales (2021, p 34).

Another risk in the shifting focus from safety to symptoms is the depoliticization of domestic abuse and the domestic abuse sector (Sweet, 2018, p 83). In examining the bi-directional influence of the Exo-system (DVA organisations, legislation, and policy) and the Macro-system (attitudes, culture, ideology), consideration could be given to the way in which organisations are recording and reporting data streams to evidence the worthiness of the service they are offering to potential funders. For example, rather than simply recording the number of referrals received/accepted by this kind of service and demographic information about service users (which might demonstrate the prevalence of harm done to women by men), services classing themselves as trauma-informed must record outcomes in relation to symptom reduction measures demonstrating their efficacy. The burden of proof falls not only on the female survivors but on the services that support them, which are left in the position of fighting for their own survival as well as the survival of the women they support (Simmonds, 2019; Helminen, 2019; Bellini et al., 2019).

Summary

This discussion chapter critically synthesised and analysed findings that illuminate the complex relationship between trauma-informed approaches and domestic abuse service provision and serve to deepen the current understanding of the potential benefits and limitations of framing domestic abuse through the lens of trauma. Themes generated from interviews with domestic abuse practitioners and survivors relevant for understanding and engaging in trauma-informed approaches were mapped across four levels of Bronfenbrenner's (1979) socio-ecological model: the interpersonal layer (Micro-system), the professional layers (Meso-system and Exo-system), and wider socio-cultural layers (Macro-systems) (See figure 15 in Chapter 8: Ecological Model).

The chapter started by considering the importance of language in naming harm associated with domestic abuse and the appropriateness of trauma as a conceptual lens and framing for non-physical abuse. The domestic abuse practitioners acknowledged and conceptualised trauma as a probable, if not inevitable consequence of domestic abuse, making explicit reference to the ways in which verbal and psychological abuse can harm survivors as well as physical violence. When asked to describe trauma in relation to domestic abuse, practitioners spoke about the acts of harm (abusive behaviour demonstrated by the perpetrator), as well as the impact on the survivor, seemingly locating trauma in the event (SAMSHA) and the wound, as well as the 'reaction to the wound' (Erikson, 1995 cited in Burstow, 2003, p 1301). Within medicalised and psychiatric discourses, such traumatic wound reactions would be understood as symptoms. Some practitioners identified symptoms associated with post-traumatic stress (as classified within the DSM 5) in their work with domestic abuse survivors, particularly negative thoughts such as exaggerated self-blame (DSM 5, Criterion D), arousal effects such as irritability or aggression (DSM 5, Criterion E) and intrusive symptoms such as flashbacks (DSM 5, Criterion B).

Given that many practitioners said they did not talk about trauma directly with survivors or screen for trauma, and given the fact that very few survivors explicitly spoke about trauma, it could seem that the language of trauma has limited utility in helping survivors of domestic abuse to articulate or process their experiences. However, words like 'recovery', 'needs', 'safety' and 'triggering' were all commonly referred to by practitioners and survivors and this language may offer more clues about the way in which trauma theory more broadly has value for domestic abuse service provision.

Burstow (2003) argues that conceptualising abusive experiences through a broader, non-medicalised/pathologised definition of trauma can be helpful for survivors if utilised in conjunction with models or approaches that acknowledge power, control, structural oppression and strategies of resistance

While practitioners may not have spoken explicitly about trauma with the survivors they supported, most acknowledged that trauma training had impacted their practice in more indirect ways, such as enabling them to employ psychological distancing, emotional regulation and compassion. In this sense, the domestic abuse practitioners in this study highlighted the important distinction between trauma specific and trauma-informed in their emphasis on the more reflexive aspects of communication with survivors. Knowledge around trauma enabled them to protect themselves and create a more 'zoomed out' perspective on their interactions with survivors. This knowledge also contributed to changing the broader discourse around domestic abuse. A form of pro-social modelling was described by some more experienced practitioners as a means of them to protect themselves and create a more 'zoomed out' perspective on their interactions with survivors. This knowledge also contributed to changing the broader discourse around domestic abuse. A form of pro-social modelling was described by some more experienced practitioners as a means of passing on certain skills (distancing, self-regulation and record keeping) to survivors to better enable them to get their needs met by a wider system of professionals that still struggles to recognise domestic abuse or trauma.

Trauma training seemed to support the informal educative role often inhabited by domestic abuse practitioners, educating other professionals as well as providing guidance and information to survivors. Practitioners harnessed the relevance and utility of trauma knowledge in their advocacy for survivors, identifying trauma knowledge as something that enhanced their credibility and legitimacy in multi-agency contexts. The consequent impact is to legitimize and strengthen the rights and needs of domestic abuse survivors.

The potential benefits of adopting a trauma-informed approach to service provision and offering specialist trauma training to practitioners were also understood by some as an opportunity to legitimise and upskill the sector. This finding was examined in relation to the well-established 'professionalisation' literature on the domestic abuse sector. Some practitioners explained that the focus on trauma could risk role confusion, in terms of how they would utilise this knowledge in their support and advocacy roles,

without veering into the role of a therapist. Nonetheless, most practitioners found trauma knowledge useful in reinforcing their specialist knowledge and approach to domestic abuse survivors. This was largely supported by the comparisons drawn by survivors between their domestic abuse practitioner and other professionals. Survivors commented very positively on their domestic abuse practitioners' 'soft' skills while reiterating the common complaints about statutory services (police, social services, health professionals), specifically alluding to occlusion and re-traumatisation.

Finally, this discussion highlighted the potential implications of adopting a trauma-informed approach in domestic abuse service provision in relation to societal attitudes and discourses about domestic abuse survivors, specifically in relation to gender, recovery, motherhood, and victim status.

While the language of trauma can offer a powerful tool for legitimizing the experiences of survivors and advocating for improved services, it is crucial to remain attentive to the potential pitfalls of medicalization and individualization associated with the epistemological and theoretical routes of trauma theory and trauma practice. The findings presented in this chapter underscore the importance of a holistic approach that recognizes the multifaceted nature of domestic abuse, moving beyond symptom-focused interventions to address the broader social, cultural, and political contexts that perpetuate gender-based violence. By embracing a critical yet compassionate lens, service providers can strive to develop trauma-informed practices that empower survivors, challenge systemic inequalities, and foster a society where domestic abuse is not only recognised but actively prevented.

CHAPTER 9: CONCLUSION

This research study set out to examine how trauma-informed approaches are conceptualised and operationalised by domestic abuse services and how these approaches are understood by survivors accessing those services. The growing emphasis on 'trauma-informed' service provision in the domestic abuse sector warrants closer investigation to establish what TIA can offer to domestic abuse organisations, practitioners, and survivors as well as the potential challenges and limitations of adopting this approach. Very little qualitative research has been carried out exploring the implementation, benefits and challenges of domestic abuse organisations utilising a trauma-informed approach within the UK.

This chapter revisits the goals of the research, summarizes the main discoveries made during the study, and emphasizes the contributions to the existing body of knowledge. It outlines potential avenues for future inquiry, offers suggestions for policy and practice, and reports on how the research has been disseminated. As elaborated below, the implications of these findings are considerable for funders, policymakers, and organizations addressing domestic abuse. They may also offer helpful insights to other statutory agencies working with survivors of domestic abuse who are also part of the turn towards 'Trauma-informed' service provision.

Revisiting the Research Questions

This chapter will synthesise the thesis findings in relation to the research questions:

1. How do domestic abuse practitioners and survivors understand the links between trauma and domestic abuse?
2. How is a Trauma-informed Approach (TIA) being harnessed and utilised in the context of this specific domestic abuse service provision?
3. How do domestic abuse survivors understand and experience a TIA in relation to domestic abuse?
4. What are the key barriers and facilitating factors to implementing a TIA within domestic abuse service provision?

To answer these questions, the research aimed to provide an in-depth insight into how domestic abuse practitioners and survivors understand and experience a trauma-

informed approach, to explore what they feel this approach offers them including any unique benefits or challenges, and to contribute original findings that could be used to inform domestic abuse service delivery, commissioning and policy.

The findings are based on a series of interviews undertaken in 2020-2023 with 15 domestic abuse practitioners (fourteen from Service A and one from Service B) and six survivors, four supported by Service A and two supported by Service B. Data collection and analysis were informed by ecological theory as well as trauma-informed and feminist research principles.

The research utilised Bronfenbrenner's ecological systems theory and model to map and analyse domestic abuse and trauma by examining the various layers of context within which domestic abuse service provision is taking place, and the bi-directional interactions between service provision and contextual layers of influence that affected survivors and practitioners included within the study.

Summary of Key Research Findings

How Do Domestic Abuse Practitioners and Survivors Understand the Links Between Trauma and Domestic Abuse?

Practitioners included within this study saw the clear relevance of trauma theory in relation to their work with domestic abuse survivors. Practitioners valued trauma knowledge for understanding survivor behaviours, interpreting non-engagement or resistance as trauma responses rather than symptoms. They emphasised the importance of viewing survivors' actions as adaptive survival strategies rather than pathologies. The study explored how practitioners applied trauma-informed approaches in their interactions with survivors, focusing on methods like distancing, coaching, and care, which helped them navigate relational challenges with survivors and advocate for them in multi-agency discussions. This approach is linked to social justice through effective advocacy and awareness raising with other professionals to combat victim blaming and punitive rhetoric about female survivors of abuse. Many of the practitioners discussed the importance of a gendered lens when addressing the conditions that perpetuate domestic abuse.

The services involved in the study did not routinely screen for trauma, instead using general wellbeing scales that do not specifically address physiological symptoms of traumatic stress. Practitioners preferred conversational methods over formal assessments, which they felt could hinder relationship-based practice. A review by Clark et al. (2023) noted that existing assessment tools, including the Warwick Edinburgh Wellbeing scale, were not specifically designed for domestic abuse and could inadvertently cause participants to relive their trauma (Clark et al 2023).

Survivors in this study were less likely to characterise their experiences of domestic abuse as traumatic but did use some associated language such as discussing 'triggers'. Many described physiological manifestations of traumatic stress such as headaches and shaking but rarely sought professional help for these symptoms specifically. Instead, most survivors focussed on the importance of being believed, cared for by their advocates and supported to navigate the web of multi-disciplinary services with various agendas and priorities. Survivors used more dynamic and anatomical metaphors when discussing the pain inflicted upon them by the system than they did when talking about their abuser.

How is a Trauma-informed Approach (TIA) Being Harnesssed and Utilised in the Context of Domestic Abuse Service Provision?

The trauma literature emphasizes the significance of a trauma-informed approach to prevent re-traumatisation, focusing on how services can inadvertently replicate oppressive relationships that distress trauma survivors. Practitioners reported that their training in trauma-informed care allowed them to respond more calmly and compassionately to survivors, fostering psychological safety and enabling them to avoid personalizing aggressive behaviours. This aligns with existing research suggesting that understanding trauma can help practitioners reframe problematic behaviours as coping strategies that may have been adaptive in traumatic contexts. The interplay of trauma theory, attachment theory, and interpersonal neurobiology highlights the need for practitioners to manage emotional distance to prevent reactivating familiar relational dynamics. This finding is supported by the pre-existing literature in relation to psychological distancing (see Discussion chapter) and relates to concepts like emotional neutrality and emotional labour. Practitioners discussed the toll that gender-responsive emotional labour can take on them as service providers, underscoring the complexities of emotional regulation in professional roles.

At the Micro-system level, the research highlights the direct interactions between survivors and their domestic abuse practitioners. Practitioners utilised their trauma knowledge to enable them to enact a form of psychological distancing which allowed practitioners to not take survivor behaviours personally, instead viewing them as coping strategies learnt from past trauma. Practitioners benefited from training that helped them remain calm and compassionate, creating a safe environment for themselves and survivors, even when faced with aggression. The ability to manage emotional distance is important for practitioners to avoid repeating negative relational patterns and to respond appropriately to survivors' behaviours. In this sense, the practitioners in this sample demonstrated a way in which they were able to utilise their trauma knowledge at the interpersonal level to prevent re-traumatisation and avoid triggering distress in survivors by recognizing power dynamics in services.

Practitioners can further support survivors of domestic abuse by encouraging them to adopt a 'distancing' technique in their interactions with professionals, promoting a focus on case-building rather than emotional confrontation. This collaborative approach helped survivors adjust their communication styles to better meet their needs in multi-agency meetings. However, some practitioners struggled with the idea of coaching survivors to conform to the notion of the 'perfect victim,' reflecting on the societal expectations of emotional responses. Despite efforts to challenge stereotypes that label emotionally expressive survivors as irrational, practitioners acknowledged that broader institutional attitudes still perpetuate these views. Survivors' passionate expressions often disrupt bureaucratic processes, leading to scepticism about their victimhood and intentions. The subthemes of 'perfect victims' and 'playing the game' in the current study highlight the concept of 'epistemic injustice,' where advocacy efforts provide survivors with testimonial and hermeneutical justice. Practitioners can empower survivors by validating their experiences and encouraging them to channel their resilience into building cases against their abusers, fostering control over their narratives in a system that often marginalizes them.

The Meso-system level is often overlooked or mischaracterised in other research utilising an ecological framework in relation to domestic abuse service provision. Professional interactions such as phone calls or multi-agency meetings are Meso-system contexts in which domestic abuse practitioners can emphasise the importance of their trauma knowledge in influencing the collective professional response to a survivor they are working with. Practitioners reported that trauma-informed knowledge provided them with an elevated form of legitimacy as domestic abuse advocates

working for a specialist trauma-informed service. This legitimacy better enabled them to challenge victim-blaming narratives, rationalize revictimization, and advocate for better services tailored to survivors' needs. Practitioners leveraged their understanding of trauma to reframe the behaviour of domestic abuse survivors, promoting a needs-led approach in multi-agency contexts. They viewed their unique insight as a means to influence the multi-agency response and emphasised the importance of contextualizing survivor behaviour within their experiences of abuse and trauma.

Practitioners positioned themselves as intermediaries between survivors and a broader, often less empathetic system, sometimes coaching survivors on effective communication with other professionals. The emotional and psychological impacts of trauma and domestic abuse often impede or complicate survivors' engagement with services, and this study identified the role of domestic abuse workers in educating other professionals about their misconceptions, with trauma language proving useful in this effort. A trauma-informed framework is seen as beneficial in legitimizing survivors and their support needs, while the socio-political context influences legislation and resource allocation.

This could be framed as a kind of strategic resistance, a way of pre-empting and effectively manoeuvring around such obstacles to ensure good outcomes for survivors. In this sense, trauma knowledge and skilled domestic abuse advocacy can offer pragmatic solutions for domestic abuse survivors in an imperfect system. On the other hand, this conceptualisation of a trauma-informed approach to domestic abuse service provision could be seen as de-politicising and delegitimising the harm caused by domestic abuse and the real-world consequences and manifestations of the distress it causes.

When considering a survivor's Exo-system it is important to consider the service ethos, focus, training, and resources available to the professionals they have direct contact with. This study focussed on survivors and their domestic abuse advocates, all of whom were working for voluntary sector organisations affiliated with the Women's Aid Federation. All practitioners had undergone some form of trauma training (VOICES and TIME) and both organisations in this study characterised their service provision as trauma informed.

Practitioners in this study felt that Trauma-Informed Approaches (TIAs) were helping to legitimise domestic abuse advocacy service providers as well as domestic abuse

survivors. Terms used by practitioners such as 'credentialise' and 'legitimise' reflect a continuation of the professionalization of the domestic abuse sector, providing an opportunity to amplify marginalised feminist voices, emphasizing domestic abuse as a significant social issue requiring visibility and skilled attention.

The Macro-system encompasses broader societal and cultural factors that influence domestic abuse and trauma. The study has addressed how societal attitudes towards gender, domestic abuse, victim-blaming, and the prioritization of child protection over women's safety, can affect resource allocation, the experiences of survivors and the responses of practitioners. Shifting from a structural gendered perspective to an individualised gender-neutral approach may benefit women's services seeking funding through competitive tender processes. The application of trauma theory in domestic abuse services may influence societal views on female survivors and their support systems. Some practitioners believed that framing domestic abuse as trauma can help validate survivors as deserving of resources. However, others emphasised the necessity of maintaining a gendered focus, discussing issues like male privilege and societal structures that enable abuse. They advocated for educational campaigns to raise awareness of the gendered socio-political context of domestic abuse and the effects of trauma on women.

Domestic abuse practitioners highlighted the hidden impacts of domestic abuse on the operation and sustainability of support services. Traditionally, these services focused on helping victims escape and prosecuting perpetrators. However, challenges such as local authority funding cuts, reduced refuge availability, and low conviction rates for perpetrators have created significant structural issues. There is some concern expressed in the literature examining domestic abuse service commissioning processes that the emphasis on survivors' psychological recovery may overshadow necessary structural interventions (Simmonds, 2019; Bellini et al, 2019), such as ensuring physical safety, which some survivors described as the most effective intervention in terms of alleviating fear and anxiety.

Despite this, counselling and therapeutic support remain the most sought-after forms of assistance for survivors in England and Wales (Office of Domestic Abuse Commissioner, 2021, p34). This growing demand for emotional support underscores the need for a balanced approach that integrates both psychological and structural solutions to effectively address the complexities of domestic abuse. This need for balance was also emphasised by a small number of practitioners in this study who

spoke about a need to balance the focus on risk with a needs-led approach (see Chapter 6, Needs, Safety and Risk section). Interestingly, a needs-led approach seemed to be more closely associated with trauma-informed approaches by most practitioners than a risk-based approach, which somewhat mirrors the rationale and justification provided for the creation of the VOICES framework, which was developed as part of an effort to move away from risk-focus towards needs-focus when working with domestic abuse survivors.

The shift from a focus on safety to symptoms in domestic abuse services risks depoliticizing the issue and the sector itself. This shift requires organizations to adapt their data recording and reporting practices to demonstrate their effectiveness, particularly in relation to trauma-informed care and symptom reduction. As a result, the burden of proof is placed on both female survivors and the services that support them, compelling these organizations to advocate for their own sustainability alongside that of the women they serve. This dual responsibility can lead to a strain on resources and may inadvertently prioritize organizational survival over the immediate needs of survivors, highlighting the necessity for systemic changes that empower both parties.

Professional perspectives on the intersection of gender, vulnerability, and risk differ significantly. Children's social workers focus on the risks to children in cases of reported domestic abuse, while domestic abuse advocacy workers prioritize the rights of survivors, typically mothers (Arnall & Stewart, 2021; Robbins et al., 2016). For some survivors, regaining custody of their children becomes a critical goal, especially when their parenting is scrutinised after seeking help for domestic abuse. Survivors who were mothers of younger children all spoke about the difficulties they faced in maintaining or regaining custody of their children since disclosing and seeking professional support for domestic abuse and described behaviours from statutory services which could be characterised as 'mother blame' (Millet 1969). Findings in this study echoed findings from other research on the difficult interface between domestic abuse victimhood and child protection processes (Jackson and Mannix 2004; Douglas and Walsh, 2010; Neale, 2018, Arnall & Stewart, 2021; Hale et al., 2024).

Adopting a trauma-informed approach in a holistic sense is extremely difficult, and the services in this study may not have achieved trauma-informed status as defined by Trauma-Informed Oregon (2018) as complete alignment in policy and practice which has been evidenced through independent evaluation, they may be achieving trauma awareness, sensitivity or responsiveness at various levels of

operation (see Figure 13,). The graphic below depicts a phased approach or a roadmap towards trauma-informed care which organisations such as the Lancashire Violence Reduction Network have found useful in planning and charting their commitment to becoming trauma-informed.

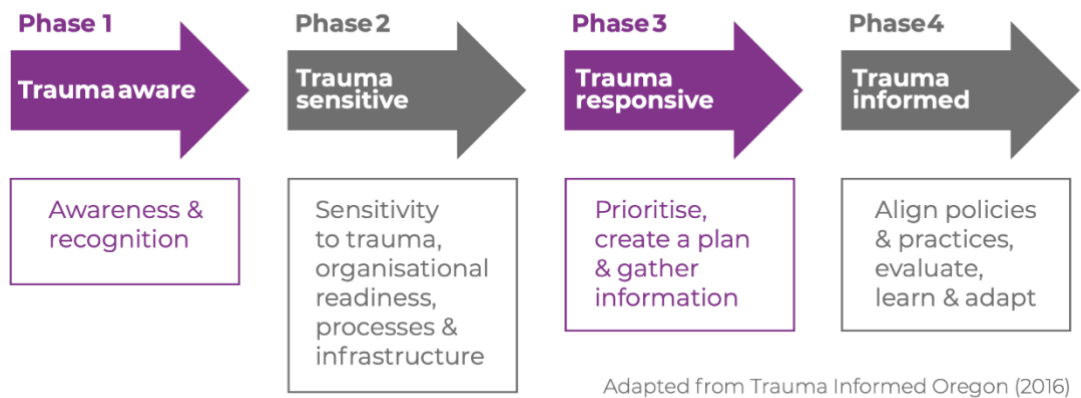


Figure 14: A Phased Approach, Lancashire Violence Reduction Network: A Trauma Informed Organisational Development Framework (2020, p 7).

How Do Domestic Abuse Survivors Understand and Experience a TIA in Relation to Domestic Abuse?

Survivors preferred a friendly, trustworthy relationship with their support workers, valuing qualities such as warmth, non-judgment, and emotional support. While some survivors favoured informal conversations, others preferred pragmatic discussions, especially during legal processes. Practitioners acknowledged the importance of gender and shared experiences, sometimes drawing from personal backgrounds to connect with survivors. The findings highlight the necessity of gender-responsive, relational approaches in domestic abuse support services to build trust and effective engagement. A difference in priorities was noted between survivors' desire for caring relationships and practitioners' emphasis on professionalism, raising questions about bridging this gap. Survivors interpreted 'needs-led' support as a demonstration of positive regard, aligning with Care Ethics, which emphasizes empathy and compassion. Practitioners recognised domestic abuse as a gender-based oppression and were motivated by their care for other women. Overall, the study underscores the significance of kindness, empathy, and relationship-based practices in supporting survivors of domestic abuse. Survivors of domestic abuse shared profound insights regarding the intersection of gender and their personal experiences, as well as the broader implications of gender dynamics in their interactions with various professional agencies, including social services, the judicial system, and law enforcement.

Throughout their interviews, survivors underscored a critical observation: abusive behaviour by perpetrators is unlikely to cease without a concerted effort from the professionals involved. A recurring theme in their narratives was the pervasive cultural misconception that abusers will voluntarily cease their harmful actions without external intervention. This belief reflects an unrealistic expectation that overlooks the complexities of abusive behaviour and the psychological factors at play. Survivors articulated a collective call to action, urging that if professionals fully understood the reality that many perpetrators do not intend to stop their abusive patterns, they would be more inclined to adopt proactive measures aimed at curtailing such behaviour. Survivors in this study conveyed scepticism regarding the dedication of various services and institutions to effect meaningful change. While some expressed a sense of hope that increased awareness among professionals could lead to more effective interventions, others conveyed a lack of faith in the system's willingness to prioritize the safety and well-being of survivors. This duality in their outlook highlights a significant gap between the potential for systemic support and the current reality faced

by many survivors navigating the complexities of domestic abuse and its aftermath.

What Are the Key Barriers to Implementing A TIA Within Domestic Abuse Service Provision?

Practitioners emphasised the promise held by trauma-informed approaches to upskill and *credentialise* the sector, but the trauma-informed route to professionalisation and legitimacy did present some challenges.

Practitioners who were involved in providing trauma training highlighted its potential to enhance skills and credibility in addressing domestic abuse, particularly regarding non-physical forms and emotional impacts. However, training experiences varied between the two organisations: Service A utilised VOICES training focused on holistic, trauma-informed practices, while Service B employed TIME training that examined trauma's effects on behaviour and staff. While many practitioners found the training relevant, some struggled to apply theoretical concepts in practice, with practitioners noting the complexity of the information they had received. Managers expressed a desire for more practical learning opportunities through supervision and reflective sessions to better integrate trauma theory into their work. These insights underscore the importance of tailored training programmes that not only impart theoretical knowledge but also emphasize practical application, enabling professionals to effectively support survivors while minimizing their own risk of secondary trauma.

Calls for trauma training (Bradley et al., 2020; Gundacker et al 2021; Purtle, 2020; Yatchmenoff, et al., 2017; Wilson et al., 2015; Elliot et al., 2005) and improvement in training standards more generally (Wilson, 2013) have emerged from various UK sectors including the domestic abuse sector; Wilson (2013, p 50) highlights the necessity to standardise good practices across domestic abuse organizations as a key driver for developing accredited training. This suggests a need to improve and unify training standards to ensure consistent and effective responses to domestic abuse. However, challenges exist for traditional victim support organizations in maintaining distinctiveness amid funding pressures.

Challenges In the Wider Context

The wider context presents challenges to survivors and domestic abuse practitioners alike, particularly when various agencies or institutions have differing approaches to

intervening in domestic abuse, some of which would not be characterised as trauma-informed or survivor-centred (Neale, 2018, Trevillion et al., 2012, Sweeney et al., 2018) and others where successful implementation of trauma-informed principles have not been robustly evaluated (Berring et al, 2024) or sufficiently evidenced (Goodman et al, 2016).

Survivors in the study highlighted significant differences in agency responses and reported positive experiences with specialist domestic abuse services but negative interactions with social workers, health professionals, and police. These issues, described as 'wicked problems' (Devaney & Spratt, 2009 and Stanley & Humphreys 2013), arise from differing agency models and understandings of domestic abuse. Survivors in this study emphasised the importance of being believed, noting the trauma caused by disbelief and a lack of compassion from various services. The survivor's emphasis on being believed mirrors the practitioner's emphasis on credibility, reinforcing legitimacy as an important theme that cuts across different ecological levels.

Survivors' attempts at 'agentic resistance' were often misinterpreted by other services as defiance, further complicating their interactions with professionals. Additionally, efforts to clarify or correct misinformation were perceived as overly defensive, resulting in conflict. These challenges highlight the critical need for improved training and awareness among all relevant professionals to foster a more empathetic and supportive environment for survivors, ensuring that their voices are heard and validated throughout the recovery process. This study demonstrates the need for Trauma-informed practice training to really focus on helping professionals outside of the domestic abuse service provision context accurately identify why and how trauma can lead to 'challenging' behaviour (such as overactive fight or flight responses, lack of trust, misplaced intense anger) in service users of all types. While many professionals are starting to successfully reframe challenging behaviour exhibited by children and young people through a trauma-informed lens, there is less evidence of professionals applying this lens to adult behaviour. The domestic abuse practitioners in this study found this reframing particularly helpful in their work with survivors and this understanding could play an important role in supporting other professionals in this learning.

Public sector professionals may become desensitised to societal issues like poverty as a defence against feelings of powerlessness due to limited resources. Survivors of

domestic abuse included within this study echo the sentiment of survivors in other studies, stating that they often felt blamed or dismissed by public sector workers. Lipsky's concept of the 'Cognitive Shield' describes how these workers protect themselves from accountability, which can lead to client blaming, rationed services, occlusion of the victim and the perpetrator of the abuse itself (Neale, 2018) that serve to obscure professionals' understanding of clients' situations (Ash, 2013). However, those working with specialised domestic abuse agencies reported better communication regarding their cases, not least due to the efforts of the domestic abuse worker to bridge the gap between the survivor and other professionals/services. This highlights the importance of targeted joint training initiatives and awareness raising programmes across agencies and disciplines to ensure some kind of consistency for survivors accessing support from a range of services (Turner et al, 2017).

Contribution to Knowledge

Much of the existing research on how trauma-informed approaches are conceptualised and implemented in domestic abuse service provision within the UK has not included responses from both survivors and practitioners, with few exceptions (Warwick-Booth & Coan., 2024; Domoney et al., 2019). Other primary qualitative research in the UK on exploring the implementation of a trauma-informed approach to domestic abuse service provision has focussed on practitioner responses (Ward-Lasher et al., 2017; Bailey et al., 2020; Harris & Hodge, 2019) or survivor responses (Fuller, 2023).

While other researchers have utilised the ecological system model to analyse domestic abuse and domestic abuse service provision, the findings relating to the Meso-system in this study are an important and original contribution to the existing body of literature. In other domestic abuse research that utilises an ecological framework for analysis, the Meso-system is vaguely and misleadingly characterised as 'community influence' (WHO, 2022; Conley, 2019) or completely ignored within the analysis of findings (Heise, 1989; Bliss, 2014).

This study explored the potential utility of a trauma-informed approach to domestic abuse service provision and practitioners in two services. Both highlighted how adopting a trauma-informed lens strengthened their institutional advocacy. The ecological framework has been helpful in considering how changes to the Chrono-system and Macro-system have enhanced the utility of trauma theory at the Meso-

system layer, which benefits domestic abuse survivors. Specifically, it has enabled a focus on the evolving status of trauma and trauma-informed approaches in Western society and the legitimacy afforded to trauma theory and research through the positivist and medical traditions. Additionally, this study found that another key utility of trauma theory and adopting a trauma-informed approach in domestic service provision is the upskilling and sustainability of the domestic abuse sector.

Recommendations for Domestic Abuse Practice and Research

The recommendations below are intended to contribute to understanding of the utility and challenges presented by trauma-informed approaches to domestic abuse service provision. Trauma-informed approaches sit at the intersection between grassroots feminist ideals and modernist professionalisation of this sector. The recommendations for service delivery and further research encompass both the potential gains and potential losses for the domestic abuse sector in adopting a trauma-informed approach.

Recommendations for Domestic Abuse Practice

The language of trauma was found to be useful for practitioners in the process of dismantling the conceptual hierarchy between physical and nonphysical forms of domestic abuse (Penttinen, 2023). This study highlights the need for caution in utilising the language of trauma with survivors: practitioners must walk a fine line between offering language that helps a survivor contextualise their experience in a way that is resonant for them and making assumptions or labelling survivors in a way that is stigmatising.

Domestic abuse practitioners seemed to conceptualise their role in this needed sea change as influencing and educating one professional at a time, in relation to a specific survivor. Practitioners involved in leadership and training highlighted their efforts to train and share knowledge with the broader work force. This need was emphasised by survivors who highlighted the many contexts in which they felt unsafe, describing an impending sense of doom and fear within their own homes, communities, and other service provision contexts (i.e. interactions with police, social services, and health care settings).

A primary recommendation from this study is for any professionals working with domestic abuse survivors (from both statutory and third sector provisions) to gain a better understanding of the ways in which trauma can impact survivors (e.g. over-sensitised fight/flight responses) to enable them to appropriately respond to survivors on the Micro-interpersonal level. Multi-agency training is important to avoid professional silos and echo chambers in relation to knowledge or practice wisdom. As highlighted above (Chapter 9: summary of key research findings), the domestic abuse sector has a vital role to play, not just in Meso-system level interactions but at the Exo-system level of upskilling all front-line practitioners in this regard.

Practitioners in this study clearly pointed to the utility of trauma knowledge in helping them to cope with the emotional demands of their role through psychological distancing. More specifically, psychological distancing or the 'don't take it personally' mindset was crucial in helping practitioners reframe and cope with relational challenge or rupture with domestic abuse survivors. This finding could inform the trauma-informed training provided by domestic abuse service providers to other professionals. However, it is also important to consider the different demands placed on statutory services which may bring about relational rupture with domestic abuse survivors. The domestic abuse sector currently has a degree of independence allowing the advocates to focus on and prioritise the needs of the survivor in a way that may not be realistic for a children's social worker or a police officer who are balancing competing priorities.

This study highlighted the need to create more formal support structures for generic domestic abuse refuge workers such as regular supervision, shorter shifts and consistent trauma-informed leadership. Outreach staff similarly felt they could benefit from clinical supervision while the outreach team included in this study benefitted from strong, consistent and supportive leadership as well as supportive team dynamics, which seemed to buffer the work-related stress they experienced.

Services could draw from and amend existing examples of trauma-informed service delivery models and principles such as those offered by Elliot et al (2005) Wilson et al., (2015) or Hanson and Lang (2016). Additionally, services could utilise the 'phased' or 'roadmap' TIC implementation tool (Figure 14) which was first introduced by Trauma Informed Oregon (2018), to assist them in their journey towards implementation of a whole system trauma-informed approach. As discussed earlier in Chapter 4 (Similarities and differences in the way in which TIAs are understood) other large

systems in the UK are working towards holistic implementations of TIAs such as the Lancashire Violence Reduction Network.

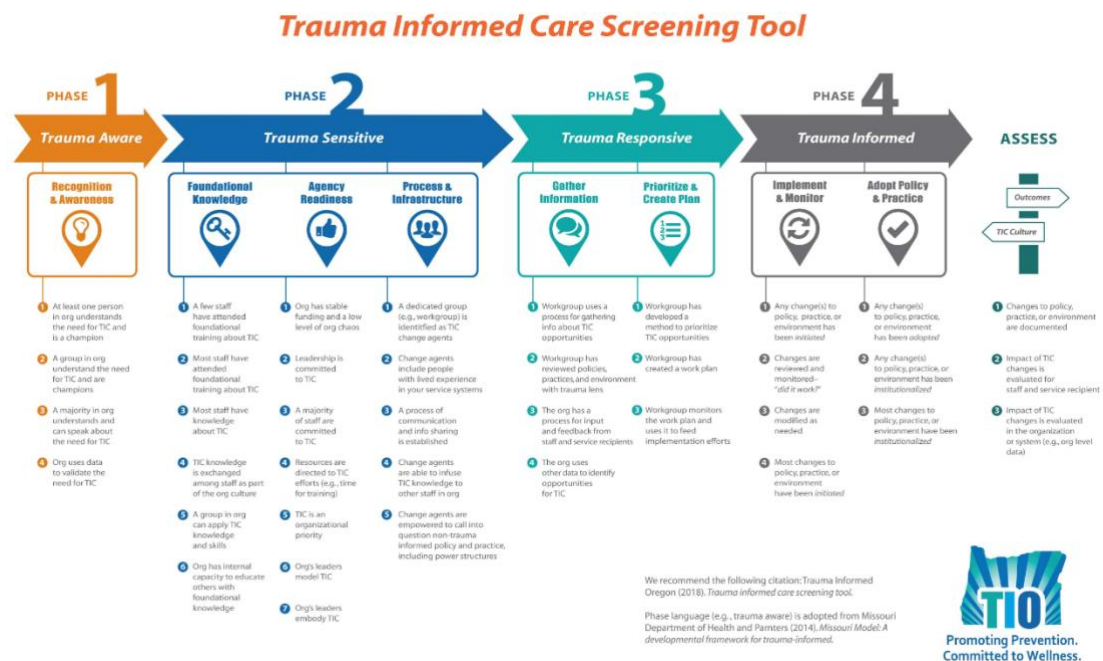


Figure 15: Trauma Informed Oregon (2018)

It seems important that service design is both advocate and survivor led, and domestic abuse services are in a strong position to facilitate this kind of collaboration given the trust they are able to develop with survivors, which is partly made possible through their independence from statutory services. Domestic abuse advocates are not therapists, social workers, or medical practitioners, they have a unique position and perspective which is not solely derived from knowledge about trauma.

The following operational recommendations are based on the challenges highlighted by the practitioners included within this small qualitative study and may not be generalisable to others domestic abuse organisations.

Managers included within this study highlighted the need to provide more opportunities for domestic abuse practitioners to engage in reflective, ‘formative’ and ‘restorative’ supervision (Proctor, 1987) with an experienced and trained supervisor. This could help practitioners to embed and apply the knowledge they have learned in their initial training. Additionally, the need for practitioners to refresh or embed their learning on trauma-informed approaches through reflecting ‘with’ others was considered to be more useful than asking practitioners to engage with paper based individual reflective

activities.

One potentially helpful utilisation of trauma knowledge that was not being fully harnessed by the services included within this study was the use of trauma screening tools, which could provide opportunities for practitioners to attend to the physiological manifestations of traumatic stress though providing opportunities for bottom-up regulation such as movement, walking, singing or breathing exercises. Domestic abuse advocates could be in particularly good position to facilitate or signpost towards these non-clinical interventions. This could also help survivors meet one another and engage with community resources (i.e. signposting a group of survivors to a local choir, walking group or yoga group).

Written policies relating to trauma-informed service provision such as a trauma informed workforce development strategy or a trauma informed staff wellbeing commitment/strategy could play an important role in providing information to practitioners pertaining to vicarious traumatisation, secondary traumatic stress and burnout.

Recommendations for Domestic Abuse Research

There is a dearth of peer reviewed qualitative research focussing on the implementation of a trauma informed approach to domestic abuse service provision in the UK which includes the views of both practitioners and survivors. More qualitative research focussing on the implementation of a trauma informed approach to domestic abuse service provision in the UK would greatly improve our understanding of the ways in which trauma-informed approaches are being interpreted and implemented in different domestic abuse service provisions and provide understanding of the usefulness and limitations of trauma-informed approaches in this sector.

In future, it will be important for organisations, and subsequently researchers, to clearly define the version or model of trauma-informed service provision they are implementing, especially when the concept of trauma itself has a degree of cultural elasticity as highlighted by Haslam's notion of 'concept creep' (Haslam, 2016; Haslam & McGrath, 2020). Existing frameworks cited within the trauma-informed service literature could prove a useful starting point. For example, Hanson and Lang (2016) clearly define the components of trauma-informed service provision which includes specific domains such as: workforce development (training, awareness, secondary

traumatic stress); trauma-focused services (use of standardised screening measures and evidence-based practices); and organizational environment and practices (collaboration, service coordination, safe physical environment, written policies, defined leadership) (2016, p 96). This framework provides a useful reference point for service providers and researchers alike. The authors additionally provide a list of components of trauma-informed care, and other researchers have offered trauma-informed principles specifically for women's services (Elliot et al, 2005). Researchers should try to establish which set of trauma-informed principles an organisation is adhering to.

This study struggled to engage domestic abuse survivors, which was due to the context of a global pandemic as well as reliance on domestic abuse practitioners as gatekeepers (see detailed discussion in Methodology chapter). Alternative sampling methods such as voluntary response sampling through social media or community groups which could be combined with snowball sampling may encourage larger, more diverse, and inclusive range of domestic abuse survivor voices within research on this topic. Larger and more diverse survivor samples will be an essential step in deepening understanding of the potential benefits and limitations of adopting this approach.

Trauma language was also reported as emboldening domestic abuse professionals in multi-agency contexts. This study offers suggests a possible explanation that trauma knowledge and language offer legitimacy to domestic abuse advocates and survivors, conferring a form of 'worthiness' or perhaps even 'deservedness' in terms of societal perceptions (Macro-system) about domestic abuse survivors. However, this assertion calls for further research which incorporates a broader consideration of how society assesses the legitimacy of victimhood when it comes to female survivors of domestic abuse. Survivors in this study still reported feeling largely dismissed by other professionals they came into contact with and felt that professionals often failed to acknowledge that perpetrators of domestic abuse will not simply stop being abusive through their own volition, pointing to the need for a consistent and robust multi-agency response.

Trauma-informed advocacy and education for other professionals, formal or informal, may not be enough to combat an inadequate multi-agency response to domestic abuse that leaves survivors feeling and being unsafe in their homes and their communities. It requires structural change by way of policy directives and resources for front line services. This raises an interesting question about where trauma-informed approaches

fall within the risk-vs-needs dichotomy alluded to by domestic abuse practitioners within this study and this would be a valuable point of enquiry for further research.

Skills demonstrated by practitioners within this study such as demonstrating care, empathy, pro-social modelling, power sharing, co-regulation and effective communication are not unique to trauma-informed practice and can all be researched and evaluated. Some of the qualities or characteristics most valued by survivors working with the domestic abuse services included in this study could be described as 'woolly notions of care and relationship' that are seen as a bridge too far for the modernist mind with its need for checks and balance' (Steckley and Smith, 2011, p 192). The domestic abuse sector could be an important voice in the public conversation in evidencing the efficacy of relational practice (and associated skills listed above) in effective risk management and advocacy. Risk management and survivor focussed advocacy are essential components of feminist domestic abuse support and part of what distinguishes the role of a domestic abuse sector from statutory service provision.

Key Questions for Further Research

This study has illuminated some important areas for future enquiry on the adoption of trauma-informed approaches in domestic abuse service provision, including:

- How can the social activist feminist ethos of domestic abuse service provisions for women integrate a medicalised trauma-informed paradigm in a way that enables them to extract the most useful facets of both paradigms?
- Given the lack of clarity or unity about the definition of trauma and what constitutes a trauma-informed approach, how can service evaluations best assess uniqueness or fidelity of trauma-informed models in comparison to other models or approaches?
- Is trauma recovery a helpful or well aligned goal of domestic abuse service provision? How do services centralised around an anti-oppressive and emancipatory ethos avoid the risk of paternalism and other possible unintended consequences of adopting a recovery or behaviour change model?
- What is the value of trauma-informed service provision for domestic abuse without accessible referral routes to trauma-specific treatment for domestic abuse survivors which many domestic abuse services lack?

A New Ecological Model for Domestic Abuse Service Research

In order to examine the potential impact of domestic abuse service delivery on domestic abuse survivors engaging with that service, this study adapted the ecological framework offered by Bronfenbrenner (1979) to consider the bi-directional and interconnected layers of influence between the various layers of context.

This framework could be utilised by other researchers wishing to apply an ecological framework analysis to service user- service provision interaction. Table 8 offers an outline of this framework.

Ecological systems framework for mapping service user- service provision interaction:

Ecological system	Definition (as defined by Bronfenbrenner)	Service User- Service Provision Considerations
The Micro-system	'the pattern of 'activities, social roles and interpersonal relations experienced by the person' (Bronfenbrenner, 1994, p 40)	Direct interaction between service and service user; a survivor's Micro system includes those professionals who they have direct contact with.
Meso-system	'the Meso-system is a system of Micro-systems' (Bronfenbrenner, 1994, p 40).	The interactions between these professionals that does not directly involve the service user but influences what happens to them, including professional meetings or phone calls.
The Exo-system	Is comprised of 'linkages and processes taking place between two or more settings, at least one of which does not contain the person in question' (Bronfenbrenner, 1994, p 40).	While the domestic abuse survivor has direct interaction with their advocate/practitioner, there are events that occur that indirectly influence this interaction, such as the organisational ethos, policies and training initiatives influencing that practitioner and consequently that survivor.
The Macro-system	Describes overarching 'characteristics of the culture, belief systems, bodies of knowledge, customs, opportunities and structures' in the societal context within which the other nested systems exist (Bronfenbrenner, 1994, p 40).	In relation to domestic abuse this relates to policy, legislation and societal attitudes and conceptualisation of domestic abuse, gender, harm and victimisation. It also includes consideration of dominant paradigms informing research, academic commentary and guidance on the nature of domestic abuse and the recommendations for domestic abuse support/service provision.
The Chronosystem	'Encompasses change or consistency over time not only in the characteristics of the person but also in the environment in which the person lives' (Bronfenbrenner, 1994, p 40).	The Chrono-system in relation to domestic abuse and domestic abuse service provision could include any changes through the life course of the survivor as well as changes in the broader environmental factors in the Meso, Exo and Macro systems (as listed above).

Table 8: Ecological systems framework for mapping service user- service provision interaction

The Shifting Policy Landscape of Domestic Abuse Services

Domestic abuse has emerged as a critical priority for the UK Government, reflecting a growing recognition of the urgent need to address this pervasive issue. The Home Office is currently in the process of revising its comprehensive cross-Government strategy aimed at Tackling Violence against Women and Girls (Home Office, 2021).

Among the proposed measures is the introduction of Raneem's Law (Home Office, 2024) which will initiate a pilot programme that will embed domestic abuse specialists directly within 999 emergency control rooms starting in early 2025. These specialists will possess knowledge and expertise in domestic abuse cases, enabling them to conduct nuanced risk assessments and collaborate closely with first responders. This strategic integration aims to ensure that victims receive immediate and appropriate responses when they reach out for help, facilitating quicker referrals to essential support services. This emphasises the potential value of offering domestic abuse practitioners' access to training in trauma theory to assist other practitioners to recognise and respond appropriately to survivors in crisis. If trauma-informed approaches are offering legitimacy to domestic abuse services, they may also be offering distinctiveness in the way they treat victimisation, which could be helpful in the context of 'austerity and mixed welfare economies... in the eyes of funders' (Helminen 2019, p 159) and the competitive tendering process. It is likely that this specific measure will most significantly address responses to physical domestic abuse. While it has been discussed that one of the main utilities of trauma knowledge is helpful in providing a language for non-physical domestic abuse, the potential utility of a trauma-informed approach to crisis or emergency intervention should not be dismissed and research in this area should inform workforce development.

In addition to this initiative, Domestic Abuse Protection Orders, which came into effect in November 2024 (Home Office, 2024) have been designed to significantly broaden the scope of legal protections available to victims. These orders encompass all manifestations of domestic abuse, including physical violence, stalking, and coercive control. Importantly, the ability to apply for domestic abuse protection order extends beyond the police and criminal courts; family and civil courts: third-party entities such as local authorities, charities, and social services, also have the authority to seek these protective measures. Victims themselves can apply to apply directly for these orders,

thereby empowering them in their pursuit of safety and justice. Through broadening the access of application for Domestic Abuse Protection Orders this could serve to provide legitimacy to domestic abuse advocates and survivors alike. However, it remains to be seen as to whether the criminal justice system will be able to adequately the demand this will place on them, given that 'Often police don't know how to use them, and courts have no time to hear applications' (Topping, 2024). This may have an unintended consequence of placing more survivors at risk and increasing the workload for domestic abuse services.

Additionally legal obligations will now be placed on perpetrators, mandating them to notify the police of any changes to their name or address. This will be complemented by the implementation of electronic tagging and compulsory assessments for behaviour change programmes, aimed at addressing the root causes of abusive behaviour (Home Office, 2024). Notably, there will be no maximum duration for these orders, allowing for sustained protection for victims as needed. Given that the survivors in this study identified that domestic abuse and the suffering survivors endure does not stop until domestic abuse perpetrators are stopped, most will likely welcome the measures described above, which seem to focus on increasing the visibility and accountability of domestic abuse perpetrators.

To promote a comprehensive approach to combatting violence against women and girls, the 'Safer Streets Mission', with a Board led by the Home Secretary, has been established to coordinate response across government sectors. The introduction of the Domestic Abuse Act 2021 has also established a statutory duty for local authorities to provide funding for refuge services, further reinforcing the commitment to supporting victims. Additionally, the appointment of a dedicated domestic abuse commissioner signifies a formal acknowledgment of the importance of this issue at the highest levels of governance. These developments indicate that tackling domestic abuse is transitioning into a mainstream societal concern, and the domestic abuse sector is likely to experience a significant shift in its operational landscape. The widespread adoption or at least discourse around the adoption of trauma-informed approaches to domestic abuse service provision may have assisted this shift in part however this rationale is not present within any of the existing communication coming from the UK government at the time of writing this. Those with a more cynical view may see these measures part of a larger recursive pattern in which successive governments set out bold plans to tackle 'wicked problems' (Devaney and Spratt, 2009) in order to secure their mandate. Currently the Labour government has not outlined how it will measure

attempts to 'halve violence to women and girls' or indeed what exactly they are halving (e.g. half the number of women killed by men, or double prosecution rates for VAWG related crimes). Regardless, the new measures will impact policy and practice for domestic abuse advocates and survivors and the application of trauma-informed approaches in this setting (and others) will likely evolve, adapting to the changing dynamics and demands of this critical area of public policy.

Concluding Comment

This small qualitative study has taken the conversation about the utility of trauma-informed approaches in domestic abuse service provision forward in several ways.

This study clearly identifies the ways in which trauma-informed approaches are perceived and experienced as valuable for domestic abuse practitioners. It emphasises the potential utility of trauma-informed approaches in their communication with other professionals, showing how trauma knowledge can be harnessed to better advocate for domestic abuse survivors and tackle victim blaming.

Trauma-informed approaches can be difficult to distinguish from needs-led and strengths-based approaches; however, practitioners in this study pointed to some of the unique benefits offered to them by adopting a trauma-informed approach. The additional expertise gained through trauma training provided domestic abuse practitioners with a form of specialism, a superior 'epistemic power' (Fricker, 2006 p 235) that was not associated with needs-led and strengths-based approaches in the same way. This could be simply because such approaches are seen as less specialist in terms of expertise, or it can be attributed to trauma's theoretical roots in the medical paradigm. Practitioners in this study acknowledged the current interest in trauma and the cultural caché of TIAs as instrumental in trauma's educative and persuasive power.

However, the ever-increasing references to trauma within cultural discourse and the growing demand for all services to become 'trauma-informed' could have a detrimental impact on the utility of trauma knowledge for domestic abuse practitioners in multi-agency contexts. If there is wholesale acceptance of the proposition that most people, if not everyone, have experienced trauma, and consequently that all services should be trauma-informed, do trauma-informed domestic abuse practitioners lose their epistemic power? If trauma knowledge is being cited as the basis on which they are

perceived by others as more credible, or more legitimate in some way, what happens when trauma knowledge and trauma-informed working becomes ubiquitous?

Domestic abuse services are already specialist; they specialise in supporting domestic abuse survivors. The need for women to support other women and girls in their community to survive and successfully flee from domestic abuse was born out of an acknowledgement of the pervasiveness of male violence towards women. Their work is supported by a wealth of literature from various disciplines, including feminist theory, gender studies, critical race theory, intersectionality, psychotherapy, and indigenous knowledge. While a trauma-informed approach could compliment these varying perspectives, its promotion as the source of credibility for the domestic abuse sector, while perhaps strategically advantageous in the short term, could be short-sighted in terms of the long-term goal of eradicating violence towards women and girls. As highlighted by the survivors in this study, domestic abuse only stops when the perpetrators of domestic abuse are stopped. One of the concerns highlighted within this study is that TIAs' focus on individual or survivor recovery could risk depoliticising or shifting focus away from the structural conditions that place women at risk of domestic abuse.

Another unique benefit of TIAs cited by practitioners is that trauma theory offers practitioners a clear rationale for survivor responses that they interpret as challenging or counterintuitive, such as non-engagement, aggression towards professionals or returning to an abusive partner. Practitioners emphasised that this helped them to distance themselves during a difficult or frustrating encounter with a survivor, remain calm and retain compassion for the survivors they work with. Despite the obvious benefits of this psychological distancing, attributing any relational difficulties that occur between practitioner and survivor to the survivor's trauma could also stifle curiosity or critical reflection on the part of the practitioner. Adopting a both/and approach or adopting a 'not-knowing' ethical position, could help practitioners to remain connected and curious while allowing a safe psychological distance when working with domestic abuse survivors. Without this, domestic abuse practitioners (as well as other non-clinical service providers) risk falling into the trap of pathologisation, not through diagnosis but through the way in which they interpret signals of distress, anger or frustration exhibited by survivors. The particular challenge for domestic abuse practitioners is finding a way to utilise the neurological and psychiatric theory base of trauma, while maintaining their own non-clinical and ideological (i.e. feminist) ethos and identity.

In relation to the non-clinical advocacy and therapeutic service provisions offered by domestic abuse organisations, the second-generation approach to working with trauma survivors, outlined by SAMHSA (2014) as a 'psycho-social education empowerment approach', may be better suited to these settings. These approaches reach beyond the first-generation emphasis on individualised clinical intervention models, which more closely aligns with trauma-specific support than trauma-informed support. This is an important distinction, as it does not stipulate trauma-recovery as a specific goal of trauma-informed support but instead privileges the goals of education and empowerment. The real-world challenge presented to domestic abuse services in this study and others is the limited availability of accessible and timely trauma-specific services to refer into if the survivor's trauma response limits their capacity to engage with a trauma-informed service.

Almost all survivors in this study emphasised the damaging impact of working with other services and professionals who blamed, shamed or disbelieved them. If survivors of domestic abuse have been traumatised, the risk of re-traumatisation through engaging with services is significant. The most beneficial aspects of their work with the domestic abuse services in this study centred around being believed, cared for and understood. While this could be understood through the lens of trauma-informed care, it could also be seen through the lens of relationship-based practice or feminist care ethics.

While TIAs can be harnessed and utilised in ways that can support domestic abuse survivors and practitioners, this study concludes that critical engagement and consultation within the domestic abuse sector around the potential gains and limitations associated with trauma-informed service delivery will be essential in determining the future of sustainable and ethical domestic abuse service delivery.

REFERENCES

- Abdulai, R. T., & Owusu-Ansah, A. (2014). Essential ingredients of a good research proposal for undergraduate and postgraduate students in the social sciences. *Sage Open*, 4(3), <https://doi.org/10.1177/2158244014548178>
- Abrams, L. S. (2010). 'Sampling 'Hard to Reach' Populations in Qualitative Research: The Case of Incarcerated Youth. *Qualitative Social Work*, 9(4), 536–550. <https://doi.org/10.1177/1473325010367821>
- Acker, J., Barry, K., & Esseveld, J. (1983, January). Objectivity and truth: Problems in doing feminist research. In *Women's Studies International Forum*. Pergamon, 6(4), 423–435. [https://doi.org/10.1016/0277-5395\(83\)90035-3](https://doi.org/10.1016/0277-5395(83)90035-3)
- Ainsworth, M. D. (1963). The development of infant–mother interaction among the Ganda. *Determinants of infant behavior*, pp. 67–112.
- Alaggia, R., Regehr, C., & Jenney, A. (2012). Risky business: An ecological analysis of intimate partner violence disclosure. *Research on Social Work Practice*, 22(3), 301–312. <https://doi.org/10.1177/1049731511425503>
- Ali, P. A., & Naylor, P. B. (2013). Intimate partner violence: A narrative review of the feminist, social and ecological explanations for its causation. *Aggression and Violent Behavior*, 18(6), 611–619. <https://doi.org/10.1016/j.avb.2013.07.009>
- Al Jowf, G. I., Ahmed, Z. T., Reijnders, R. A., de Nijs, L., & Eijssen, L. M. T. (2023). To predict, prevent, and manage post-traumatic stress disorder (PTSD): A review of pathophysiology, treatment, and biomarkers. *International Journal of Molecular Sciences*, 24(6), 5238. <https://doi.org/10.3390/ijms24065238>
- Allen, J. (2017). Our town: Foucault and knowledge-based politics in London. In S. J. Mandelbaum, L. Mazza, R. W. Burchell (Eds.), *Explorations in planning theory* (pp. 328–344). Routledge. <https://doi.org/10.4324/9780203792506-16>
- Allen, J. G. (2008). *Coping with trauma: Hope through understanding*. American Psychiatric Publishing.

- Allen, P. G. (1992). *The sacred hoop: Recovering the feminine in American Indian traditions*. Beacon Press.
- Almeida, R., & Lockard, J. (2005). The cultural context model. *Domestic violence at the margins: Readings in race, class, gender and culture*, pp. 319–332.
- Anderson, D. K., Saunders, D. G., Yoshihama, M., Bybee, D. I., & Sullivan, C. M. (2003). Long-term trends in depression among women separated from abusive partners. *Violence Against Women*, 9(7), 807–838. <https://doi.org/10.1177/1077801203009007004>
- Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 27(4), 371–393. <https://doi.org/10.1111/j.1545-5300.1988.00371.x>
- Arata, C. M. (2002). Child sexual abuse and sexual revictimization. *Clinical Psychology: Science and Practice*, 9(2), 135–164. <https://doi.org/10.1093/clipsy.9.2.135>
- Arnold, G., & Ake, J. (2013). Reframing the narrative of the battered women's movement. *Violence Against Women*, 19(5), 557–578. <https://doi.org/10.1177/1077801213490508>
- Arnall, E., & Stewart, S. (2021). Developing a theoretical framework to discuss mothers experiencing domestic violence and being subject to interventions: A cross-national perspective. *International Journal for Crime, Justice and Social Democracy*, 10(2), 113–126. <https://doi.org/10.5204/ijcjsd.1561>
- Ash, A. (2013). A cognitive mask? Camouflaging dilemmas in street-level policy implementation to safeguard older people from abuse. *British Journal of Social Work*, 43(1), 99–115. <https://doi.org/10.1093/bjsw/bcr161>
- Ashby, B. D., Ehmer, A. C., & Scott, S. M. (2019). Trauma-informed care in a patient-centered medical home for adolescent mothers and their children. *Psychological Services*, 16(1), 67–74. <https://doi.org/10.1037/ser0000315>
- Ashley, F. (2021). Accounting for research fatigue in research ethics. *Bioethics*, 35(3), 270–276. <https://doi.org/10.1111/bioe.12829>

- Avery, J. C., Morris, H., Galvin, E., Misso, M., Savaglio, M., & Skouteris, H. (2021). Systematic review of school-wide trauma-informed approaches. *Journal of Child and Adolescent Trauma*, 14(3), 381–397. <https://doi.org/10.1007/s40653-020-00321-1>
- Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing*, 24(1), 11–15. <https://doi.org/10.1111/j.1744-6171.2010.00262.x>
- Backwith, D. (2015). *Social work, poverty and social exclusion*.
- Bailey, C., Klas, A., Cox, R., Bergmeier, H., Avery, J., & Skouteris, H. (2019). ‘Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings’. *Health and Social Care in the Community*, 27(3), e10–e22. <https://doi.org/10.1111/hsc.12621>
- Bailey, K., Trevillion, K., & Gilchrist, G. (2020). ‘We have to put the fire out first before we start rebuilding the house’: Practitioners’ experiences of supporting women with histories of substance use, interpersonal abuse and symptoms of post-traumatic stress disorder. *Addiction Research and Theory*, 28(4), 289–297. <https://doi.org/10.1080/16066359.2019.1644323>
- Baird, S., & Jenkins, S. R. (2003). Vicarious traumatisation, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, 18(1), 71–86. <https://doi.org/10.1891/vivi.2003.18.1.71>
- Baird, S. L. (2018). *Conceptualizing and responding to trauma among women who have experienced intimate partner violence (IPV)*. University of Toronto.
- Balaev, M. (2018). Trauma studies. *A companion to literary theory*, 360–371.
- Balaev, M. (Ed.). (2014). *Contemporary approaches in literary trauma theory*. Springer.
- Barlow, M. R., Turow, R. E. G., & Gerhart, J. (2017). Trauma appraisals, emotion regulation difficulties, and self-compassion predict posttraumatic stress symptoms following childhood abuse. *Child abuse & neglect*, 65, 37–47.

- Barnett, O. W. (2001). Why battered women do not leave, part 2: External inhibiting factors—Social support and internal inhibiting factors. *Trauma, Violence, and Abuse*, 2(1), 3–35. <https://doi.org/10.1177/1524838001002001001>
- Barrett, J. E. (2019). Trauma-informed nursing care. In M. R. Gerber (Ed.), *Trauma-informed healthcare approaches: A guide for primary care* (pp. 181–193). Springer International Publishing. https://doi.org/10.1007/978-3-030-04342-1_10
- Bartky, S. L. (2015). *Femininity and domination: Studies in the phenomenology of oppression*. Routledge. <https://doi.org/10.4324/9780203825259>
- Batchelor, S., Burman, M., & McIvor, G. (2004). Working with girls and young women. *Women who offend*, pp. 266–287.
- Bates, E. A., & Douglas, E. M. (2020). Services for domestic violence victims in the United Kingdom and United States: Where are we today? *Partner Abuse*, 11(3), 350–382. <https://doi.org/10.1891/PA-2020-0019>
- Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth*, 17(3), 17–21.
- BBC News. (2023). [Social workers lack training to tackle coercive abuse, BBC finds] [Online]. Retrieved Sept. 2024, <https://www.bbc.co.uk/news/articles/cn4970jdqg7o>
- Beck, J. G., McNiff, J., Clapp, J. D., Olsen, S. A., Avery, M. L., & Hagewood, J. H. (2011). Exploring negative emotion in women experiencing intimate partner violence: Shame, guilt, and PTSD. *Behavior Therapy*, 42(4), 740–750. <https://doi.org/10.1016/j.beth.2011.04.001>
- Becker-Blease, K. A. (2017). As the world becomes trauma-informed, work to do. *Journal of Trauma and Dissociation*, 18(2), 131–138. <https://doi.org/10.1080/15299732.2017.1253401>
- Beckett, H., & Warrington, C. (2024). ‘Do no harm’? Rethinking risk and harm narratives in abuse-focused research with children. *Child Protection and Practice*, 2, Article 100037. <https://doi.org/10.1016/j.chipro.2024.100037>

- Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society*, 84(4), 463–470. <https://doi.org/10.1606/1044-3894.131>
- Bell, K. M., & Higgins, L. (2015). The impact of childhood emotional abuse and experiential avoidance on maladaptive problem solving and intimate partner violence. *Behavioural Sciences*, 5(2), 154–175. <https://doi.org/10.3390/bs5020154>
- Bellini, R., Strohmer, A., Olivier, P., & Crivellaro, C. (2019, May). Mapping the margins: Navigating the ecologies of domestic violence service provision. In *Proceedings of the 2019 CHI Conference on Human Factors in Computing Systems* (pp. 1–13). ACM. <https://doi.org/10.1145/3290605.3300352>
- Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C., & Lowey, H. (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England. *BMC Medicine*, 12, 72. <https://doi.org/10.1186/1741-7015-12-72>
- Bendall, S., Eastwood, O., Cox, G., Farrelly-Rosch, A., Nicoll, H., Peters, W., Bailey, A. P., McGorry, P. D., & Scanlan, F. (2021). A systematic review and synthesis of trauma-informed care within outpatient and counselling health settings for young people. *Child Maltreatment*, 26(3), 313–324. <https://doi.org/10.1177/1077559520927468>
- Beresford, P. (2016). The role of survivor knowledge in creating alternatives to psychiatry. *Searching for a rose garden: Challenging psychiatry, fostering mad studies*, pp. 25–34.
- Beresford, P., Croft, S., & Adshead, L. (2008). 'We don't see her as a social worker': A service user case study of the importance of the social worker's relationship and humanity. *British Journal of Social Work*, 38(7), 1388–1407. <https://doi.org/10.1093/bjsw/bcm043>
- Berger, E. (2019). Multi-tiered approaches to trauma-informed care in schools: A systematic review. *School Mental Health*, 11(4), 650–664. <https://doi.org/10.1007/s12310-019-09326-0>

- Berring, L. L., Holm, T., Hansen, J. P., Delcomyn, C. L., Søndergaard, R., & Hvidhjelm, J. (2024, April). 'Implementing Trauma-Informed Care-Settings, Definitions, Interventions, Measures, and Implementation across Settings: A Scoping Review' In *Healthcare*. MDPI, 12(9), Article 908. <https://doi.org/10.3390/healthcare12090908>
- Birdsey, N., & Kustner, C. (2021). Reviewing the Social GRACES: What Do They Add and Limit in Systemic Thinking and Practice? *The American Journal of Family Therapy*, 49(5), 429–442. <https://doi.org/10.1080/01926187.2020.1830731>
- Blazejewski, L. A. (2021). *Nurse perspectives of trauma-informed care* (Doctoral dissertation, Walden University).
- Bliss, M. J., Cook, S. L., & Kaslow, N. J. (2014). An ecological approach to understanding incarcerated women's responses to abuse. In *Inside and Out*. Routledge, (97–115).
- Bloom, S. L. (1994). The sanctuary model: Developing generic inpatient programs for the treatment of psychological trauma. In M. B. Williams & J. F. Sommer (Eds.), *Handbook of post-traumatic therapy* (pp. pp-474).
- Bloom, S. L. (1997). *Creating sanctuary: Toward the evolution of sane societies*. Routledge.
- Bloom, S. L., & Farragher, B. (2013). *Restoring sanctuary: A new operating system for trauma-informed systems of care*. Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780199796366.001.0001>
- Boals, A. (2018). Trauma in the eye of the beholder: Objective and subjective definitions of trauma. *Journal of Psychotherapy Integration*, 28(1), 77–89. <https://doi.org/10.1037/int0000050>
- Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, 6(1), 1–9. <https://doi.org/10.1093/brief-treatment/mhj001>
- Boden, M. T., Westermann, S., McRae, K., Kuo, J., Alvarez, J., Kulkarni, M. R., Gross, J. J., & Bonn-Miller, M. O. (2013). Emotion regulation and posttraumatic stress

- disorder: A prospective investigation. *Journal of Social and Clinical Psychology*, 32(3), 296–314. <https://doi.org/10.1521/jscp.2013.32.3.296>
- Bonnan-White, J., Hetzel-Riggin, M. D., Diamond-Welch, B. K., & Tollini, C. (2018). 'You blame me, therefore I blame me': The importance of first disclosure partner responses on trauma-related cognitions and distress. *Journal of Interpersonal Violence*, 33(8), 1260–1286. <https://doi.org/10.1177/0886260515615141>
- Bostock, J. A. N., Plumpton, M., & Pratt, R. (2009). Domestic violence against women: Understanding social processes and women's experiences. *Journal of Community and Applied Social Psychology*, 19(2), 95–110. <https://doi.org/10.1002/casp.985>
- Bowlby, J. (1951). Maternal care and mental health. *Bulletin of the World Health Organization*, 3(3), 355–533.
- Bowles, G., & Klein, R. D. (1983). Introduction: Theories of women's studies and the autonomy/integration debate. In *Theories of women's studies* (pp. 1–26). Routledge.
- Bows, H., Bromley, P., & Walklate, S. (2024). Practitioner understandings of older victims of abuse and their perpetrators: Not ideal enough? *The British Journal of Criminology*, 64(3), 620–637. <https://doi.org/10.1093/bjc/azad057>
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage Publications.
- Boyce, M., Dadswell, A., Burch, S., & Sandu, A. (2025). Delivering trauma-informed outreach to women involved in street-based prostitution: enablers and barriers. *European Journal of Social Work*, 28(1), 200-213.
- Bradbury-Jones, C., Taylor, J., Kroll, T., & Duncan, F. (2014). Domestic abuse awareness and recognition among primary healthcare professionals and abused women: A qualitative investigation. *Journal of Clinical Nursing*, 23(21–22), 3057–3068. <https://doi.org/10.1111/jocn.12534>
- Bradley, N. L., DiPasquale, A. M., Dillabough, K., & Schneider, P. S. (2020). Health care practitioners' responsibility to address intimate partner violence related to the

- COVID-19 pandemic. *CMAJ*, 192(22), E609–E610.
<https://doi.org/10.1503/cmaj.200634>
- Brandon, M., & Lewis, A. (1996). Significant harm and children's experiences of domestic violence. *Child and Family Social Work*, 1(1), 33–42.
<https://doi.org/10.1111/j.1365-2206.1996.tb00005.x>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
<https://doi.org/10.1191/1478088706qp063oa>
- Breckenridge, J. P., Devaney, J., Kroll, T., Lazenbatt, A., Taylor, J., & Bradbury-Jones, C. (2014). Access and utilisation of maternity care for disabled women who experience domestic abuse: A systematic review. *BMC Pregnancy and Childbirth*, 14, 234. <https://doi.org/10.1186/1471-2393-14-234>
- Bremner, J. D. (2007). 'Neuroimaging in posttraumatic stress disorder and other stress-related disorders'. *Neuroimaging Clinics of North America*, 17(4), 523–538.
<https://doi.org/10.1016/j.nic.2007.07.003>
- Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice*, 14(1), 27–35. <https://doi.org/10.1177/1049731503254106>
- British Psychological Society. (2016). Recommendations for education and training of psychologists when working with psychological trauma [Online]. Retrieved November 27, 2024, <https://cms.bps.org.uk/sites/default/files/2022->
- Broadwell, M. M. (1969). Teaching for learning (XVI). *The Gospel Guardian*, 20(41), 1–3.
- Bromley, H., Davis, S. K., Morgan, B., & Taylor-Dunn, H. (2024). The professional quality of life of domestic and sexual violence advocates: A systematic review of possible risk and protective factors. *Trauma, Violence and Abuse*, 25(2), 1113–1128. <https://doi.org/10.1177/15248380231171187>

- Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. *American Psychologist*, 34(10), 844–850. <https://doi.org/10.1037/0003-066X.34.10.844>
- Bronfenbrenner, U. (1994). Ecological models of human development. *International encyclopaedia of education*, 3(2), 37–43.
- Brosnan, L. (2019). The Lion's Den: The epistemic dimensions of invisible emotional labour in service-user involvement spaces. *Journal of Ethics in Mental Health*, 10, 1–16.
- Brown, C., & O'Brien, K. M. (1998). Understanding stress and burnout in shelter workers. *Professional Psychology: Research and Practice*, 29(4), 383–385. <https://doi.org/10.1037/0735-7028.29.4.383>
- Brown, S. M., Baker, C. N., & Wilcox, P. (2012). Risking connection trauma training: A pathway toward trauma-informed care in child congregate care settings. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(5), 507–515. <https://doi.org/10.1037/a0025269>
- Brown, V. B., Harris, M., & Fallot, R. (2013). Moving toward trauma-informed practice in addiction treatment: A collaborative model of agency assessment. *Journal of Psychoactive Drugs*, 45(5), 386–393. <https://doi.org/10.1080/02791072.2013.844381>
- Bruce, M. M., Kassam-Adams, N., Rogers, M., Anderson, K. M., Sluys, K. P., & Richmond, T. S. (2018). Trauma providers' knowledge, views, and practice of trauma-informed care. *Journal of Trauma Nursing| JTN*, 25(2), 131–138. <https://doi.org/10.1097/JTN.0000000000000356>
- Brunovskis, A., & Surtees, R. (2010). Untold stories: Biases and selection effects in research with victims of trafficking for sexual exploitation. *International Migration*, 48(4), 1–37. <https://doi.org/10.1111/j.1468-2435.2010.00628.x>
- Bryman, A. (2016). *Social research methods*. Oxford University Press.
- Bryson, S. A., Gauvin, E., Jamieson, A., Rathgeber, M., Faulkner-Gibson, L., Bell, S., Davidson, J., Russel, J., & Burke, S. (2017). What are effective strategies for

- implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International Journal of Mental Health Systems*, 11, 36. <https://doi.org/10.1186/s13033-017-0137-3>
- Buchanan, F., & Moulding, N. T. (2021). Mothering during domestic abuse: Protective agency as a force for change. *Qualitative Social Work*, 20(3), 665–680. <https://doi.org/10.1177/1473325020917743>
- Bumiller, K. (2008). *In an abusive state: How neoliberalism appropriated the feminist movement against sexual violence*. Duke University Press. <https://doi.org/10.2307/j.ctv11vc8wj>
- Bunting, L., Montgomery, L., Mooney, S., MacDonald, M., Coulter, S., Hayes, D., & Davidson, G. (2019). Trauma informed child welfare systems—A rapid evidence review. *International Journal of Environmental Research and Public Health*, 16(13), 2365. <https://doi.org/10.3390/ijerph16132365>
- Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *The American Journal of Psychiatry*, 131(9), 981–986. <https://doi.org/10.1176/ajp.131.9.981>
- Burman, M., Crowley, A., Gomes-Ferreira, J., Gelsthorpe, L., & Glinski, J. (2023). WOMEN WORKING TO SUPPORT WOMEN: PSYCHOSOCIAL CHALLENGES Final report [Online]. Retrieved October 16, 2024, <https://www.sccjr.ac.uk/wp-content/uploads/2023/11/Final-Report-WWSWWS.pdf>
- Burnham, J. (1992). Approach-method-technique: Making distinctions and creating connections. *Human Systems*, 3(1), 3–26.
- Burnham, J. (1993). Systemic supervision: The evolution of systemic reflexivity in the context of the supervisory relationship. *Human Systems: The Journal of Systemic Consultation and Management*, 4(3–4), 349–381.
- Burnham, J. (2012). Developments in Social GRRRAACCEEESSS: Visible–invisible and voiced–unvoiced. In *Culture and reflexivity in systemic psychotherapy*, 1 (pp. 139–160). Routledge.

- Burnham, J., Alvis Palma, D., & Whitehouse, L. (2008). Learning as a context for differences and differences as a context for learning. *Journal of Family Therapy*, 30(4), 529–542. <https://doi.org/10.1111/j.1467-6427.2008.00436.x>
- Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women*, 9(11), 1293–1317. <https://doi.org/10.1177/1077801203255555>
- Butler, L. D., Critelli, F. M., & Rinfrette, E. S. (2011). Trauma-informed care and mental health. *Directions in Psychiatry*, 31(3), 197–212.
- Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality and Quantity*, 56(3), 1391–1412. <https://doi.org/10.1007/s11135-021-01182-y>
- Campbell, J. C., Webster, D. W., & Glass, N. (2009). The danger assessment: Validation of a lethality risk assessment instrument for intimate partner femicide. *Journal of Interpersonal Violence*, 24(4), 653–674. <https://doi.org/10.1177/0886260508317180>
- Campbell, R., Goodman-Williams, R., & Javorka, M. (2019). A trauma-informed approach to sexual violence research ethics and open science. *Journal of Interpersonal Violence*, 34(23–24), 4765–4793. <https://doi.org/10.1177/0886260519871530>
- Cancian, F. M. (1992). Feminist science: Methodologies that challenge inequality. *Gender and Society*, 6(4), 623–642. <https://doi.org/10.1177/089124392006004006>
- Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse*, 3(2), 231–280. <https://doi.org/10.1891/1946-6560.3.2.231>
- Cárdenas-García, J. F. (2020). The process of info-autopoiesis—the source of all information. *Biosemiotics*, 13(2), 199–221. <https://doi.org/10.1007/s12304-020-09384-x>

- Carr, O. (2024). *A qualitative study of women's long-term experience of trauma more than ten years after exiting domestic abuse* (Doctoral dissertation, National University of Ireland Maynooth).
- Carter-Visscher, R. M., Naugle, A. E., Bell, K. M., & Suvak, M. K. (2007). Ethics of asking trauma-related questions and exposing participants to arousal-inducing stimuli. *Journal of Trauma and Dissociation*, 8(3), 27–55. https://doi.org/10.1300/J229v08n03_03
- Caruth, C. (Ed.). (1995). *Trauma: Explorations in memory*. JHU Press.
- Caruth, C. (2016). *Unclaimed experience: Trauma, narrative, and history*. JHU press.
- Cattagni Kleiner, A., & Romain-Glassey, N. (2024). How the current management of intimate partner violence can endanger victimised mothers and their children. *Journal of Family Violence*, 39(8), 1593–1607. <https://doi.org/10.1007/s10896-023-00596-6>
- Champine, R. B., Lang, J. M., Nelson, A. M., Hanson, R. F., & Tebes, J. K. (2019). Systems measures of a trauma-informed approach: A systematic review. *American Journal of Community Psychology*, 64(3–4), 418–437. <https://doi.org/10.1002/ajcp.12388>
- Chandan, J. S., Thomas, T., Bradbury-Jones, C., Russell, R., Bandyopadhyay, S., Nirantharakumar, K., & Taylor, J. (2020). Female survivors of intimate partner violence and risk of depression, anxiety and serious mental illness. *The British Journal of Psychiatry*, 217(4), 562–567. <https://doi.org/10.1192/bjp.2019.124>
- Chandhok, G., & Anand, M. (2020). Practising strength-based approach with women survivors of domestic violence. In M. Anand (Ed.), *Gender and mental health: Combining theory and practice* (pp. 237–251). Springer Singapore. https://doi.org/10.1007/978-981-15-5393-6_16
- Change that lasts impact briefing. (2018) [Online]. Retrieved December 2024, <https://www.womensaid.org.uk/wp-content/uploads/2020/11/Change-That-Lasts-Impact-Briefing.pdf>

- Chatterjee, A., & Park, Y. (2024). Trauma as the “belief that the world is a dangerous place”: The obfuscation of systemic violence in social work’s discourses of trauma. *The British Journal of Social Work*, p.bcae016, 54(5), 1988–2005. <https://doi.org/10.1093/bjsw/bcae016>
- Chavis, A. Z., & Hill, M. S. (2008). Integrating multiple intersecting identities: A multicultural conceptualization of the power and control wheel. *Women and Therapy*, 32(1), 121–149. <https://doi.org/10.1080/02703140802384552>
- Christie, N. (1986). The ideal victim. In E. A. Fattah (Ed.), *From crime policy to victim policy: Reorienting the justice system* (pp. 17–30). Palgrave Macmillan UK. https://doi.org/10.1007/978-1-349-08305-3_2
- Chung, S., Domino, M. E., & Morrissey, J. P. (2009). Changes in treatment content of services during trauma-informed integrated services for women with co-occurring disorders. *Community Mental Health Journal*, 45(5), 375–384. <https://doi.org/10.1007/s10597-009-9192-9>
- Church, K. (1996). Beyond “bad manners”: The power relations of “consumer participation” in Ontario’s community mental health system. *Canadian Journal of Community Mental Health*, 15(2), 27–44. <https://doi.org/10.7870/cjcmh-1996-0009>
- Church, K., & Reville, D. (1988, November). User involvement in mental health services in Canada: A work in progress. In *Report of common concerns: International conference on user involvement in mental health services*, E15 (pp. 53–76). Broadway Book Company 4BQ: MIND Publications, Granta House.
- Clark, C., & Fearday, F. (2003). *Triad women’s project: Group treatment manual*.
- Clark, S. E., Kimber, M., Downes, L., Feder, G. S., Fulton, E., Howarth, E., Johns, K., Lindenberg, U., D’Oliveira, A. F., Shaheen, A., Vindrola-Padros, C., & Powell, C. (2023). Engaging domestic abuse practitioners and survivors in a review of outcome tools: –reflections on differing priorities. *Research for All*, 7(1). <https://doi.org/10.14324/RFA.07.1.06>
- Cobban, S. J., Edgington, E. M., & Pimlott, J. F. (2008). An ethical perspective on research using shared data. *Canadian Journal of Dental Hygiene*, 42(5).

- Cohen, J. A., Mannarino, A. P., Berliner, L., & Deblinger, E. (2000). Trauma-focused cognitive behavioural therapy for children and adolescents: An empirical update. *Journal of Interpersonal Violence*, 15(11), 1202–1223. <https://doi.org/10.1177/088626000015011007>
- Coker, A. L., Smith, P. H., McKeown, R. E., & King, M. J. (2000). Frequency and correlates of intimate partner violence by type: Physical, sexual, and psychological battering. *American Journal of Public Health*, 90(4), 553–559. <https://doi.org/10.2105/ajph.90.4.553>
- College of Policing. (2016). Authorised professional practice: Understanding risk and vulnerability in the context of domestic abuse. Retrieved May 2024, <https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/understanding-risk-and-vulnerability-context-domestic-abuse>
- Collins, P. H. (1986). Learning from the outsider within: The sociological significance of Black feminist thought. *Social Problems*, 33(6), s14–s32
- Collins, P. H. (2015). The social construction of black feminist thought. In *Women, knowledge, and reality* (pp. 222–248). Routledge
- Conley, S. C. (2019). *An ecological approach to understanding help-seeking by lesbians experiencing intimate partner violence*. University of Johannesburg.
- Constantino, R., Kim, Y., & Crane, P. A. (2005). Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: A pilot study. *Issues in Mental Health Nursing*, 26(6), 575–590. <https://doi.org/10.1080/01612840590959416>
- Cooper, N., & Burnett, S. (2006). Using discursive reflexivity to enhance the qualitative research process: An example from accounts of teenage conception. *Qualitative Social Work*, 5(1), 111–129. <https://doi.org/10.1177/1473325006061541>
- Corbin, J., & Morse, J. M. (2003). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics. *Qualitative Inquiry*, 9(3), 335–354. <https://doi.org/10.1177/1077800403009003001>

- Courpasson, D., & Vallas, S. (2016). Resistance studies: A critical introduction. In *The Sage handbook of resistance* (pp. 1–28).
- Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, and Policy*, S(1), 86–100. <https://doi.org/10.1037/1942-9681.S.1.86>
- Courtois, C. A., & Ford, J. D. (2012). *Treatment of complex trauma: A sequenced, relationship-based approach*. Guilford Press.
- Coy, M., & Kelly, L. (2019). The responsabilisation of women who experience domestic violence: A case study from England and Wales. In C. Hagemann-White, L. Kelly, T. Meysen (Eds.), *Interventions against child abuse and violence against women* p. 151–163. Verlag Barbara Budrich. <https://doi.org/10.2307/j.ctvr7fcsw.12>
- Cozolino, L. J. (2002). *The neuroscience of psychotherapy: Building and rebuilding the human brain (Norton series on interpersonal neurobiology)*. WW Norton & Company.
- CPS. (2022). Domestic abuse. Crown Prosecution Service [Online]. Retrieved May 2024, <https://www.cps.gov.uk/crime-info/domestic-abuse>
- Craig, L. A., & Dixon, L. (2022). *The Wiley handbook on what works with girls and women in conflict with the law: A critical review of theory, practice, and policy*.
- Craig, L. A., Gannon, T. A., & Dixon, L. (Eds.). (2013). *What works in offender rehabilitation: An evidence-based approach to assessment and treatment*. John Wiley & Sons.
- Crenshaw, K. (1989). Demarginalising the intersection of race and sex: A black feminist critique of antidiscrimination doctrine. *Feminist Theory*.
- Crespo, M., & Arinero, M. (2010). Assessment of the efficacy of a psychological treatment for women victims of violence by their intimate male partner. *The Spanish Journal of Psychology*, 13(2), 849–863. <https://doi.org/10.1017/s113874160000250x>

- Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage Publications.
- Creswell, J. W., Hanson, W. E., Clark Plano, V. L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counselling Psychologist*, 35(2), 236–264. <https://doi.org/10.1177/0011000006287390>
- Crittenden, P. M., & Heller, M. B. (2017). The roots of chronic posttraumatic stress disorder: Childhood trauma, information processing, and self-protective strategies. *Chronic Stress*, 1, p.2470547016682965, Article 2470547016682965. <https://doi.org/10.1177/2470547016682965>
- Crocq, M. A., & Crocq, L. (2000). From shell shock and war neurosis to posttraumatic stress disorder: A history of psychotraumatology. *Dialogues in Clinical Neuroscience*, 2(1), 47–55. <https://doi.org/10.31887/DCNS.2000.2.1/Macrocg>
- Daindridge. (2023). Psychiatry won't solve our mental health crisis. *Only Politics Can do* [Online]. <https://jacobin.com/2023/12/psychiatry-history-trauma-politics-medicine-mental-health> Retrieved September 2024.
- Damant, D., Lapierre, S., Kouraga, A., Fortin, A., Hamelin-Brabant, L., Lavergne, C., & Lessard, G. (2008). Taking child abuse and mothering into account: Intersectional feminism as an alternative for the study of domestic violence. *Affilia*, 23(2), 123–133. <https://doi.org/10.1177/0886109908314321>
- Damian, A. J., Gallo, J., Leaf, P., & Mendelson, T. (2017). Organizational and provider level factors in implementation of trauma-informed care after a city-wide training: An explanatory mixed methods assessment. *BMC Health Services Research*, 17(1), 750. <https://doi.org/10.1186/s12913-017-2695-0>
- Davidson, C. (2009). Transcription: Imperatives for qualitative research. *International Journal of Qualitative Methods*, 8(2), 35–52. <https://doi.org/10.1177/160940690900800206>
- Davies, J. (2009). *Advocacy beyond leaving: Helping battered women in contact with current or former partners: A guide for domestic violence advocates*.

- Davies, J., & Lyon, E. (2013). *Domestic violence advocacy: Complex lives/difficult choices*. Sage Publications.
- Davies, J. M., Lyon, E., & Monti-Catania, D. (1998). *Safety planning with battered women: Complex lives/difficult choices*, 7. Sage Publications.
<https://doi.org/10.4135/9781452232034>
- Davies, L., & Krane, J. (2006). Collaborate with caution: Protecting children, helping mothers. *Critical Social Policy*, 26(2), 412–425.
<https://doi.org/10.1177/0261018306062592>
- Day, A. S., Jenner, A., & Weir, R. (2018). Domestic abuse: Predicting, assessing and responding to risk in the criminal justice system and beyond. In E. Milne, K. Brennan, N. South, J. Turton (Eds.), ? (pp. 67–94). Springer International Publishing. https://doi.org/10.1007/978-3-319-76774-1_4
- De Vaus, D., & de Vaus, D. (2013). *Surveys in social research*. Routledge.
<https://doi.org/10.4324/9780203519196>
- DeJonghe, E. S., Bogat, G. A., Levendosky, A. A., & von Eye, A. (2008). Women survivors of intimate partner violence and post-traumatic stress disorder: Prediction and prevention. *Journal of Postgraduate Medicine*, 54(4), 294–300.
<https://doi.org/10.4103/0022-3859.41435>
- Department for Education (DfE). (2021). Characteristics of children in need, reporting year 202 [Online]. Retrieved April 2024, <https://explore-education-statistics.service.gov.uk/find-statistics/characteristics-of-children-in-need/2021>
- Department for Levelling Up, Housing and Communities. (2023). Trauma-informed approaches to supporting people experiencing multiple disadvantage. A rapid evidence assessment [Online]. Retrieved May 30, 2024, https://assets.publishing.service.gov.uk/media/642af3a77de82b000c31350d/Changing_Futures_Evaluation_-_Trauma_informed_approaches_REA.pdf
- Department of Health. (2002). *Women's mental health: Into the mainstream – Strategic development of mental health care for women*. Department of Health.

- Department of Health. (2003). *Mainstreaming gender and women's mental health: Implementation guidance*. Department of Health.
- Department of Health. (2010). *Responding to violence against women and children – The role of the NHS*. Department of Health.
- Department of Health and Social Care with Agenda. (2018). The Women's Mental Health Taskforce [Final report].
- DePrince, A. P., & Chu, A. (2008). Perceived benefits in trauma research: Examining methodological and individual difference factors in responses to research participation. *Journal of Empirical Research on Human Research Ethics*, 3(1), 35–47. <https://doi.org/10.1525/jer.2008.3.1.35>
- DePrince, A. P., & Freyd, J. J. (2006). Costs and benefits of being asked about trauma history. *Journal of Trauma Practice*, 3(4), 23–35. https://doi.org/10.1300/J189v03n04_02
- Devaney, J., & Spratt, T. (2009). Child abuse as a complex and wicked problem: Reflecting on policy developments in the United Kingdom in working with children and families with multiple problems. *Children and Youth Services Review*, 31(6), 635–641. <https://doi.org/10.1016/j.childyouth.2008.12.003>
- DeVault, M. L. (1999). *Liberating method: Feminism and social research*. Temple University Press.
- Dewey, S. C., & Germain, T. P. S. (2014). Social services fatigue in domestic violence service provision facilities. *Affilia*, 29(4), 389–403. <https://doi.org/10.1177/0886109914528700>
- Johnstone, L. & Boyle, M. with Cromby, Dillon, J., J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. British Psychological Society.
- Dixon, J., & Robb, M. (2016). Working with women with a learning disability experiencing domestic abuse: How social workers can negotiate competing

- definitions of risk. *British Journal of Social Work*, 46(3), 773–788. <https://doi.org/10.1093/bjsw/bcu149>
- Dokkedahl, S., Kristensen, T. R., Murphy, S., & Elklit, A. (2021). The complex trauma of psychological violence: Cross-sectional findings from a Cohort of four Danish Women Shelters. *European Journal of Psychotraumatology*, 12(1), Article 1863580. <https://doi.org/10.1080/20008198.2020.1863580>
- Dolezal, L., & Gibson, M. (2022). Beyond a trauma-informed approach and towards shame-sensitive practice. *Humanities and Social. Science Communication*, 9(1), 1–10.
- Domestic Abuse Commissioner. (2021). *Domestic abuse A patchwork of provision*. Summary Report [Online]. Retrieved November 2024, https://domesticabusecommissioner.uk/wp-content/uploads/2023/02/DAC_Mapping-Abuse-Suvivors_Summary-Report_Feb-2023_Digital.pdf
- Domestic Abuse Commissioner. (2022). *Joining the Dots: The importance of TI approaches across all frontline responses to Domestic Abuse* [Online]. Retrieved January 2024, <https://domesticabusecommissioner.uk/wp-content/uploads/2023/09/Joining-the-Dots-Ejaye-Moran-My-Sisters-Place-Presentation.pdf>
- Dominelli, L. (2017). Globalisation and gender relations in social work. In *Countering discrimination in social work* (pp. 15–32). Routledge.
- Domoney, J., Fulton, E., Stanley, N., McIntyre, A., Heslin, M., Byford, S., Bick, D., Ramchandani, P., MacMillan, H., Howard, L. M., & Trevillion, K. (2019). For Baby's Sake: Intervention Development and Evaluation Design of a Whole-Family Perinatal Intervention to Break the Cycle of Domestic Abuse. *Journal of Family Violence*, 34(6), 539–551. <https://doi.org/10.1007/s10896-019-00037-3>
- Doolabh, K., Fisher, C., & O'Donnell, M. (2022). Understanding the dynamics of support seeking in women with lived experience of non-physical intimate partner violence (IPV) and the service responses—A qualitative study. *Australian Journal of Social Issues*, 57(4), 861–879. <https://doi.org/10.1002/ajs4.227>

- Douglas, H., & Walsh, T. (2010). Mothers, domestic violence, and child protection: Toward collaboration and engagement. *Violence Against Women*, 16(5), 537–542. <https://doi.org/10.1177/1077801210366291>
- Dragiewicz, M., Woodlock, D., Easton, H., Harris, B., & Salter, M. (2023). 'I'll be okay': Survivors' perspectives on participation in domestic violence research. *Journal of Family Violence*, 38(6), 1139–1150. <https://doi.org/10.1007/s10896-023-00518-6>
- Duffy, S., & Hyde, C. (2011). *Women at the centre*. The Centre for Welfare Reform.
- Dunmore, E., Clark, D. M., & Ehlers, A. (1999). Cognitive factors involved in the onset and maintenance of posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy*, 37(9), 809–829. [https://doi.org/10.1016/s0005-7967\(98\)00181-8](https://doi.org/10.1016/s0005-7967(98)00181-8)
- Duthie, D. L. (2012). *Reinvigorating the domestic violence sector: Systemically addressing conflict, power and practitioner turnover* (Doctoral dissertation, Queensland University of Technology).
- Dutton, M. (1996). *Battered Women's Strategic Response to Violence: The role of context. Future interventions with battered women and their families*/Sage.
- Dutton, M. A., Goodman, L., & Schmidt, R. J. (2006). *Development and validation of a coercive control measure for intimate partner violence* [Final technical report] Article 214438. NCJ Publication.
- Dvir, Y., Ford, J. D., Hill, M., & Frazier, J. A. (2014). Childhood maltreatment, emotional dysregulation, and psychiatric comorbidities. *Harvard Review of Psychiatry*, 22(3), 149–161. <https://doi.org/10.1097/HRP.000000000000014>
- Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse*, 4(2), 196–231. <https://doi.org/10.1891/1946-6560.4.2.196>
- Edelman, N. L. (2023). Trauma and resilience informed research principles and practice: A framework to improve the inclusion and experience of disadvantaged

- populations in health and social care research. *Journal of Health Services Research and Policy*, 28(1), 66–75. <https://doi.org/10.1177/13558196221124740>
- Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33(4), 461–477. <https://doi.org/10.1002/jcop.20063>
- Elwyn, L. J., Esaki, N., & Smith, C. A. (2017). Importance of leadership and employee engagement in trauma-informed organizational change at a girls' juvenile justice facility. *Human Service Organizations: Management, Leadership and Governance*, 41(2), 106–118. <https://doi.org/10.1080/23303131.2016.1200506>
- Erikson, K. (1995). Notes on trauma and community. *American Imago*, 48(4), 455–472.
- Ernst, A. A., Weiss, S. J., & Enright-Smith, S. (2006). Child witnesses and victims in homes with adult intimate partner violence. *Academic Emergency Medicine*, 13(6), 696–699. <https://doi.org/10.1197/j.aem.2005.12.020>
- Evans, A., & Coccoma, P. (2014). *Trauma-informed care: How neuroscience influences practice*. Routledge.
- Evans, M., Gregory, A., Feder, G., Howarth, E., & Hegarty, K. (2016). Even'Daily'is not enough. *Violence and Victims*, 31(1), 3–26. <https://doi.org/10.1891/0886-6708.VV-D-15-00024>
- Evans, M. A., & Feder, G. S. (2016). Help-seeking amongst women survivors of domestic violence: A qualitative study of pathways towards formal and informal support. *Health Expectations*, 19(1), 62–73. <https://doi.org/10.1111/hex.12330>
- Fagerlund, M., Houtsonen, J., Notko, M., & Husso, M. (2022). Conceptualising violence in close relationships: Discrepancies between police conceptions and the letter of the law in Finland. *European Journal on Criminal Policy and Research*, 28(1), 37–56. <https://doi.org/10.1007/s10610-020-09448-1>
- Fallot, R. D., & Harris, M. (2002). The Trauma Recovery and Empowerment Model (TREM): Conceptual and practical issues in a group intervention for women.

- Community Mental Health Journal*, 38(6), 475–485.
<https://doi.org/10.1023/a:1020880101769>
- Fallot, R. D., McHugo, G. J., Harris, M., & Xie, H. (2011). The Trauma Recovery and Empowerment Model: A Quasi-Experimental Effectiveness Study. *Journal of Dual Diagnosis*, 7(1–2), 74–89. <https://doi.org/10.1080/15504263.2011.566056>
- Fassin, D., & Rechtman, R. (2009). *The empire of trauma: An inquiry into the condition of victimhood*. Princeton University Press.
- Featherstone, B., & Peckover, S. (2007). Letting them get away with it: Fathers, domestic violence and child welfare. *Critical Social Policy*, 27(2), 181–202. <https://doi.org/10.1177/0261018306075708>
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245–258. [https://doi.org/10.1016/s0749-3797\(98\)00017-8](https://doi.org/10.1016/s0749-3797(98)00017-8)
- Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual abuse, adolescent sexual behaviors and sexual revictimization. *Child Abuse and Neglect*, 21(8), 789–803. [https://doi.org/10.1016/s0145-2134\(97\)00039-2](https://doi.org/10.1016/s0145-2134(97)00039-2)
- Fernández-Fillol, C., Pitsiakou, C., Perez-Garcia, M., Teva, I., & Hidalgo-Ruzzante, N. (2021). Complex PTSD in survivors of intimate partner violence: Risk factors related to symptoms and diagnoses. *European Journal of Psychotraumatology*, 12(1), Article 2003616. <https://doi.org/10.1080/20008198.2021.2003616>
- Ferrari, G., Feder, G., Agnew-Davies, R., Bailey, J. E., Hollinghurst, S., Howard, L., Howarth, E., Sardinha, L., Sharp, D., & Peters, T. J. (2018). Psychological advocacy towards healing (PATH): A randomised controlled trial of a psychological intervention in a domestic violence service setting. *PLOS One*, 13(11), Article e0205485. <https://doi.org/10.1371/journal.pone.0205485>
- Ferraro, K. J. (2017). The words change, but the melody lingers: The persistence of the battered woman syndrome in criminal cases involving battered women. In *Feminist Theories of Crime*. Routledge, (377–396).

- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder-An overview. *Compassion fatigue*.
- Figley, C. R. (2013). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised*. Routledge.
- Figley, C. R., & McCubbin, H. I. (1983). Catastrophes: An overview of family reactions. *ARIEL*, 129(81), 82–190.
- Finkel, E. J., Eastwick, P. W., & Reis, H. T. (2015). Best research practices in psychology: Illustrating epistemological and pragmatic considerations with the case of relationship science. *Journal of Personality and Social Psychology*, 108(2), 275–297. <https://doi.org/10.1037/pspi0000007>
- Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Re-victimization patterns in a national longitudinal sample of children and youth. *Child Abuse and Neglect*, 31(5), 479–502. <https://doi.org/10.1016/j.chiabu.2006.03.012>
- Finley, L. L. (2010). Where's the peace in this movement? A domestic violence advocate's reflection on the movement. *Contemporary Justice Review*, 13(1), 57–69. <https://doi.org/10.1080/10282580903549219>
- Flyvbjerg, B. (2011). Case study. *The Sage handbook of qualitative research*, 4, 301–316.
- Foa, E. B., Chrestman, K. R., & Gilboa-Schechtman, E. (2009). *Prolonged exposure therapy for adolescents with PTSD emotional processing of traumatic experiences, therapist guide*. Oxford University Press.
- Fogarty, C. T., Fredman, L., Heeren, T. C., & Liebschutz, J. (2008). Synergistic effects of child abuse and intimate partner violence on depressive symptoms in women. *Preventive Medicine*, 46(5), 463–469. <https://doi.org/10.1016/j.ypmed.2007.12.009>
- Fohring, S. (2018). Revisiting the non-ideal victim. In *Revisiting the 'Ideal Victim'* (pp. 195–210). Policy Press. <https://doi.org/10.1332/policypress/9781447338765.003.0012>

- Fondren, K., Lawson, M., Speidel, R., McDonnell, C. G., & Valentino, K. (2020). Buffering the effects of childhood trauma within the school setting: A systematic review of trauma-informed and trauma-responsive interventions among trauma-affected youth. *Children and Youth Services Review*, 109, Article 104691. <https://doi.org/10.1016/j.childyouth.2019.104691>
- Forke, C. M., Myers, R. K., Fein, J. A., Catallozzi, M., Localio, A. R., Wiebe, D. J., & Grisso, J. A. (2018). Witnessing intimate partner violence as a child: How boys and girls model their parents' behaviors in adolescence. *Child Abuse and Neglect*, 84, 241–252. <https://doi.org/10.1016/j.chiabu.2018.07.031>
- Framework: A Reflective Framework for Mapping the Implementation Journey of Trauma-informed Care. medRxiv, pp.2022-04.
- Franke, H. A. (2014). Toxic stress: Effects, prevention and treatment. *Children*, 1(3), 390–402. <https://doi.org/10.3390/children1030390>
- Frankland, J., & Bloor, M. (1999). *Some issues arising in the systematic analysis of focus group materials*.
- Franklin, C. A., & Kercher, G. A. (2012). The intergenerational transmission of intimate partner violence: Differentiating correlates in a random community sample. *Journal of Family Violence*, 27(3), 187–199. <https://doi.org/10.1007/s10896-012-9419-3>
- Franzblau, S. H., Echevarria, S., Smith, M., & Van Cantfort, T. E. (2008). A preliminary investigation of the effects of giving testimony and learning yogic breathing techniques on battered women's feelings of depression. *Journal of Interpersonal Violence*, 23(12), 1800–1808. <https://doi.org/10.1177/0886260508314329>
- Fricke, M. (2007). Epistemic injustice: Power and the ethics of knowing. Oxford University Press. *Frontiers in psychiatry*, 9, 516.
- Frueh, B. C., Dalton, M. E., Johnson, M. R., Hiers, T. G., Gold, P. B., Magruder, K. M., & Santos, A. B. (2000). Trauma within the psychiatric setting: Conceptual framework, research directions, and policy implications. *Administration and Policy in Mental Health*, 28(2), 147–154. <https://doi.org/10.1023/a:1026611608299>

- Fuller, G. (2023). *On becoming trauma informed: Exploring the narratives of female survivors of intimate partner violence* (Doctoral dissertation, University of Essex).
- Gadd, D. (2012). Domestic abuse prevention after Raoul Moat. *Critical Social Policy*, 32(4), 495–516. <https://doi.org/10.1177/0261018312439361>
- Garland, D. (1996). The limits of the sovereign state: Strategies of crime control in contemporary society. *British Journal of Criminology*, 36(4), 445–471. <https://doi.org/10.1093/oxfordjournals.bjc.a014105>
- Garland, D. (2001). *The culture of control* Oxford University Press.
- Gatz, M., Brown, V., Hennigan, K., Rechberger, E., O'Keefe, M., Rose, T., & Bjelajac, P. (2007). Effectiveness of an integrated, trauma-informed approach to treating women with co-occurring disorders and histories of trauma: The Los Angeles site experience. *Journal of Community Psychology*, 35(7), 863–878. <https://doi.org/10.1002/jcop.20186>
- Gelsthorpe, L., & Hedderman, C. (2012). Providing for women offenders: The risks of adopting a payment by results approach. *Probation Journal*, 59(4), 374–390. <https://doi.org/10.1177/0264550512458477>
- George, A. L. (2005). *Case studies and theory development in the social sciences*. Belfer Center for Science and International Affairs.
- George, E., Iveson, C., & Ratner, H. (1999). *Problem to solution: Brief therapy with individuals and families*. BT Press, Iveson, E., C., & Ratner, H. (1999). *Problem to solution: Brief therapy with individuals and families*. BT Press.
- Gerber, M. R. (Ed.). (2019). *Trauma-informed healthcare approaches: A guide for primary care*. Springer.
- Giard, J., Hennigan, K., Huntington, N., Vogel, W., Rinehart, D., Mazelis, R., Nadlicki, T., & Veysey, B. M. (2005). Development and implementation of a multisite evaluation for the Women, Co-Occurring Disorders and Violence Study. *Journal of Community Psychology*, 33(4), 411–427. <https://doi.org/10.1002/jcop.20060>

- Gilfus, M. E., Fineran, S., Cohan, D. J., Jensen, S. A., Hartwick, L., & Spath, R. (1999). Research on violence against women: Creating survivor-informed collaborations. *Violence Against Women*, 5(10), 1194–1212. <https://doi.org/10.1177/10778019922183327>
- Gilligan, C. (1982). *In a different voice*. Harvard University Press.
- Glenn, C., & Goodman, L. (2015). Living with and within the rules of domestic violence shelters: A qualitative exploration of residents' experiences. *Violence Against Women*, 21(12), 1481–1506. <https://doi.org/10.1177/1077801215596242>
- Goddard, T. (2012). Post-welfarist risk managers? Risk, crime prevention and the responsabilization of community-based organizations. *Theoretical Criminology*, 16(3), 347–363. <https://doi.org/10.1177/1362480611433432>
- Goldthorpe, J., Khan, K., Stewart, H., Wheeler, P., & Coast, C. N. W. (2022). An evaluation of the Lancashire violence reduction network's trauma informed Lancashire communities early adopters [Online]. Retrieved January 2025, <https://traumainformedlancashire.co.uk/wp-content/uploads/2023/01/ARC-Evaluation-Trauma-Informed.pdf>
- Goodman, L., Dutton, M. A., Weinfurt, K., & Cook, S. (2003). The intimate partner violence strategies index: Development and application. *Violence Against Women*, 9(2), 163–186. <https://doi.org/10.1177/1077801202239004>
- Goodman, L. A., & Epstein, D. (2008). *Listening to battered women: A survivor-centered approach to advocacy, mental health, and justice*. American Psychological Association. <https://doi.org/10.1037/11651-000>
- Goodman, L. A., Sullivan, C. M., Serrata, J., Perilla, J., Wilson, J. M., Fauci, J. E., & DiGiovanni, C. D. (2016). Development and validation of the trauma-informed practice scales. *Journal of Community Psychology*, 44(6), 747–764. <https://doi.org/10.1002/jcop.21799>
- Gover, A. R., Kaukinen, C., & Fox, K. A. (2008). The relationship between violence in the family of origin and dating violence among college students. *Journal of Interpersonal Violence*, 23(12), 1667–1693. <https://doi.org/10.1177/0886260508314330>

- Grandey, A. A. (2000). Emotional regulation in the workplace: A new way to conceptualize emotional labor. *Journal of Occupational Health Psychology*, 5(1), 95–110. <https://doi.org/10.1037//1076-8998.5.1.95>
- Gray, M. J., Hassija, C. M., Jaconis, M., Barrett, C., Zheng, P., Steinmetz, S., & James, T. (2015). Provision of evidence-based therapies to rural survivors of domestic violence and sexual assault via telehealth: Treatment outcomes and clinical training benefits. *Training and Education in Professional Psychology*, 9(3), 235–241. <https://doi.org/10.1037/tep0000083>
- Griffin, M. G., Resick, P. A., Waldrop, A. E., & Mechanic, M. B. (2003). Participation in trauma research: Is there evidence of harm? *Journal of Traumatic Stress*, 16(3), 221–227. <https://doi.org/10.1023/A:1023735821900>
- Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, 85(2), 348–362. <https://doi.org/10.1037/0022-3514.85.2.348>
- Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit*. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Guillén, A. I., Panadero, S., Rivas, E., & Vázquez, J. J. (2015). Suicide attempts and stressful life events among female victims of intimate partner violence living in poverty in Nicaragua. *Scandinavian Journal of Psychology*, 56(3), 349–356. <https://doi.org/10.1111/sjop.12207>
- Gunby, C., Isham, L., Smailes, H., Bradbury-Jones, C., Damery, S., Harlock, J., Maxted, F., Smith, D., & Taylor, J. (2024). Working the edge: The emotional experiences of commissioning and funding arrangements for service leaders in the sexual violence voluntary sector. *Violence Against Women*, 30(8), 1783–1803. <https://doi.org/10.1177/10778012241239945>
- Gundacker, C., Barry, C., Laurent, E., & Sieracki, R. (2021). A scoping review of trauma-informed curricula for primary care providers. *Family Medicine*, 53(10), 843–856. <https://doi.org/10.22454/FamMed.2021.500263>

- Hacking, I. (1995). *The looping effects of human kinds*.
- Hague, G. (2021). *History and memories of the domestic violence movement: We've come further than you think*. Policy Press.
<https://doi.org/10.51952/9781447356349>
- Hague, G., & Mullender, A. (2006). Who listens? The voices of domestic violence survivors in service provision in the United Kingdom. *Violence Against Women*, 12(6), 568–587. <https://doi.org/10.1177/1077801206289132>
- Hague, G. M., & Malos, E. M. (1998). *Domestic violence: Action for change*. New Clarion Press.
- Hale, H., Bracewell, K., Bellussi, L., Jenkins, R., Alexander, J., Devaney, J., & Callaghan, J. E. M. (2024). The child protection response to domestic violence and abuse: A scoping review of interagency interventions, models and collaboration. *Journal of Family Violence*, 1–21. <https://doi.org/10.1007/s10896-024-00681-4>
- Hales, T. W., Green, S. A., Bissonette, S., Warden, A., Diebold, J., Koury, S. P., & Nochajski, T. H. (2019). Trauma-informed care outcome study. *Research on Social Work Practice*, 29(5), 529–539. <https://doi.org/10.1177/1049731518766618>
- Hales, T. W., Nochajski, T. H., Green, S. A., Hitzel, H. K., & Woike-Ganga, E. (2017). An association between implementing trauma-informed care and staff satisfaction. *Advances in Social Work*, 18(1), 300–312. <https://doi.org/10.18060/21299>
- Halliwell, G., Daw, J., Hay, S., Dheensa, S., & Jacob, S. (2021). 'A life barely half lived': Domestic abuse and sexual violence practitioners' experiences and perceptions of providing care to survivors of non-physical abuse within intimate partner relationships. *Journal of Gender-Based Violence*, 5(2), 249–269. <https://doi.org/10.1332/239868020X16068765721643>
- Hanford, W. (2020). *Trauma-informed approaches-What they are and how to introduce them*.
- Hanmer, J., & Itzin, C. (2013). *Home truths about domestic violence: Feminist influences on policy and practice-A reader*. Routledge.

- Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment*, 21(2), 95–100. <https://doi.org/10.1177/1077559516635274>
- Hanson, R. F., Lang, J. M., Fraser, J. G., Agosti, J. R., Ake, G. S., Donisch, K. M., & Gewirtz, A. H. (2018). Trauma-informed care: Definitions and state-wide initiatives. In *The APSAC handbook on child maltreatment* (pp. 272–291).
- Hanson, S. (2021). *How California became ACEs aware: A case study examining programme implementation during the COVID-19 pandemic* (Doctoral dissertation, The Claremont Graduate University).
- Hanson, S., & Patel, L. (2014). How theory shapes practice: Approaches to woman abuse and child abuse in South Africa. *British Journal of Social Work*, 44(8), 2237–2253. <https://doi.org/10.1093/bjsw/bct057>
- Harding, J. (2018). *Qualitative data analysis: From start to finish*.
- Harding, N. A. (2020). Co-constructing feminist research: Ensuring meaningful participation while researching the experiences of criminalised women. *Methodological Innovations*, 13(2), p.2059799120925262. <https://doi.org/10.1177/2059799120925262>
- Harding, S. (1986). *The science question in feminism*. Cornell University Press.
- Harne, L., & Radford, J. (2008). *Tackling domestic violence: Theories, policies and practice*. McGraw-Hill Education.
- Harnett, N. G., Goodman, A. M., & Knight, D. C. (2020). PTSD-related neuroimaging abnormalities in brain function, structure, and biochemistry. *Experimental Neurology*, 330, Article 113331. <https://doi.org/10.1016/j.expneurol.2020.113331>
- Harris. (2015). How childhood trauma affects health across a lifetime | Nadine Burke Harris. *Trans. Educ.* [Online]. Retrieved January 2024, <https://www.youtube.com/watch?v=95ovIJ3dsNk>
- Harris, H., Urdaneta, V., Triana, V., Vo, C. S., Walden, D., & Myers, D. (2018). A pilot study with Spanish-speaking Latina survivors of domestic violence comparing

- EMDR & TF-CBT group interventions. *Open Journal of Social Sciences*, 6(11), 203–222. <https://doi.org/10.4236/jss.2018.611015>
- Harris, L., & Hodges, K. (2019). Responding to complexity: Improving service provision for survivors of domestic abuse with “complex needs”. *Journal of Gender-Based Violence*, 3(2), 167–184. <https://doi.org/10.1332/239868019X15538587319964>
- Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services*, (89), 3–22. <https://doi.org/10.1002/yd.23320018903>
- Hartsock, N. C. (1983). *Money, sex, and power: Toward a feminist historical materialism*.
- Haslam, N. (2016). Concept creep: Psychology's expanding concepts of harm and pathology. *Psychological Inquiry*, 27(1), 1–17. <https://doi.org/10.1080/1047840X.2016.1082418>
- Haslam, N., Dakin, B. C., Fabiano, F., McGrath, M. J., Rhee, J., Vylomova, E., Weaving, M., & Wheeler, M. A. (2020a). Harm inflation: Making sense of concept creep. *European Review of Social Psychology*, 31(1), 254–286. <https://doi.org/10.1080/10463283.2020.1796080>
- Haslam, N., & McGrath, M. J. (2020). The creeping concept of trauma. *Social Research: An International Quarterly*, 87(3), 509–531. <https://doi.org/10.1353/sor.2020.0052>
- Haslam, N., Vylomova, E., Zyphur, M., & Kashima, Y. (2021). The cultural dynamics of concept creep. *The American Psychologist*, 76(6), 1013–1026. <https://doi.org/10.1037/amp0000847>
- Hawkesworth, M. E. (1987). Feminist epistemology: A survey of the field. *Journal of Women, Politics & Policy*, 7(3), 115–127. <https://doi.org/10.1080/1554477X.1987.9970498>
- Hayes, S., & Jeffries, S. (2013). Why do they keep going back? Exploring women's discursive experiences of intimate partner abuse. *International Journal of*

- Criminology and Sociology*, 2, 57–71. <https://doi.org/10.6000/1929-4409.2013.02.6>
- Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women*, 4(3), 262–290. <https://doi.org/10.1177/1077801298004003002>
- Helminen, M. (2019). ‘We need to make sure that we are always something else’: Victim support organisations and the increasing responsibility of the state in supporting crime victims in Finland and Norway. *International Review of Victimology*, 25(2), 157–179. <https://doi.org/10.1177/0269758018767668>
- Hendrix, E., Barusch, A., & Gringeri, C. (2021). Eats me alive!: Social workers reflect on practice in neoliberal contexts. *Social Work Education*, 40(2), 161–173. <https://doi.org/10.1080/02615479.2020.1718635>
- Heracleous, L., & Jacobs, C. D. (2008). Crafting strategy: The role of embodied metaphors. *Long Range Planning*, 41(3), 309–325. <https://doi.org/10.1016/j.lrp.2008.02.011>
- Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377–391. <https://doi.org/10.1002/jts.2490050305>
- Herman, J. L. (1992b). *Trauma and recovery* Judith Lewis Herman MD.
- Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence—From domestic abuse to political terror*. Palgrave Macmillan.
- Hermolle, M. (2023). I think if you cut me open, it runs through my veins: *Trauma-informed practice provision and training in Suffolk*.
- Hernández, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process*, 46(2). pp.229-241.ne, 229–241. <https://doi.org/10.1111/j.1545-5300.2007.00206.x>
- Heron, R. L., Eisma, M., & Browne, K. (2022). Why do female domestic violence victims remain in or leave abusive relationships? A qualitative study. *Journal of*

- Aggression, Maltreatment and Trauma*, 31(5), 677–694.
<https://doi.org/10.1080/10926771.2021.2019154>
- Heron, R. L., & Eisma, M. C. (2021). Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research. *Health and Social Care in the Community*, 29(3), 612–630.
<https://doi.org/10.1111/hsc.13282>
- Herry, C., & Garcia, R. (2002). Prefrontal cortex long-term potentiation, but not long-term depression, is associated with the maintenance of extinction of learned fear in mice. *The Journal of Neuroscience*, 22(2), 577–583.
<https://doi.org/10.1523/JNEUROSCI.22-02-00577.2002>
- Hertz, S. (2003). At arbejde systemisk i et diagnostisk felt. *Fokus På Familien*, 31(1), 22–32. <https://doi.org/10.18261/ISSN0807-7487-2003-01-03>
- Hesse-Biber, S. N., & Leavy, P. (2010). *The practice of qualitative research*. Sage Publications.
- Hester, M. (2006). Making it through the criminal justice system: Attrition and domestic violence. *Social Policy and Society*, 5(1), 79–90.
<https://doi.org/10.1017/S1474746405002769>
- Hester, M. (2011). The three planet model: Towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence. *British Journal of Social Work*, 41(5), 837–853.
<https://doi.org/10.1093/bjsw/bcr095>
- Hester, M. (2013). Who does what to whom? Gender and domestic violence perpetrators in English police records. *European Journal of Criminology*, 10(5), 623–637. <https://doi.org/10.1177/1477370813479078>
- Hickle, K. (2018). *Embedding a trauma-informed approach in the community and voluntary sector (YMCA)*.
- Hickle, K. (2019). Understanding trauma and its relevance to child sexual exploitation. In *Child sexual exploitation: Why theory matters* (pp. 151–172). Policy Press.
<https://doi.org/10.1332/policypress/9781447351412.003.0008>

- Higgins, D. J., & McCabe, M. P. (2001). Multiple forms of child abuse and neglect: Adult retrospective reports. *Aggression and Violent Behavior*, 6(6), 547–578. [https://doi.org/10.1016/S1359-1789\(00\)00030-6](https://doi.org/10.1016/S1359-1789(00)00030-6)
- Hilton, N. Z., Harris, G. T., & Rice, M. E. (2010). *Risk assessment for domestically violent men: Tools for criminal justice, offense*.
- Hinsliff-Smith, K., & McGarry, J. (2017). Understanding management and support for domestic violence and abuse within emergency departments: A systematic literature review from 2000–2015. *Journal of Clinical Nursing*, 26(23–24), 4013–4027. <https://doi.org/10.1111/jocn.13849>
- Hirst, A., & Rinne, S. (2012). *The impact of changes in commissioning and funding on women-only services*. Equality and Human Rights Commission.
- Hochschild, A. R. (2019). *The managed heart: Commercialization of human feeling*. University of California Press.
- Holliday, A. (2010). Submission, emergence and personal knowledge: New takes and principles for validity in decentred qualitative research. *Perils, Pitfalls and Reflexivity in Qualitative Research in Education*, 10–30.
- Holly, J. (2017). Mapping the Maze: Services for women experiencing multiple disadvantage in England and Wales. *London: Agenda & AVA*.
- Holstein, J. A., & Gubrium, J. F. (2004). Context: Working it up, down and across. In *Qualitative research practice* (pp. 267–281). Sage Publications, Ltd.. <https://doi.org/10.4135/9781848608191.d24>
- Holt, S. (2016). Domestic violence and the paradox of post-separation mothering. *British Journal of Social Work*, 47(7), 2049–2067. <https://doi.org/10.1093/bjsw/bcw162>
- Home Office. (2024). New measures set out to combat violence against women and girls [Online]. GOV.uk. <https://www.gov.uk/government/news/new-measures-set-out-to-combat-violence-against-women-and-girls>

- Home Office (2022) Domestic Abuse Act 2021 statutory guidance [Online]. Retrieved January 2025, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic Abuse Act 2021 Statutory Guidance.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf)
- Hooks, B., 2014. (1984). *Ain't I a woman: Black women and feminism*.
- Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings~!2009–08-20~!2009–09-28~!2010–03-22~! *The Open Health Services and Policy Journal*, 3(2), 80–100. <https://doi.org/10.2174/1874924001003020080>
- Howard, L. M. (2017). Routine enquiry about violence and abuse is needed for all mental health patients. *The British Journal of Psychiatry*, 210(4), 298–298. <https://doi.org/10.1192/bjp.210.4.298>
- Howarth, E., & Robinson, A. (2016). Responding effectively to women experiencing severe abuse: Identifying key components of a British advocacy intervention. *Violence Against Women*, 22(1), 41–63. <https://doi.org/10.1177/1077801215597789>
- Howarth, E. L., Stimpson, L., Barran, D., & Robinson, A. L. (2009). *Safety in numbers: A multisite evaluation of independent domestic violence advisor services*.
- Huberman, A. (2022). Dr. Paul Conti: Therapy, treating trauma & other life challenges | Huberman lab Podcast # 75 [Online]. YouTube. Retrieved January 2023, https://www.youtube.com/watch?v=IOI28gj_RXw
- Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet. Public Health*, 2(8), e356–e366. [https://doi.org/10.1016/S2468-2667\(17\)30118-4](https://doi.org/10.1016/S2468-2667(17)30118-4)
- Humphreys, C. (2000). *Social work, domestic violence and child protection: Challenging practice*. Policy Press.

- Humphreys, C., & Absler, D. (2011). History repeating: Child protection responses to domestic violence. *Child and Family Social Work*, 16(4), 464–473. <https://doi.org/10.1111/j.1365-2206.2011.00761.x>
- Humphreys, C., Diemer, K., Bornemisza, A., Spiteri-Staines, A., Kaspiw, R., & Horsfall, B. (2019). More present than absent: Men who use domestic violence and their fathering. *Child and Family Social Work*, 24(2), 321–329. <https://doi.org/10.1111/cfs.12617>
- Humphreys, C., & Healey, L. (2017). *PATHways and Research into Collaborative Interagency practice: Collaborative work across the child protection and specialist domestic and family violence interface: Final report (ANROWS Horizons 03/2017)*. ANROWS.
- Humphreys, C., & Joseph, S. (2004). Domestic violence and the politics of trauma. *Women's Studies International Forum*, 27(5–6), 559–570. <https://doi.org/10.1016/j.wsif.2004.09.010>
- Humphreys, C., Regan, L., River, D., & Thiara, R. K. (2005). Domestic violence and substance use: Tackling complexity. *British Journal of Social Work*, 35(8), 1303–1320. <https://doi.org/10.1093/bjsw/bch212>
- Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: “I call it symptoms of abuse”. *British Journal of Social Work*, 33(2), 209–226. <https://doi.org/10.1093/bjsw/33.2.209>
- Ishkanian, A. (2014). Neoliberalism and violence: The Big Society and the changing politics of domestic violence in England. *Critical Social Policy*, 34(3), 333–353. Islam, T.M. <https://doi.org/10.1177/0261018313515973>
- Isobel, S., & Edwards, C. (2017). Using trauma informed care as a nursing model of care in an acute inpatient mental health unit: A practice development process. *International Journal of Mental Health Nursing*, 26(1), 88–94. <https://doi.org/10.1111/inm.12236>
- Itzin, C. (2013). Gendering domestic violence: The influence of feminism on policy and practice. In *Home truths about domestic violence* (pp. 356–380). Routledge.

- Iverson, K. M., Gradus, J. L., Resick, P. A., Suvak, M. K., Smith, K. F., & Monson, C. M. (2011). Cognitive-behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. *Journal of Consulting and Clinical Psychology*, 79(2), 193–202. <https://doi.org/10.1037/a0022512>
- Jackson, C., Nissenson, K., & Cloitre, M. (2009). Cognitive-behavioral therapy. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders. An evidence-based guide*. Guilford Press.
- Jackson, D., & Mannix, J. (2004). Giving voice to the burden of blame: A feminist study of mothers' experiences of mother blaming. *International Journal of Nursing Practice*, 10(4), 150–158. <https://doi.org/10.1111/j.1440-172X.2004.00474.x>
- Jaffe, A. E., DiLillo, D., Hoffman, L., Haikal, M., & Dykstra, R. E. (2015). Does it hurt to ask? A meta-analysis of participant reactions to trauma research. *Clinical Psychology Review*, 40, 40–56. <https://doi.org/10.1016/j.cpr.2015.05.004>
- Jaggar, A. M. (2000). Ethics naturalised: Feminism's contribution to moral epistemology. *Metaphilosophy*, 31(5), 452–468. <https://doi.org/10.1111/1467-9973.00163>
- Jaggar, A. M. (2014). Love and knowledge: Emotion in feminist epistemology. In *Feminist social thought* (pp. 384–405). Routledge
- Jankowski, M. K., Leitenberg, H., Henning, K., & Coffey, P. (1999). Intergenerational transmission of dating aggression as a function of witnessing only same sex parents vs. opposite sex parents vs. both parents as perpetrators of domestic violence. *Journal of Family Violence*, 14(3), 267–279. <https://doi.org/10.1023/A:1022814416666>
- Janoff-Bulman, R. (1979). Characterological versus behavioral self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology*, 37(10), 1798–1809. <https://doi.org/10.1037//0022-3514.37.10.1798>
- Johnson, D. M., Zlotnick, C., & Perez, S. (2011). Cognitive behavioral treatment of PTSD in residents of battered women's shelters: Results of a randomised clinical

- trial. *Journal of Consulting and Clinical Psychology*, 79(4), 542–551.
<https://doi.org/10.1037/a0023822>
- Johnson, M. P. (2008). *A typology of domestic violence: Intimate terrorism, violent resistance and situational couple violence*. Northeastern University Press.
- Jolof, L., Rocca, P., & Carlsson, T. (2024). Women's experiences of trauma-informed care for forced migrants: A qualitative interview study. *Heliyon*, 10(7)
- Index of Multiple Deprivation (IMD). (2015). *North east information, English indices of deprivation 2015* [Online]. Retrieved December 2023, <https://www.vonne.org.uk/sites/default/files/files/resources/North%20East%20IMD%20info.pdf>
- Islam, T. M., Tareque, M. I., Tiedt, A. D., & Hoque, N. (2014). The intergenerational transmission of intimate partner violence in Bangladesh. *Global Health Action*, 7(1), Article 23591. <https://doi.org/10.3402/gha.v7.23591>
- JTAI inspection report. (2020). Retrieved March 28, 2023, <https://assets-hmicfrs.justiceinspectors.gov.uk/uploads/Plymouth-JTAI-inspection-report-.pdf>
- Kail, A. (2011). Why violence against women charities may be vulnerable. *NPC Blog*, 28.
- Kalmuss, D. (1984). The intergenerational transmission of marital aggression. *Journal of Marriage and the Family*, 46(1), 11–19. <https://doi.org/10.2307/351858>
- Karakurt, G., Smith, D., & Whiting, J. (2014). Impact of intimate partner violence on women's mental health. *Journal of Family Violence*, 29(7), 693–702. <https://doi.org/10.1007/s10896-014-9633-2>
- Karatzias, T., Hyland, P., Ben-Ezra, M., & Shevlin, M. (2018). Hyper and hypo-activation affective dysregulation symptoms are integral in complex PTSD (CPTSD): Results from a nonclinical Israeli sample. *International Journal of Methods in Psychiatric Research*, 27(4). <https://doi.org/10.1002/mpr.1745>
- Karatzias, T., Shevlin, M., Hyland, P., Brewin, C. R., Cloitre, M., Bradley, A., Kitchiner, N. J., Jumbe, S., Bisson, J. I., & Roberts, N. P. (2018). The role of negative

- cognitions, emotion regulation strategies, and attachment style in complex post-traumatic stress disorder: Implications for new and existing therapies. *British Journal of Clinical Psychology*, 57(2), 177–185. <https://doi.org/10.1111/bjc.12172>
- Kaslow, N. J., Leiner, A. S., Reviere, S., Jackson, E., Bethea, K., Bhaju, J., Rhodes, M., Gantt, M.-J., Senter, H., & Thompson, M. P. (2010). Suicidal, abused African American women's response to a culturally informed intervention. *Journal of Consulting and Clinical Psychology*, 78(4), 449–458. <https://doi.org/10.1037/a0019692>
- Katz, J., & Moore, L. (Eds.). (2013). *The 1980s*. Jossey-Bass.
- Kaukinen, C. (2004). Status compatibility, physical violence, and emotional abuse in intimate relationships. *Journal of Marriage and Family*, 66(2), 452–471. <https://doi.org/10.1111/j.1741-3737.2004.00031.x>
- Keeling, J., & Van Wormer, K. (2012). Social worker interventions in situations of domestic violence: What we can learn from survivors' personal narratives? *British Journal of Social Work*, 42(7), 1354–1370. <https://doi.org/10.1093/bjsw/bcr137>
- Keeney, B. P. (1979). Ecosystemic epistemology: An alternative paradigm for diagnosis. *Family Process*, 18(2), 117–129. <https://doi.org/10.1111/j.1545-5300.1979.00117.x>
- Keesler, J. M. (2016). Trauma-informed day services for individuals with intellectual/developmental disabilities: Exploring staff understanding and perception within an innovative programme. *Journal of Applied Research in Intellectual Disabilities*, 29(5), 481–492. <https://doi.org/10.1111/jar.12197>
- Keesler, J. M., & Isham, C. (2017). Trauma-informed day services: An initial conceptualization and preliminary assessment. *Journal of Policy and Practice in Intellectual Disabilities*, 14(2), 164–175. <https://doi.org/10.1111/jppi.12206>
- Kelly, A. (2015). Trauma-informed mindfulness-based stress reduction: A promising new model for working with survivors of interpersonal violence. *Smith College Studies in Social Work*, 85(2), 194–219. <https://doi.org/10.1080/00377317.2015.1021191>

- Kelly, A., & Garland, E. L. (2016). Trauma-informed mindfulness-based stress reduction for female survivors of interpersonal violence: Results from a stage I RCT. *Journal of Clinical Psychology*, 72(4), 311–328. <https://doi.org/10.1002/jclp.22273>
- Kelly, L. (2003). The wrong debate: Reflections on why force is not the key issue with respect to trafficking in women for sexual exploitation. *Feminist Review*, 73(1), 139–144. <https://doi.org/10.1057/palgrave.fr.9400086>
- Kelly, L. (2005). Inside outsiders: Mainstreaming violence against women into human rights discourse and practice. *International Feminist Journal of Politics*, 7(4), 471–495. <https://doi.org/10.1080/14616740500284391>
- Kelly, L., & Coy, M. (2011). *Islands in the stream: An evaluation of four London independent domestic violence advocacy schemes*.
- Kelly, L., Sharp-Jeffs, N., & Klein, R. (2014). *Finding the costs of freedom: How women and children rebuild their lives after domestic violence*.
- Kelly, P. (2001). Youth at risk: Processes of individualisation and responsibilisation in the risk society. *Discourse: Studies in the Cultural Politics of Education*, 22(1), 23–33. <https://doi.org/10.1080/01596300120039731>
- Kemp, A., Green, B. L., Hovanitz, C., & Rawlings, E. I. (1995). Incidence and correlates of posttraumatic stress disorder in battered women: Shelter and community samples. *Journal of Interpersonal Violence*, 10(1), 43–55. <https://doi.org/10.1177/088626095010001003>
- Kemshall, H. (2001). *Risk, social policy and welfare*. McGraw-Hill Education.
- Kendall, A. C., & C. (2024). Social workers ‘must be taught’ to spot controlling behaviour [Online]. Retrieved December 2024, <https://www.bbc.co.uk/news/articles/cn4970jdqq7o>
- Kendall, S., & Halliday, L. E. (2014). Undertaking ethical qualitative research in public health: Are current ethical processes sufficient? *Australian and New Zealand Journal of Public Health*, 38(4), 306–310. <https://doi.org/10.1111/1753-6405.12250>

- Kennedy, A. C., Prock, K. A., Adams, A. E., Littwin, A., Meier, E., Saba, J., & Vollinger, L. (2024). Can this provider be trusted? A review of the role of trustworthiness in the provision of community-based services for intimate partner violence survivors. *Trauma, Violence and Abuse*, 25(2), 982–999. <https://doi.org/10.1177/15248380231168641>
- Kernic, M. A., Holt, V. L., Stoner, J. A., Wolf, M. E., & Rivara, F. P. (2003). Resolution of depression among victims of intimate partner violence: Is cessation of violence enough? *Violence and Victims*, 18(2), 115–129. <https://doi.org/10.1891/vivi.2003.18.2.115>
- Kesteren, J. V., Dijk, J. V., & Mayhew, P. (2014). The international crime victims surveys: A retrospective. *International Review of Victimology*, 20(1), 49–69. <https://doi.org/10.1177/0269758013511742>
- Khadra, C., Wehbe, N., Lachance Fiola, J., Skaff, W., & Nehmé, M. (2015). Symptoms of post-traumatic stress disorder among battered women in Lebanon: An exploratory study. *Journal of Interpersonal Violence*, 30(2), 295–313. <https://doi.org/10.1177/0886260514534774>
- Killeen, T., Hien, D., Campbell, A., Brown, C., Hansen, C., Jiang, H., Kristman-Valente, A., Neuenfeldt, C., Rocz-de la Luz, N., Sampson, R., Suarez-Morales, L., Wells, E., Brigham, G., & Nunes, E. (2008). Adverse events in an integrated trauma-focused intervention for women in community substance abuse treatment. *Journal of Substance Abuse Treatment*, 35(3), 304–311. <https://doi.org/10.1016/j.jsat.2007.12.001>
- Kim, J., Aggarwal, A., Maloney, S., & Tibbits, M. (2021). Organizational assessment to implement trauma-informed care for first responders, child welfare providers, and healthcare professionals. *Professional Psychology: Research and Practice*, 52(6), 569–578. <https://doi.org/10.1037/pro0000408>
- Kim, M. (2002). *Innovative strategies to address domestic violence in Asian and Pacific Islander communities: Examining themes, models, and interventions*. San Francisco: Asian & Pacific Islander Institute on Domestic Violence.
- Kimberg, L., & Wheeler, M. (2019). Trauma and trauma-informed care. In M. R. Gerber (Ed.), *Trauma-informed healthcare approaches: A guide for primary care* (pp. 25–

- 56). Springer International Publishing. https://doi.org/10.1007/978-3-030-04342-1_2
- Kipping, C. J., & Hickey, G. (1998). Exploring mental health nurses' expectations and experiences of working in the community. *Journal of Clinical Nursing*, 7(6), 531–538. <https://doi.org/10.1046/j.1365-2702.1998.00182.x>
- Kirkwood, C. (1993). *Leaving abusive partners: From the scars of survival to the wisdom for change*. Sage Publications.
- Kitzinger, C. (1994). Anti-lesbian harassment. *Rethinking Sexual Harassment*, 125–147.
- Knudson-Martin, C., McDowell, T., & Bermudez, J. M. (2019). From knowing to doing: Guidelines for socioculturally attuned family therapy. *Journal of Marital and Family Therapy*, 45(1), 47–60. <https://doi.org/10.1111/jmft.12299>
- Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., Brymer, M. J., & Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, 39(4), 396–404. <https://doi.org/10.1037/0735-7028.39.4.396>
- Koopman, C., Ismailji, T., Holmes, D., Classen, C. C., Palesh, O., & Wales, T. (2005). The effects of expressive writing on pain, depression and posttraumatic stress disorder symptoms in survivors of intimate partner violence. *Journal of Health Psychology*, 10(2), 211–221. <https://doi.org/10.1177/1359105305049769>
- Koopman, C., Ismailji, T., Palesh, O., Gore-Felton, C., Narayanan, A., Saltzman, K. M., Holmes, D., & McGarvey, E. L. (2007). Relationships of depression to child and adult abuse and bodily pain among: Women who have experienced intimate partner violence. *Journal of Interpersonal Violence*, 22(4), 438–455. <https://doi.org/10.1177/0886260506297028>
- Kozłowska, W. (2020). A thematic analysis of practitioners' understanding of domestic abuse in terms of post-traumatic stress disorder (PTSD) and complex- PTSD (C-PTSD). *Counselling and Psychotherapy Research*, 20(2), 357–367. <https://doi.org/10.1002/capr.12272>

- Kramer, M. G. (2016). Sanctuary in a residential treatment center: Creating a therapeutic community of hope countering violence. *Therapeutic Communities*, 37(2), 69–83. <https://doi.org/10.1108/TC-01-2015-0005>
- Kramsch, C. (2014). Identity and subjectivity: Different timescales, different methodologies. In *Researching identity and interculturality* (pp. 211–230). Routledge.
- Krause, E. D., Kaltman, S., Goodman, L. A., & Dutton, M. A. (2008). Avoidant coping and PTSD symptoms related to domestic violence exposure: A longitudinal study. *Journal of Traumatic Stress*, 21(1), 83–90. <https://doi.org/10.1002/jts.20288>
- Krause, N., Shaw, B. A., & Cairney, J. (2004). A descriptive epidemiology of lifetime trauma and the physical health status of older adults. *Psychology and Aging*, 19(4), 637–648. <https://doi.org/10.1037/0882-7974.19.4.637>
- Krauss, S. E., Hamzah, A., Omar, Z., Suandi, T., Ismail, I. A., Zahari, M. Z., & Nor, Z. M. (2014). Preliminary investigation and interview guide development for studying how Malaysian farmers' form their mental models of farming. *The Qualitative Report*, 14(2), 245. <https://doi.org/10.46743/2160-3715/2009.1382>
- Krishnan, S. P., Hilbert, J. C., & VanLeeuwen, D. (2001). Domestic violence and help-seeking behaviors among rural women: Results from a shelter-based study. *Family and Community Health*, 24(1), 28–38. <https://doi.org/10.1097/00003727-200104000-00006>
- Kropp, P. R., Hart, S. D., Webster, C. D., & Eaves, D. (1994). *Manual for the spousal assault risk assessment guide*. The British Columbia Institute Against Family Violence. Kuhn, M. and Johnson, K. (2013), *Applied Predictive Modeling*. Springer.
- Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The Lancet*, 360(9339), 1083–1088. [https://doi.org/10.1016/S0140-6736\(02\)11133-0](https://doi.org/10.1016/S0140-6736(02)11133-0)
- Kubany, E. S., Hill, E. E., Owens, J. A., Iannce-Spencer, C., McCaig, M. A., Tremayne, K. J., & Williams, P. L. (2004). Cognitive trauma therapy for battered women with PTSD (CTT-BW). *Journal of Consulting and Clinical Psychology*, 72(1), 3–18. <https://doi.org/10.1037/0022-006X.72.1.3>

- Kulkarni, S. (2019). Intersectional trauma-informed intimate partner violence (IPV) services: Narrowing the gap between IPV service delivery and survivor needs. *Journal of Family Violence*, 34(1), 55–64. <https://doi.org/10.1007/s10896-018-0001-5>
- Kulkarni, S., Bell, H., Hartman, J. L., & Herman-Smith, R. L. (2013). Exploring individual and organizational factors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence service providers. *Journal of the Society for Social Work and Research*, 4(2), 114–130. <https://doi.org/10.5243/jsswr.2013.8>
- Kulkarni, S. J., Stylianou, A. M., & Wood, L. (2019). Successful rules reduction implementation process in domestic violence shelters: From vision to practice. *Social Work*, 64(2), 147–156. <https://doi.org/10.1093/sw/swz010>
- Kuruppu, J., Humphreys, C., McKibbin, G., & Hegarty, K. (2022). Tensions in the therapeutic relationship: Emotional labour in the response to child abuse and neglect in primary healthcare. *BMC Primary Care*, 23(1), 48. <https://doi.org/10.1186/s12875-022-01661-7>
- Kusmaul, N., Wilson, B., & Nochajski, T. (2015). The infusion of trauma-informed care in organizations: Experience of agency staff. *Human Service Organizations Management, Leadership & Governance*, 39(1), 25–37. <https://doi.org/10.1080/23303131.2014.968749>
- Kusmaul, N., Wolf, M. R., Sahoo, S., Green, S. A., & Nochajski, T. H. (2019). Client experiences of trauma-informed care in social service agencies. *Journal of Social Service Research*, 45(4), 589–599. <https://doi.org/10.1080/01488376.2018.1481178>
- Kvale, S. (2007). *Doing interviews*. Sage Publications. <https://doi.org/10.4135/9781849208963>
- Ladd-Taylor, M. (2004). Mother-worship/mother-blame: Politics and welfare in an uncertain age. *Journal of the Motherhood Initiative for Research and Community Involvement*.

- Laing, L., Humphreys, C., & Cavanagh, K. (2013). *Social work and domestic violence: Developing critical and reflective practice*. Sage Publications, Ltd.. <https://doi.org/10.4135/9781529681352>
- Lakoff, G., & Johnson, M. (1999). *Philosophy in the flesh—The embodied mind and its challenge to Western Thought*. Basic Books.
- Lamb, H., Moreton, R., Welford, J., Leonardi, S., O'Donnell, J., & Howe, P. (2019). What makes a difference?. *Evaluation of fulfilling lives: Supporting people with multiple needs*. The National Lottery.
- Lancashire Violence Reduction Network, & Clarke, S. (2024). Lancashire Violence Reduction Network annual report | 2023–2024 [Online]. Retrieved January 2025, <https://lancsvrn.co.uk/wp-content/uploads/2024/04/LVRN-Annual-Report.pdf>
- Lane, K., Judy, A., & Sweet, M. (2011). A practical guide for creating trauma-informed disability, domestic violence, and sexual assault organizations. *Violence against women with disabilities and deaf women project of Wisconsin*. <http://www.disabilityrightswi.org/wp-content/uploads/2012/05/Trauma-Informed-Guide.pdf>
- Lannamann, J. W., & McNamee, S. (2020). Unsettling trauma: From individual pathology to social pathology. *Journal of Family Therapy*, 42(3), 328–346. <https://doi.org/10.1111/1467-6427.12288>
- Lapierre, S. (2010). More responsibilities, less control: Understanding the challenges and difficulties involved in mothering in the context of domestic violence. *British Journal of Social Work*, 40(5), 1434–1451. <https://doi.org/10.1093/bjsw/bcp080>
- Lazar, R. (2008). Reconceptualizing victimization and agency in the discourse of battered women who kill. In *Studies in law*, (pp. 3–45). Emerald Group Publishing Limited. [https://doi.org/10.1016/S1059-4337\(08\)45001-9](https://doi.org/10.1016/S1059-4337(08)45001-9)
- LeBlanc, S., & Kinsella, E. A. (2016). Toward epistemic justice: A critically reflexive examination of 'sanism' and implications for knowledge generation. *Studies in Social Justice*, 10(1), 59–78. <https://doi.org/10.26522/ssj.v10i1.1324>

- Lee, A. T., Chin, P., Nambiar, A., & Hill Haskins, N. (2023). Addressing intergenerational trauma in Black families: Trauma-informed socioculturally attuned family therapy. *Journal of Marital and Family Therapy*, 49(2), 447–462. <https://doi.org/10.1111/jmft.12632>
- Lehrner, A., & Allen, N. E. (2009). Still a movement after all these years? Current tensions in the domestic violence movement. *Violence Against Women*, 15(6), 656–677. <https://doi.org/10.1177/1077801209332185>
- Lein, L., Jacquet, S. E., Lewis, C. M., Cole, P. R., & Williams, B. B. (2001). With the best of intentions: Family violence option and abused women's needs. *Violence Against Women*, 7(2), 193–210. <https://doi.org/10.1177/10778010122182398>
- Leiter, M. P., & Maslach, C. (1999). Six areas of worklife: A model of the organizational context of burnout. *Journal of Health and Human Services Administration*, 21(4), 472–489.
- Levenson, J. (2017). Trauma-informed social work practice. *Social Work*, 62(2), 105–113. <https://doi.org/10.1093/sw/swx001>
- Levine, P. A. (2010). In an unspoken voice: How the body releases trauma and restores goodness. *North Atlantic Books*.
- Lewis-O'Connor, A., & Chadwick, M. (2015). Engaging the voice of patients affected by gender-based violence: Informing practice and policy. *Journal of Forensic Nursing*, 11(4), 240–249. <https://doi.org/10.1097/JFN.0000000000000090>
- Liang, B., Tracy, A., Taylor, C. A., Williams, L. M., Jordan, J. V., & Miller, J. B. (2002). The relational health indices: A study of women's relationships. *Psychology of Women Quarterly*, 26(1), 25–35. <https://doi.org/10.1111/1471-6402.00040>
- Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child–parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(12), 1241–1248. <https://doi.org/10.1097/01.chi.0000181047.59702.58>

- Lilja, M., & Vinthagen, S. (2018). Dispersed resistance: Unpacking the spectrum and properties of glaring and everyday resistance. *Journal of Political Power*, 11(2), 211–229. <https://doi.org/10.1080/2158379X.2018.1478642>
- Lim, B. H. P., Valdez, C. E., & Lilly, M. M. (2015). Making meaning out of interpersonal victimization: The narratives of IPV survivors. *Violence Against Women*, 21(9), 1065–1086. <https://doi.org/10.1177/1077801215590670>
- Lipsky, M. (2010). *Street-level bureaucracy: Dilemmas of the individual in public service*. Russell Sage Foundation.
- Liu, V. C., Nelson, L. E., & Shorey, S. (2024). Experiences of women receiving trauma-informed care: a qualitative systematic review. *Trauma, Violence, & Abuse*, 25(4), 3054-3065.
- Women's aid. (2021). *Literature review on domestic abuse: A review of the current evidence base*. [pdf]. Retrieved November 27, 2024, <https://www.womensaid.org.uk/wp-content/uploads/2021/12/FINAL-WA-literature-review.pdf>
- Lloyd, M., & Ramon, S. (2017). Smoke and mirrors: UK newspaper representations of intimate partner domestic violence. *Violence Against Women*, 23(1), 114–139. <https://doi.org/10.1177/1077801216634468>
- Lohmann, S., Cowlishaw, S., Ney, L., O'Donnell, M., & Felmingham, K. (2024). The trauma and mental health impacts of coercive control: A systematic review and meta-analysis. *Trauma, Violence and Abuse*, 25(1), 630–647. <https://doi.org/10.1177/15248380231162972>
- Longino, H. E. (2017). *Feminist epistemology*. *The Blackwell guide to epistemology* (pp. 325–353).
- Lorås, L., & Sundelin, J. (2018). The multi-epistemological systemic therapist: A qualitative study. *Australian and New Zealand Journal of Family Therapy*, 39(4), 408–420. <https://doi.org/10.1002/anzf.1335>
- Lorde, A. (1984). *Sister outsider: Essays and speeches*. Berkeley, Calif (pp. 36–39). Crossing Press, 2015

- Lorde, A. (1995). *The black unicorn: Poems*. Norton.
- Lovenduski, J., & Randall, V. (1993). *Contemporary feminist politics: Women and power in Britain*.
- Lowenthal, A. (2020). Trauma-informed care implementation in the child- and youth-serving sectors: A scoping review. *International Journal of Child and Adolescent Resilience*, 7(1), 178–194. <https://doi.org/10.7202/1072597ar>
- Lundgren, E. (1998). The hand that strikes and comforts: Gender construction and the tension between body and symbol. In R. E. Dobash & R. P. Dobash (Eds.), *Rethinking violence against women* (pp. 169–198). Sage Publications. <https://doi.org/10.4135/9781452243306.n7>
- MacAlister, J. (2022). The independent review of children's social care [Online]. Retrieved April 2024, <https://bettercarenetwork.org/sites/default/files/2022-12/the-independent-review-of-childrens-social-care-final-report.pdf>
- Maclean, C., Brodie, Z., Hawkins, R., & McKinlay, J. C. (2024). 'At Times it's Too Difficult, it is Too Traumatic, it's Too Much': The Emotion Work of Domestic Abuse Helpline Staff during Covid-19. *Work, Employment and Society*, 38(5), 1267–1284. <https://doi.org/10.1177/09500170231200080>
- Maclean, S., Finch, J., & Tadam, P. (2018). *SHARE: A new model for social work*. Kirwin Maclean Associates Limited.
- Macvean, M. (2015). *The PATRICIA project: PATHways in research in collaborative interagency working*.
- Mahon, D. (2022). Implementing trauma informed care in human services: An ecological scoping review. *Behavioral Sciences*, 12(11), 431. <https://doi.org/10.3390/bs12110431>
- Mahoney, M. R. (2013). Victimization or oppression? Women's lives, violence, and agency. In *The public nature of private violence* (pp. 59–92). Routledge.

- Makice, K. (2009). Phatics and the design of community. In *CHI2009 extended abstracts on human factors in computing systems* (pp. 3133–3136). ACM. <https://doi.org/10.1145/1520340.1520445>
- Maldonado, A. I., Murphy, C. M., Davis, M., Evans, M. K., & Zonderman, A. B. (2022). Racial discrimination, mental health symptoms, and intimate partner violence perpetration in Black adults. *Journal of Consulting and Clinical Psychology, 90*(3), 209–220. <https://doi.org/10.1037/ccp0000712>
- Mallender, J., Venkatachalam, M., Onwude, O., & Jhita, T. (2013). *Economic analysis of interventions to reduce incidence and harm of domestic violence*. National Institute for Health and Care Excellence.
- Markowitz, L., & Tice, K. W. (2002). Paradoxes of professionalization: Parallel dilemmas in women's organizations in the Americas. *Gender and Society, 16*(6), 941–958. <https://doi.org/10.1177/089124302237896>
- Mars, B., Heron, J., Klonsky, E. D., Moran, P., O'Connor, R. C., Tilling, K., Wilkinson, P., & Gunnell, D. (2019). Predictors of future suicide attempt among adolescents with suicidal thoughts or non-suicidal self-harm: A population-based birth cohort study. *The Lancet. Psychiatry, 6*(4), 327–337. [https://doi.org/10.1016/S2215-0366\(19\)30030-6](https://doi.org/10.1016/S2215-0366(19)30030-6)
- Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior, 2*(2), 99–113. <https://doi.org/10.1002/job.4030020205>
- Maté, G. (2011). *When the body says no: The cost of hidden stress*. Vintage Canada.
- Mate, G. (2023). Big “T” vs Little “t” Trauma | *Understanding Our Wounding* –w/Dr. Gabor Maté [online vide]. YouTube. Retrieved 11/12/2024, <https://www.youtube.com/watch?v=Y0EPTgEDtyU>
- Matlin, S. L., Champine, R. B., Strambler, M. J., O'Brien, C., Hoffman, E., Whitson, M., Kolka, L., & Tebes, J. K. (2019). A community's response to adverse childhood experiences: Building a resilient, trauma-informed community. *American Journal of Community Psychology, 64*(3–4), 451–466. <https://doi.org/10.1002/ajcp.12386>

- Maynard, M. (1993). *Violence towards women* (pp. 99–122). Palgrave Macmillan UK.
- Mbaegbu, C. C. (2016). The mind body problem: The hermeneutics of African philosophy. *Unizik Journal of Religion and Human Relations*, 8(2), 2–18.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatisation: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131–149. <https://doi.org/10.1007/BF00975140>
- McCarthy, L. (2022). *Trauma-informed approaches in homelessness practice: An exploration of practitioner understandings and implementation*.
- McCarthy, L., & Nicholson-Pallett, P. (2022). *Are you listening? 7 Pillars for a survivor-led approach to mental health support*.
- McCarthy, L., Parr, S., Green, S., & Reeve, K. (2020). *Understanding models of support for people facing multiple disadvantage: A literature review*. Centre for Regional Economic and Social Research—Sheffield Hallam University.
- McGeown, H., Potter, L., Stone, T., Swede, J., Cramer, H., Bridging Gaps Group, Horwood, J., Carvalho, M., Connell, F., Feder, G., & Farr, M. (2023). Trauma-informed co-production: Collaborating and combining expertise to improve access to primary care with women with complex needs. *Health Expectations*, 26(5), 1895–1914. <https://doi.org/10.1111/hex.13795>
- McHugo, G. J., Kammerer, N., Jackson, E. W., Markoff, L. S., Gatz, M., Larson, M. J., Mazelis, R., & Hennigan, K. (2005). Women, co-occurring disorders, and violence study: Evaluation design and study population. *Journal of Substance Abuse Treatment*, 28(2), 91–107. <https://doi.org/10.1016/j.jsat.2004.08.009>
- McKeever, V. M., & Huff, M. E. (2003). A diathesis-stress model of posttraumatic stress disorder: Ecological, biological, and residual stress pathways. *Review of General Psychology*, 7(3), 237–250. <https://doi.org/10.1037/1089-2680.7.3.237>
- McKenzie-Mohr, S., Coates, J., & McLeod, H. (2012). Responding to the needs of youth who are homeless: Calling for politicised trauma-informed intervention. *Children and Youth Services Review*, 34(1), 136–143. <https://doi.org/10.1016/j.childyouth.2011.09.008>

- McLeod, A. (2008). *Listening to children: A practitioner's guide*. Jessica Kingsley Publishers.
- McManus, S., Walby, S., Barbosa, E. C., Appleby, L., Brugha, T., Bebbington, P. E., Cook, E. A., & Knipe, D. (2022). Intimate partner violence, suicidality, and self-harm: A probability sample survey of the general population in England. *The Lancet. Psychiatry*, 9(7), 574–583. [https://doi.org/10.1016/S2215-0366\(22\)00151-1](https://doi.org/10.1016/S2215-0366(22)00151-1)
- McNally, K., Ragan, K., Varese, F., & Lovell, K. (2023). The ongoing importance of the routine enquiry into trauma and abuse and trauma-informed care within mental health trusts in England. *Journal of Psychiatric and Mental Health Nursing*, 30(6), 1130–1136. <https://doi.org/10.1111/jpm.12947>
- McPhee, D., Hester, M., Bates, L., Lilley-Walker, S. J., & Patsios, D. (2022). Criminal justice responses to domestic violence and abuse in England: An analysis of case attrition and inequalities using police data. *Policing and Society*, 32(8), 963–980. <https://doi.org/10.1080/10439463.2021.2003358>
- McWade, B. (2016). Recovery-as-policy as a form of neoliberal state making. *Intersectionalities*, 5(3), 62–81.
- Mehrotra, G. R., Kimball, E., & Wahab, S. (2016). The braid that binds us: The impact of neoliberalism, criminalization, and professionalization on domestic violence work. *Affilia*, 31(2), 153–163. <https://doi.org/10.1177/0886109916643871>
- Melz, H., Morrison, C., Ingoldsby, E., Cairone, K., & Mackrain, M. (2019). Review of trauma-informed initiatives at the systems level. *Trauma-informed approaches: connecting research, policy, and practice to build resilience in children and families*, 37.
- Menakem, R. (Guest). (2020, November 15). How do we heal? [Audio podcast episode]. In *Talk Easy*. <https://talkeasypod.com/resmaa-menakem/>
- Mendlowicz, M. V., Gekker, M., Xavier Gomes de Araújo, A., de Oliveira, L., Pereira, M. G., Berger, W., Pires da Luz, M., Vilete, L. M. P., Marques-Portella, C., Figueira, I., & Reis da Silva Junior, T. (2024). The top-100 cited articles on post-traumatic

- stress disorder: A historical bibliometric analysis. *Psychology, Health and Medicine*, 29(3), 453–472. <https://doi.org/10.1080/13548506.2022.2147555>
- Mental Health Foundation. (n.d.). What is trauma? [Online]. Retrieved November 27, 2024, <https://www.mentalhealth.org.uk/a-to-z/t/trauma>
- Merriam, S. B. (1998). *Qualitative research and case study applications in education. Revised and expanded from Case Study Research in Education.*" Article 94104. Jossey-Bass Publishers.
- Merton, R. K. (1972). Insiders and outsiders: A chapter in the sociology of knowledge. *American Journal of Sociology*, 78(1), 9–47. <https://doi.org/10.1086/225294>
- Messman-Moore, T. L., & Coates, A. A. (2007). The impact of childhood psychological abuse on adult interpersonal conflict: The role of early maladaptive schemas and patterns of interpersonal behavior. *Journal of Emotional Abuse*, 7(2), 75–92. https://doi.org/10.1300/J135v07n02_05
- Messner, M. A., Greenberg, M. A., & Peretz, T. (2015). *Some men: Feminist allies in the movement to end violence against women.* Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780199338764.001.0001>
- Meyer, B., & Pilkonis, P. A. (2001). Attachment style. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 466–472. <https://doi.org/10.1037/0033-3204.38.4.466>
- Meyer, S., & Stambe, R.-M. (2022). Mothering in the context of violence: Indigenous and non-indigenous mothers' experiences in regional settings in Australia. *Journal of Interpersonal Violence*, 37(9–10). pp.NP, NP7958–NP7983. <https://doi.org/10.1177/0886260520975818>
- Middlesbrough Council. (2017). Domestic abuse needs assessment. [pdf]. Retrieved March 14, 2022, <https://www.middlesbrough.gov.uk/media/lyzny32h/domestic-abuse-needs-assessment.pdf>
- Milaney, K., Williams, N., Lockerbie, S. L., Dutton, D. J., & Hyshka, E. (2020). Recognizing and responding to women experiencing homelessness with gendered

- and trauma-informed care. *BMC Public Health*, 20(1), 397.
<https://doi.org/10.1186/s12889-020-8353-1>
- Miles, M. B. (1994). Qualitative data analysis: An expanded sourcebook. *Psychological Trauma: Theory, Research, Practice, and Policy*. Miller-Graff, L.E. and Cheng, P., 2017. Consequences of violence across the lifespan: Mental health and sleep quality in pregnant women, 9(5), 587.
- Miller, D., & Guidry, L. (2001). *Addictions and trauma recovery: Healing the body, mind and spirit*. WW Norton & Company.
- Miller, S. L., & Becker, P. (2021). Are we comparing apples and oranges? Exploring trauma experienced by victims of interpersonal violence and abuse and by court-involved women who have used force in relationships. *Journal of Interpersonal Violence*, 36(13–14). pp.NP, NP6951–NP6980.
<https://doi.org/10.1177/0886260518823289>
- Miller, V. (2017). Phatic culture and the status quo: Reconsidering the purpose of social media activism. *Convergence*, 23(3), 251–269.
<https://doi.org/10.1177/1354856515592512>
- Milletich, R. J., Kelley, M. L., Doane, A. N., & Pearson, M. R. (2010). Exposure to interparental violence and childhood physical and emotional abuse as related to physical aggression in undergraduate dating relationships. *Journal of Family Violence*, 25(7), 627–637. <https://doi.org/10.1007/s10896-010-9319-3>
- Millett, K. (1969). *Sexual politics*. Doubleday Publishing.
- Mind. (2023). What is trauma? [Online]. Retrieved November 27, 2024, <https://www.mind.org.uk/information-support/types-of-mental-health-problems/trauma/>
- Miracle, V. A. (2016). The Belmont Report: The triple crown of research ethics. *Dimensions of Critical Care Nursing*, 35(4), 223–228.
<https://doi.org/10.1097/DCC.0000000000000186>
- Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health.

Social Science and Medicine, 106, 128–136.
<https://doi.org/10.1016/j.socscimed.2014.01.043>

Monteith, L.L., Holliday, R., Dichter, M.E. and Hoffmire, C.A., 2022. Preventing suicide among women veterans: gender-sensitive, trauma-informed conceptualization. *Current treatment options in psychiatry*, 9(3), pp.186-201.

Moore, C. (2017). Middlesbrough domestic abuse needs assessment [Online]. Retrieved December 2023, <https://www.middlesbrough.gov.uk/media/lyzny32h/domestic-abuse-needs-assessment.pdf>

Moos, R. H. (1994). *Work Environment Scale manual* (3rd ed.). Consulting Psychologists Press.

Morse, J. M., Niehaus, L., Varnhagen, S., Austin, W., & McIntosh, M. (2008). Qualitative researchers' conceptualizations of the risks inherent in qualitative interviews! *International Review of Qualitative Research*, 1(2), 195–215.
<https://doi.org/10.1525/irqr.2008.1.2.195>

Moulding, N. T., Buchanan, F., & Wendt, S. (2015). Untangling self-blame and mother-blame in women's and children's perspectives on maternal protectiveness in domestic violence: Implications for practice. *Child Abuse Review*, 24(4), 249–260.
<https://doi.org/10.1002/car.2389>

Mu, E., Thomas, E. H. X., & Kulkarni, J. (2022). Menstrual cycle in trauma-related disorders: A mini-review. *Frontiers in Global Women's Health*, 3, Article 910220.
<https://doi.org/10.3389/fgwh.2022.910220>

Mullings, B. (1999). Insider or outsider, both or neither: Some dilemmas of interviewing in a cross-cultural setting. *Geoforum*, 30(4), 337–350.
[https://doi.org/10.1016/S0016-7185\(99\)00025-1](https://doi.org/10.1016/S0016-7185(99)00025-1)

Muñoz-Rivas, M., Bellot, A., Montorio, I., Ronzón-Tirado, R., & Redondo, N. (2021). Profiles of emotion regulation and post-traumatic stress severity among female victims of intimate partner violence. *International Journal of Environmental Research and Public Health*, 18(13), 6865. <https://doi.org/10.3390/ijerph18136865>

- Munro, V. E., & Aitken, R. (2020). From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse. *International Review of Victimology*, 26(1), 29–49. <https://doi.org/10.1177/0269758018824160>
- Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, 23(1), 51–59. <https://doi.org/10.1111/inm.12012>
- Myhill, A., Hohl, K., & Johnson, K. (2023). The “officer effect” in risk assessment for domestic abuse: Findings from a mixed methods study in England and Wales. *European Journal of Criminology*, 20(3), 856–877. <https://doi.org/10.1177/14773708231156331>
- TIME – Trauma training – My sister’s place. (2024) [Online]. Retrieved January 2024, <https://mysistersplace.org.uk/training/time/>
- Najavits, L. M., Weiss, R. D., & Liese, B. S. (1996). Group cognitive-behavioral therapy for women with PTSD and substance use disorder. *Journal of Substance Abuse Treatment*, 13(1), 13–22. [https://doi.org/10.1016/0740-5472\(95\)02025-x](https://doi.org/10.1016/0740-5472(95)02025-x)
- Nathanson, D. L. (1994). *Shame and pride: Affect, sex, and the birth of the self*. WW Norton & Company.
- Neale, J. (2018). Abused women’s perceptions of professionals’ responses: Valued support, or collusion with perpetrator? *Journal of Gender-Based Violence*, 2(3), 411–427. <https://doi.org/10.1332/239868018X15366982612051>
- Nemeroff, C. B., Bremner, J. D., Foa, E. B., Mayberg, H. S., North, C. S., & Stein, M. B. (2006). Posttraumatic stress disorder: A state-of-the-science review. *Journal of Psychiatric Research*, 40(1), 1–21. <https://doi.org/10.1016/j.jpsychires.2005.07.005>
- Newbigging, K., Rees, J., Ince, R., Mohan, J., Joseph, D., Ashman, M., Norden, B., Dare, C., Bourke, S., & Costello, B. (2020). The contribution of the voluntary sector to mental health crisis care: A mixed-methods study. *Health Services and Delivery Research*, 8(29), 1–200. <https://doi.org/10.3310/hsdr08290>

- Newman, E., Willard, T., Sinclair, R., & Kaloupek, D. (2001). Empirically supported ethical research practice: The costs and benefits of research from the participants' view. *Accountability in Research*, 8(4), 309–329. <https://doi.org/10.1080/08989620108573983>
- Newstrom, J. W., & Rubenfeld, S. A. (1983, March). The Johari window: A reconceptualization. In *Developments in business simulation and experiential learning. Proceedings of the Annual ABSEL Conference*, 10.
- Newton, B. J. (2019). Understanding child neglect in Aboriginal families and communities in the context of trauma. *Child and Family Social Work*, 24(2), 218–226. <https://doi.org/10.1111/cfs.12606>
- NICE. (2016). Domestic violence and abuse: A. *Quality Standard* [Online]. Retrieved May 2024, <https://www.nice.org.uk/guidance/qs116>
- NICE. (2018). Overview | Post-traumatic stress disorder | Guidance. Nice [Online]. Retrieved May 2023, <https://www.nice.org.uk/guidance/ng116>
- Nikulina, V., Gelin, M., & Zwillig, A. (2021). Is there a cumulative association between adverse childhood experiences and intimate partner violence in emerging adulthood? *Journal of Interpersonal Violence*, 36(3–4). pp.NP, NP1205–1232NP. <https://doi.org/10.1177/0886260517741626>
- Nikro, S. N. (2014). Situating postcolonial trauma studies. *Postcolonial Text*, 9(2).
- Nixon, J. (2009). Domestic violence and women with disabilities: Locating the issue on the periphery of social movements. *Disability and Society*, 24(1), 77–89. <https://doi.org/10.1080/09687590802535709>
- Nixon, J., & Humphreys, C. (2010). Marshalling the evidence: Using intersectionality in the domestic violence frame. *Social Politics*, 17(2), 137–158. <https://doi.org/10.1093/sp/jxq003>
- Nnawulezi, N., Godsay, S., Sullivan, C. M., Marcus, S., & Hacskeylo, M. (2018). The influence of low-barrier and voluntary service policies on survivor empowerment in a domestic violence housing organization. *The American Journal of Orthopsychiatry*, 88(6), 670–680. <https://doi.org/10.1037/ort0000291>

- Noorani, T. (2013). Service user involvement, authority and the “expert-by-experience” in mental health. *Journal of Political Power*, 6(1), 49–68. <https://doi.org/10.1080/2158379X.2013.774979>
- O'Connor, M., & Wilson, N. (2002). Vision action change: Feminist principles and practice of working on violence against women. *Women's aid*.
- Office for Health Improvement and Disparities. (n.d.). Working definition of trauma-informed practice [Online]. Retrieved November 27, 2024, <https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice>
- Office for National Statistics. (2016). *Domestic abuse victim characteristics, England and Wales: Year ending March 2019* London. Office for National Statistics.
- Office for National Statistics. (2022). How the population changed in Sunderland: Census 2021 [Online]. Retrieved December 2022, <https://www.ons.gov.uk/visualisations/censuspopulationchange/E08000024/>
- Ogbe, E., Harmon, S., Van den Bergh, R., & Degomme, O. (2020). A systematic review of intimate partner violence interventions focused on improving social support and/mental health outcomes of survivors. *PLOS One*, 15(6), Article e0235177. <https://doi.org/10.1371/journal.pone.0235177>
- Ogle, C. M., Harmon-Darrow, C., Fedina, L., Nichols, D., Mulford, C. F., & Backes, B. L. (2024). Operational definitions of poly-victimization: A scoping review. *Trauma, Violence and Abuse*, p.15248380241246522, 25(4), 3360–3376. <https://doi.org/10.1177/15248380241246522>
- Oral, R., Coohey, C., Zarei, K., Conrad, A., Nielsen, A., Wibbenmeyer, L., Segal, R., Wojciak, A. S., Jennissen, C., & Peek-Asa, C. (2020). Nationwide efforts for trauma-informed care implementation and workforce development in healthcare and related fields: A systematic review. *The Turkish Journal of Pediatrics*, 62(6), 906–920. <https://doi.org/10.24953/turkjpeds.2020.06.002>
- Oram, S., Fisher, H. L., Minnis, H., Seedat, S., Walby, S., Hegarty, K., Rouf, K., Angénieux, C., Callard, F., Chandra, P. S., Fazel, S., Garcia-Moreno, C., Henderson, M., Howarth, E., MacMillan, H. L., Murray, L. K., Othman, S.,

- Robotham, D., Rondon, M. B., . . . Howard, L. M. (2022). The Lancet Psychiatry Commission on intimate partner violence and mental health: Advancing mental health services, research, and policy. *The Lancet. Psychiatry*, 9(6), 487–524. [https://doi.org/10.1016/S2215-0366\(22\)00008-6](https://doi.org/10.1016/S2215-0366(22)00008-6)
- Oram, S., Trevillion, K., Feder, G., & Howard, L. M. (2013). Prevalence of experiences of domestic violence among psychiatric patients: Systematic review. *The British Journal of Psychiatry*, 202(2), 94–99. <https://doi.org/10.1192/bjp.bp.112.109934>
- Ortmann, A., & Hertwig, R. (1997). Is deception acceptable? *American Psychologist*, 52(7), 746–747. <https://doi.org/10.1037/0003-066X.52.7.746>
- Overton, W. F. (1997). Beyond dichotomy: An embodied active agent for cultural psychology. *Culture and Psychology*, 3(3), 315–334. <https://doi.org/10.1177/1354067X9733006>
- Oxford Health NHS Foundation Trust. (n.d.). Understanding trauma and its effects [Online]. Retrieved November 27, 2024, <https://www.oxfordhealth.nhs.uk/camhs/self-care/trauma/>
- Oxman-Martinez, J., Krane, J., Corbin, N., & Loiselle-Léonard, M. (2002). *Competing conceptions of conjugal violence: Insights form an intersectional framework*. McGill University.
- Paphitis, S. A., Bentley, A., Asher, L., Osrin, D., & Oram, S. (2022). Improving the mental health of women intimate partner violence survivors: Findings from a realist review of psychosocial interventions. *PLOS One*, 17(3), Article e0264845. <https://doi.org/10.1371/journal.pone.0264845>
- Pascual-Leone, A., Kim, J., & Morrison, O.-P. (2017). Working with victims of human trafficking. *Journal of Contemporary Psychotherapy*, 47(1), 51–59. <https://doi.org/10.1007/s10879-016-9338-3>
- Patel, S. S., Webster, R. K., Greenberg, N., Weston, D., & Brooks, S. K. (2020). Research fatigue in COVID-19 pandemic and post-disaster research: Causes, consequences and recommendations [International journal]. *Disaster Prevention and Management*, 29(4), 445–455. <https://doi.org/10.1108/DPM-05-2020-0164>

- Patton, M. Q. (1990). *Qualitative evaluation and research methods*.
- Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*. Sage Publications.
- Pearce, W. B., & Pearce, K. A. (1998). Transcendent storytelling: Abilities for systemic practitioners. *Human Systems*, 9, 173.
- Pence, E., & Paymar, M. (1993). *Education groups for men who batter: The Duluth model*. Springer Publishing Company.
- Penttinen, E. (2023). Understanding the experience of emotional abuse: The importance of naming and identifying non-physical violence from the target's perspective. *Journal of Gender-Based Violence*, 1(aop), 1–14. <https://doi.org/10.1332/23986808Y2023D000000002>
- Perry, B. D., & Szalavitz, M. (2017). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook—What traumatised children can teach us about loss, love, and healing*. Hachette UK.
- Phares, V., & Compas, B. E. (1992). The role of fathers in child and adolescent psychopathology: Make room for daddy. *Psychological Bulletin*, 111(3), 387–412. <https://doi.org/10.1037/0033-2909.111.3.387>
- Pitman, T. (2016). Living with coercive control: Trapped within a complex web of double standards, double binds and boundary violations. *British Journal of Social Work*, 47(1), 143–161. <https://doi.org/10.1093/bjsw/bcw002>
- Plymouth City Council. (2021). Trauma informed approach: A handbook for professionals in Plymouth [Online]. Retrieved November 27, 2024, <https://democracy.plymouth.gov.uk/documents/s96832/Trauma%20Informed%20Plymouth%20Approach.pdf>
- Plymouth Safeguarding Children Partnership. (2022). ANNUAL report 2021-2022. (2022) [Online] Available at: <https://www.plymouthscb.co.uk/wp-content/uploads/2022/08/PSCP-Annual-Report-April-2022-Published.pdf>

- Plymouth University. (2020). The role of education in trauma-informed practice in Plymouth: A qualitative study [Online] Available at: [Insert URL here] Retrieved November 27, 2024.
- Poole, N., & Greaves, L. (Eds.). (2012). *Becoming trauma informed*. Centre for Addiction and Mental Health.
- Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation (Norton series on interpersonal neurobiology)*. WW Norton & Company.
- Postmus, J. L., Hoge, G. L., Breckenridge, J., Sharp-Jeffs, N., & Chung, D. (2020). Economic abuse as an invisible form of domestic violence: A multicountry review. *Trauma, Violence and Abuse*, 21(2), 261–283. <https://doi.org/10.1177/1524838018764160>
- Price, M., Spinazzola, J., Musicaro, R., Turner, J., Suvak, M., Emerson, D., & van der Kolk, B. (2017). Effectiveness of an extended yoga treatment for women with chronic posttraumatic stress disorder. *Journal of Alternative and Complementary Medicine*, 23(4), 300–309. <https://doi.org/10.1089/acm.2015.0266>
- Prilleltensky, I., & Nelson, G. (2017). *Doing psychology critically: Making a difference in diverse settings*. Bloomsbury Publishing.
- Proctor, B. (1987). *Supervision: A cooperative exercise in accountability. Enabling and ensuring. Supervision in practice*.
- Prosman, G.-J., Lo Fo Wong, S. H., & Lagro-Janssen, A. L. (2014). Support by trained mentor mothers for abused women: A promising intervention in primary care. *Journal of Family Practice*, 31, 7180.
- Punch, M., & James, S. (2017). Researching law enforcement and public health. *Policing and Society*, 27(3), 251–260. <https://doi.org/10.1080/10439463.2016.1205066>
- Purtle, J. (2020). Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings. *Trauma, Violence and Abuse*, 21(4), 725–740. <https://doi.org/10.1177/1524838018791304>

- Thompson, R. S., Bonomi, A. E., Anderson, M., Reid, R. J., Dimer, J. A., Carrell, D., & Rivara, F. P. (2006). Intimate partner violence: Prevalence, types, and chronicity in adult women. *American Journal of Preventive Medicine*, 30(6), 447–457. <https://doi.org/10.1016/j.amepre.2006.01.016>
- Rabinak, C. A., Mori, S., Lyons, M., Milad, M. R., & Phan, K. L. (2017). Acquisition of CS– US contingencies during Pavlovian fear conditioning and extinction in social anxiety disorder and posttraumatic stress disorder. *Journal of Affective Disorders*, 207, 76–85. <https://doi.org/10.1016/j.jad.2016.09.018>
- Rajah, V., & Osborn, M. (2022). Understanding women’s resistance to intimate partner violence: A scoping review. *Trauma, Violence and Abuse*, 23(5), 1373–1387. <https://doi.org/10.1177/1524838019897345>
- Ramsay, J. et al. (2009). Should health professionals screen women for domestic violence? A systematic review of evidence. *Health Technology Assessment*, 13(6).
- Reid, N., Kron, A., Rajakulendran, T., Kahan, D., Noble, A., & Stergiopoulos, V. (2021). Promoting wellness and recovery of young women experiencing gender-based violence and homelessness: The role of trauma-informed health promotion interventions. *Violence Against Women*, 27(9), 1297–1316. <https://doi.org/10.1177/1077801220923748>
- Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., Mitchell, K. S., Suvak, M. K., Wells, S. Y., Stirman, S. W., & Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: Implications for DSM-5. *Journal of Traumatic Stress*, 25(3), 241–251. <https://doi.org/10.1002/jts.21699>
- Rich, K. (2019). Trauma-informed police responses to rape victims. *Journal of Aggression, Maltreatment and Trauma*, 28(4), 463–480. <https://doi.org/10.1080/10926771.2018.1540448>
- Richards, L. (2009). *Domestic abuse, stalking and harassment and honour based violence (DASH, 2009) risk identification and assessment and management model*. Association of Police Officers (ACPO).
- Richards, L. (2016). *DASH Risk Model*. Retrieved May 2024, <http://www.dashriskchecklist.co.uk/>

- Richardson, J. I. (2001). Guidebook on vicarious trauma: Recommended solutions for antiviolence workers. *National clearinghouse on family violence, family violence prevention unit*. Public Health Agency of Canada.
- Riley, D., & O'Hare, P. (2000). Harm reduction: History, definition, and practice. *Harm Reduction, 1000*, 1–26.
- Ringmar, E. (2016). How the world stage makes its subjects: An embodied critique of constructivist IR theory. *Journal of International Relations and Development, 19*(1), 101–125. <https://doi.org/10.1057/jird.2015.33>
- Risser, H. J., Hetzel-Riggin, M. D., Thomsen, C. J., & McCanne, T. R. (2006). PTSD as a mediator of sexual revictimization: The role of reexperiencing, avoidance, and arousal symptoms. *Journal of Traumatic Stress, 19*(5), 687–698. <https://doi.org/10.1002/jts.20156>
- Robbins, R., Banks, C., McLaughlin, H., Bellamy, C., & Thackray, D. (2016). Is domestic abuse an adult social work issue? *Social Work Education, 35*(2), 131–143. <https://doi.org/10.1080/02615479.2016.1140733>
- Robbins, R., & Cook, K. (2018). 'Don't even get us started on social workers': Domestic violence, social work and trust—An anecdote from research. *The British Journal of Social Work, 48*(6), 1664–1681. <https://doi.org/10.1093/bjsw/bcx125>
- Roberts, A. L., Dohrenwend, B. P., Aiello, A. E., Wright, R. J., Maercker, A., Galea, S., & Koenen, K. C. (2012). The stressor criterion for posttraumatic stress disorder: Does it matter? *The Journal of Clinical Psychiatry, 73*(2), e264–e270. <https://doi.org/10.4088/JCP.11m07054>
- Robey, N., Margolies, S., Sutherland, L., Rupp, C., Black, C., Hill, T., & Baker, C. N. (2021). Understanding staff- and system-level contextual factors relevant to trauma-informed care implementation. *Psychological Trauma: Theory, Research, Practice and Policy, 13*(2), 249–257. <https://doi.org/10.1037/tra0000948>
- Robinson, A. L., Myhill, A., & Wire, J. (2018). Practitioner (mis) understandings of coercive control in England and Wales. *Criminology and Criminal Justice, 18*(1), 29–49. <https://doi.org/10.1177/1748895817728381>

- Robinson, A. L., & Rowlands, J. (2006). *The Dyn Project: Supporting men experiencing domestic abuse*. Cardiff University.
- Roggeband, C. (2012). Shifting policy responses to domestic violence in the Netherlands and Spain (1980–2009). *Violence Against Women*, 18(7), 784–806. <https://doi.org/10.1177/1077801212455359>
- Roper-Hall, A. (1998). Working systemically with older people and their families who have “come to grief”. In P. Sutcliffe, G. Tufnell, U. Cornish (Eds.), *Working with the dying and bereaved* (pp. 177–206). Routledge. https://doi.org/10.1007/978-1-349-26222-9_7
- Roper-Hall, A. (2008). Systemic interventions and older people. In B. Woods, L. Clare (Eds.), *Handbook of the clinical psychology of ageing* (pp. 489–504). John Wiley & Sons. <https://doi.org/10.1002/9780470773185.ch29>
- Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: Qualitative study. *The British Journal of Psychiatry*, 198(3), 189–194. <https://doi.org/10.1192/bjp.bp.109.072389>
- Ross, M. W., Iguchi, M. Y., & Panicker, S. (2018). Ethical aspects of data sharing and research participant protections. *The American Psychologist*, 73(2), 138–145. <https://doi.org/10.1037/amp0000240>
- Roth, S., Newman, E., Pelcovitz, D., Van Der Kolk, B., & Mandel, F. S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV field trial for posttraumatic stress disorder. *Journal of Traumatic Stress*, 10(4), 539–555. <https://doi.org/10.1023/a:1024837617768>
- Rothery, M., Tutty, L., & Weaver, G. (1999). Touch choices: Women, abusive partners, and the ecology of decision-making. *Canadian Journal of Community Mental Health*, 18(1), 5–18. <https://doi.org/10.7870/cjcmh-1999-0001>
- Rothschild, B. (2000). *The body remembers continuing education test: The psychophysiology of trauma & trauma treatment*. WW Norton & Company.

- Royal College of Psychiatrists. (2021). Post-traumatic stress disorder (PTSD) [Online]. Retrieved November 27, 2024, <https://www.rcpsych.ac.uk/mental-health/mental-illnesses-and-mental-health-problems/post-traumatic-stress-disorder>
- Rudolph, K. (2021). Ethical considerations in trauma-informed care. *The Psychiatric Clinics of North America*, 44(4), 521–535. <https://doi.org/10.1016/j.psc.2021.07.001>
- Rumgay, J. (2004). Living with paradox. *Women Who Offend*, 44, 99.
- Ruork, A. K., McLean, C. L., & Fruzzetti, A. E. (2022). It happened matters more than what happened: Associations between intimate partner violence abuse type, emotion regulation, and post-traumatic stress symptoms. *Violence Against Women*, 28(5), 1158–1170. <https://doi.org/10.1177/10778012211013895>
- Russell, M., & Light, L. (2006). Police and victim perspectives on empowerment of domestic violence victims. *Police Quarterly*, 9(4), 375–396. <https://doi.org/10.1177/1098611104264495>
- Russo, N. F., & Pirlott, A. (2006). Gender-based violence: Concepts, methods, and findings. *Annals of the New York Academy of Sciences*, 1087(1), 178–205. <https://doi.org/10.1196/annals.1385.024>
- Saakvitne, K. W., Gamble, S., Pearlman, L. A., & Lev, B. T. (2000). *Risking connection*. The Sidran Press.
- Sachs-Ericsson, N., Cromer, K., Hernandez, A., & Kendall-Tackett, K. (2009). A review of childhood abuse, health, and pain-related problems: The role of psychiatric disorders and current life stress. *Journal of Trauma and Dissociation*, 10(2), 170–188. <https://doi.org/10.1080/15299730802624585>
- SafeLives. (2021). Understanding court support for victims of domestic abuse 2021. SafeLives. Retrieved August 14, 2021, <https://safelives.org.uk/understanding-court-support/June-2021>
- Sailer, U., Robinson, S., Fischmeister, F. P. S., König, D., Oppenauer, C., Lueger-Schuster, B., Moser, E., Kryspin-Exner, I., & Bauer, H. (2008). Altered reward processing in the nucleus accumbens and mesial prefrontal cortex of patients with

- posttraumatic stress disorder. *Neuropsychologia*, 46(11), 2836–2844.
<https://doi.org/10.1016/j.neuropsychologia.2008.05.022>
- Salter, M., Conroy, E., Dragiewicz, M., Burke, J., Ussher, J., Middleton, W., Vilenica, S., Martin Monzon, B., & Noack-Lundberg, K. (2020). A deep wound under my heart: *Constructions of complex trauma and implications for women's wellbeing and safety from violence*.
- Salyers, M. P., Evans, L. J., Bond, G. R., & Meyer, P. S. (2004). Barriers to assessment and treatment of posttraumatic stress disorder and other trauma-related problems in people with severe mental illness: Clinician perspectives. *Community Mental Health Journal*, 40(1), 17–31.
<https://doi.org/10.1023/b:comh.0000015215.45696.5f>
- SAMHSA's Trauma and Justice Strategic Initiative et al. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. Substance Abuse and Mental Health Services Administration [Online]. Retrieved May 2022,
https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf
- Samuel, M. (2021). Women's aid, and women's aid. *Fragile funding landscape: The extent of local authority commissioning in the domestic abuse refuge sector in England 2020* [Report] p. 204 [Online]. Women's Aid Federation of England. Retrieved May 2024,
<https://www.womensaid.org.uk/wp-content/uploads/2021/02/Fragile-funding-landscape-the-extent-of-local-authority-commissioning-in-the-domestic-abuse-refuge-sector-in-England-2020.pdf>
- Sangeetha, J., Mohan, S., Hariharasudan, A., & Nawaz, N. (2022). Strategic analysis of intimate partner violence (IPV) and cycle of violence in the autobiographical text—when I hit you. *Heliyon*, 8(6), Article e09734.
<https://doi.org/10.1016/j.heliyon.2022.e09734>
- Sarason, S. B. (1981). *Psychology misdirected*. Free Press.
- Saunders, K. R. K., McGuinness, E., Barnett, P., Foye, U., Sears, J., Carlisle, S., Allman, F., Tzouvara, V., Schlieff, M., Vera San Juan, N., Stuart, R., Griffiths, J., Appleton, R., McCrone, P., Rowan Olive, R., Nyikavaranda, P., Jeynes, T., K, T., Mitchell, L., . . . Trevillion, K. (2023). A scoping review of trauma informed

- approaches in acute, crisis, emergency, and residential mental health care. *BMC Psychiatry*, 23(1), 567. <https://doi.org/10.1186/s12888-023-05016-z>
- Schwarz, J. E., Baber, D., Barter, A., & Dorfman, K. (2020). A mixed methods evaluation of EMDR for treating female survivors of sexual and domestic violence. *Counseling Outcome Research and Evaluation*, 11(1), 4–18. <https://doi.org/10.1080/21501378.2018.1561146>
- Scott, S., Watson, G., & Williams, J. (2020). Women’s mental health: The essential contribution of feminist services. Retrieved June 2024, <https://www.tnlcommunityfund.org.uk/media/insights/documents/WGI-Briefings-Feminist-Services.pdf?mtime=20230420112403&focal=none>
- Scottish Government. (2020). Adverse childhood experiences (ACEs) and trauma [Online]. Retrieved November 26, 2024, <https://www.gov.scot/publications/psychological-trauma-and-adversity/>
- Seff, L. R., Beaulaurier, R. L., & Newman, F. L. (2008). Nonphysical abuse: Findings in domestic violence against older women study. *Journal of Emotional Abuse*, 8(3), 355–374. <https://doi.org/10.1080/10926790802278933>
- Seligman, M. E., & Maier, S. F. (1967). Failure to escape traumatic shock. *Journal of Experimental Psychology*, 74(1), 1–9. <https://doi.org/10.1037/h0024514>
- Seligman, M. E. P. (1972). Learned helplessness. *Annual Review of Medicine*, 23(1), 407–412. <https://doi.org/10.1146/annurev.me.23.020172.002203>
- Selvini, M. P., Boscolo, L., Cecchin, G., & Prata, G. (1980). Hypothesizing—Circularity—Neutrality: Three guidelines for the conductor of the session. *Family Process*, 19(1), 3–12. <https://doi.org/10.1111/j.1545-5300.1980.00003.x>
- Serrata, J. V., Rodriguez, R., Castro, J. E., & Hernandez-Martinez, M. (2020). Well-being of Latina survivors of intimate partner violence and sexual assault receiving trauma-informed and culturally specific services. *Journal of Family Violence*, 35(2), 169–180. <https://doi.org/10.1007/s10896-019-00049-z>
- Sevelius, J. M., Gutierrez-Mock, L., Zamudio-Haas, S., McCree, B., Ngo, A., Jackson, A., Clynes, C., Venegas, L., Salinas, A., Herrera, C., Stein, E., Operario, D., &

- Gamarel, K. (2020). Research with marginalised communities: Challenges to continuity during the COVID-19 pandemic. *AIDS and Behavior*, 24(7), 2009–2012. <https://doi.org/10.1007/s10461-020-02920-3>
- Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, 2(2), 199–223. <https://doi.org/10.1002/jts.2490020207>
- Sharp-Jeffs, N., Kelly, L., & Klein, R. (2018). Long journeys toward freedom: The relationship between coercive control and space for action—Measurement and emerging evidence. *Violence Against Women*, 24(2), 163–185. <https://doi.org/10.1177/1077801216686199>
- Shaw, D. J., Czekóová, K., Mareček, R., Havlice Špiláková, B. H., & Brázdil, M. (2023). The interacting brain: Dynamic functional connectivity among canonical brain networks dissociates cooperative from competitive social interactions. *NeuroImage*, 269, Article 119933. <https://doi.org/10.1016/j.neuroimage.2023.119933>
- Sherin, J. E., & Nemeroff, C. B. (2011). Post-traumatic stress disorder: The neurobiological impact of psychological trauma. *Dialogues in Clinical Neuroscience*, 13(3), 263–278. <https://doi.org/10.31887/DCNS.2011.13.2/jshein>
- Shields, A., & Cicchetti, D. (1998). Reactive aggression among maltreated children: The contributions of attention and emotion dysregulation. *Journal of Clinical Child Psychology*, 27(4), 381–395. https://doi.org/10.1207/s15374424jccp2704_2
- Shipman, K., Zeman, J., Penza, S., & Champion, K. (2000). Emotion management skills in sexually maltreated and nonmaltreated girls: A developmental psychopathology perspective. *Development and Psychopathology*, 12(1), 47–62. <https://doi.org/10.1017/s0954579400001036>
- Siegel, D. J. (2015). *Brainstorm: The power and purpose of the teenage brain*. Penguin.
- Silverstein, M., & Spark, R. (2007). Social bridges falling down: Reconstructing a 'troublesome population' of battered women through individual responsabilization

- strategies. *Critical Criminology*, 15(4), 327–342. <https://doi.org/10.1007/s10612-007-9039-z>
- Simmonds, L. (2019). The impact of local commissioning on victim services in England and Wales: An empirical study. *International Review of Victimology*, 25(2), 181–199. <https://doi.org/10.1177/0269758018787938>
- Sinyor, M., Knipe, D., Borges, G., Ueda, M., Pirkis, J., Phillips, M. R., Gunnell, D., & International COVID-19 Suicide Prevention Research Collaboration. (2022). Suicide risk and prevention during the COVID-19 pandemic: One year on. *Archives of Suicide Research*, 26(4), 1944–1949. <https://doi.org/10.1080/13811118.2021.1955784>
- Slattery, S. M., & Goodman, L. A. (2009). Secondary traumatic stress among domestic violence advocates: Workplace risk and protective factors. *Violence Against Women*, 15(11), 1358–1379. <https://doi.org/10.1177/1077801209347469>
- Sosenko, F., Bramley, G., & Johnsen, S. (2020). *Gender Matters: Gendered patterns of severe and multiple disadvantage in England*.
- Speed, A. (2022). Domestic abuse and the provision of advocacy services: Mapping support for victims in family proceedings in England and Wales. *Journal of Social Welfare and Family Law*, 44(3), 347–368. <https://doi.org/10.1080/09649069.2022.2126605>
- Sprague, J., & Zimmerman, M. K. (1989). Quality and quantity: Reconstructing feminist methodology. *The American Sociologist*, 20(1), 71–86. <https://doi.org/10.1007/BF02697788>
- Stake, R. (1995). Case study research. *thousand oaks*. Sage Publications.
- Stamm, B. (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. The Sidran Press.
- Stanko, E. A. (1996). Warnings to women: Police advice and women's safety in Britain. *Violence Against Women*, 2(1), 5–24. <https://doi.org/10.1177/1077801296002001002>

- Stanko, E. A. (1997). Safety Talk: Conceptualizing women's risk assessment as a technology of the soul. *Theoretical Criminology*, 1(4), 479–499. <https://doi.org/10.1177/1362480697001004004>
- Stanley, L., & Wise, S. (1983). Back into the personal/or: Our attempt to construct “feminist research”. In *Theories of women's studies* (pp. 192–209). Routledge.
- Stanley, N. (1997). Domestic violence and child abuse: Developing social work practice. *Child and Family Social Work*, 2(3), 135–145. <https://doi.org/10.1046/j.1365-2206.1997.00052.x>
- Stanley, N., Barter, C. A., Bracewell, K., Chantler, K., Howarth, E., Radford, L., Richardson Foster, H., Robbins, R., Tudor Edwards, R., Martin, K., & Winrow, E. (2021). *Roadmap report and executive summary*.
- Stanley, N., & Humphreys, C. (2014). Multi-agency risk assessment and management for children and families experiencing domestic violence. *Children and Youth Services Review*, 47, 78–85. <https://doi.org/10.1016/j.childyouth.2014.06.003>
- Stanley, N., Miller, P., Richardson Foster, H., & Thomson, G. (2011). A stop-start response: Social Services' interventions with children and families notified following domestic violence incidents. *British Journal of Social Work*, 41(2), 296–313. <https://doi.org/10.1093/bjsw/bcq071>
- Stark, E. (2007). *Coercive control: How men entrap women in personal life*. Oxford University Press.
- Stark, E. (2016). Policing partner abuse and the new crime of coercive control in the United Kingdom. *Family & Intimate Partner Violence Quarterly*, 8(4).
- Stark, E., & Hester, M. (2019). Coercive control: Update and review. *Violence Against Women*, 25(1), 81–104. <https://doi.org/10.1177/1077801218816191>
- Staton, M., Leukefeld, C., & Logan, T. K. (2001). Health service utilization and victimization among incarcerated female substance users. *Substance Use and Misuse*, 36(6–7), 701–716. <https://doi.org/10.1081/ja-100104086>

- Steckley, L., & Smith, M. (2011). Care ethics in residential child care: A different voice. *Ethics and Social Welfare*, 5(2), 181–195. <https://doi.org/10.1080/17496535.2011.571068>
- Stein, M. B., Kennedy, C. M., & Twamley, E. W. (2002). Neuropsychological function in female victims of intimate partner violence with and without posttraumatic stress disorder. *Biological Psychiatry*, 52(11), 1079–1088. [https://doi.org/10.1016/s0006-3223\(02\)01414-2](https://doi.org/10.1016/s0006-3223(02)01414-2)
- Stewart, S., & Arnall, E. (2023). Mothers, domestic violence, and child protection: The UK response. *Violence Against Women*, 29(3–4), 626–647. <https://doi.org/10.1177/10778012221097141>
- Stoever, J. K. (2012). Transforming domestic violence representation. *Kentucky Law Journal*, 101, 483.
- Stover, C. S., Meadows, A. L., & Kaufman, J. (2009). Interventions for intimate partner violence: Review and implications for evidence-based practice. *Professional Psychology: Research and Practice*, 40(3), 223–233. <https://doi.org/10.1037/a0012718>
- Stang, H., & Braithwaite, J. (Eds). (2001) *Restorative justice and civil society*. Cambridge University Press
- Sullivan, C. M., & Cain, D. (2004). Ethical and safety considerations when obtaining information from or about battered women for research purposes. *Journal of Interpersonal Violence*, 19(5), 603–618. <https://doi.org/10.1177/0886260504263249>
- Sullivan, C. M., Goodman, L. A., Virden, T., Strom, J., & Ramirez, R. (2018). Evaluation of the effects of receiving trauma-informed practices on domestic violence shelter residents. *The American Journal of Orthopsychiatry*, 88(5), 563–570. <https://doi.org/10.1037/ort0000286>
- Swan, S. C., & Snow, D. L. (2006). The development of a theory of women's use of violence in intimate relationships. *Violence Against Women*, 12(11), 1026–1045. <https://doi.org/10.1177/1077801206293330>

- Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal*, 21(3), 174–192. <https://doi.org/10.1108/MHRJ-01-2015-0006>
- Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances*, 24(5), 319–333. <https://doi.org/10.1192/bja.2018.29>
- Sweeney, A., & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental health. *Journal of Mental Health*, 27(5), 383–387. <https://doi.org/10.1080/09638237.2018.1520973>
- Sweet, P. L. (2018). *Traumatizing politics: Legibility and survivorhood after domestic violence* (Doctoral dissertation, University of Illinois at Chicago).
- Sweet, P. L. (2019). The paradox of legibility: Domestic violence and institutional survivorhood. *Social Problems*, 66(3), 411–427. <https://doi.org/10.1093/socpro/spy012>
- Tanesini, A. (1999). *An introduction to feminist epistemologies*. Blackwell Publishing.
- Tarquinio, C., Brennstuhl, M.-J., Rydberg, J. A., Schmitt, A., Mouda, F., Lourel, M., & Tarquinio, P. (2012). Eye movement desensitization and reprocessing (EMDR) therapy in the treatment of victims of domestic violence: A pilot study. *European Review of Applied Psychology*, 62(4), 205–212. <https://doi.org/10.1016/j.erap.2012.08.006>
- Tashakkori, A., & Teddlie, C. (2003). Issues and dilemmas in teaching research methods courses in social and behavioural sciences: US perspective. *International Journal of Social Research Methodology*, 6(1), 61–77. <https://doi.org/10.1080/13645570305055>
- Taylor, A. K., Gregory, A., Feder, G., & Williamson, E. (2019). ‘We’re all wounded healers’: A qualitative study to explore the well-being and needs of helpline workers supporting survivors of domestic violence and abuse. *Health and Social Care in the Community*, 27(4), 856–862. <https://doi.org/10.1111/hsc.12699>

- Taylor, T. F. (2015). The influence of shame on posttrauma disorders: Have we failed to see the obvious? *European Journal of Psychotraumatology*, 6(1), Article 28847. <https://doi.org/10.3402/ejpt.v6.28847>
- Taylor-Dunn, H., Bates, L., Reed, D., Hopkins, A., & Morrison, S. (2023). Researching gender-based violence remotely during a pandemic: Challenges, opportunities and methodological implications. *Journal of Gender-Based Violence*, 1(aop), 1–17.
- Taylor-Dunn, H., & Erol, R. (2021). Improving the safety and well-being of domestic abuse survivors: The role of a specialist Organisation in supporting the work of independent domestic violence advisors. *Crime Prevention and Community Safety*, 23(2), 115–136. <https://doi.org/10.1057/s41300-021-00115-z>
- Testa, M., Livingston, J. A., & VanZile-Tamsen, C. (2011). Advancing the study of violence against women using mixed methods: Integrating qualitative methods into a quantitative research program. *Violence Against Women*, 17(2), 236–250. <https://doi.org/10.1177/1077801210397744>
- Thirkle, S. A., Kennedy, A., & Sice, P. (2021). Instruments for exploring trauma-informed care. *Journal of Health and Human Services Administration*, 44(1), 30–44. <https://doi.org/10.37808/jhhsa.44.1.2>
- Thirkle, S. A., Kennedy, A., Sice, P., & Patel, P. (2022). The Co-production of the roots framework: A reflective framework for mapping the implementation journey of trauma-informed care. *medRxiv*, pp.2022-04.
- Thompson, J. (1997). *Words in edgeways: Radical learning for social change*. National Institute of Adult Continuing Education, Leicester LE11 7GE, United Kingdom
- Timmer, S. G., Ware, L. M., Urquiza, A. J., & Zebell, N. M. (2010). The effectiveness of parent–child interaction therapy for victims of interparental violence. *Violence and Victims*, 25(4), 486–503. <https://doi.org/10.1891/0886-6708.25.4.486>
- Timothy, R. K. (2012). Anti-oppression psychotherapy as trauma-informed practice. *Becoming trauma informed*, pp. 47–56.
- Tolman, R. M. (1995). *Psychological maltreatment of women inventory*.

- Tolman, R. M., & Raphael, J. (2000). A review of research on welfare and domestic violence. *Journal of Social Issues*, 56(4), 655–682. <https://doi.org/10.1111/0022-4537.00190>
- Tomes, N. (2006). The patient as a policy factor: A historical case study of the consumer/survivor movement in mental health. *Health Affairs*, 25(3), 720–729. <https://doi.org/10.1377/hlthaff.25.3.720>
- Topping, A. (2024). How can Labour deliver on its pledge to halve violence against women and girls? *The Guardian*. Retrieved October 13, <https://www.theguardian.com/society/2024/oct/13/labour-violence-against-women-and-girls-vawg-policy>, Retrieved January 2025
- Towers, J., & Walby, S. (2012). Estimating the economic and social costs of domestic violence. *Journal of Financial Crime*, 19(4), 448–467.
- Trabold, N., O'Malley, A., Rizzo, L., & Russell, E. (2018). A gateway to healing: A community-based brief intervention for victims of violence. *Journal of Community Psychology*, 46(4), 418–428. <https://doi.org/10.1002/jcop.21948>
- Trauma informed Oregon. (2018). *Trauma informed care screening tool*. Portland Press.
- Trauma Responsive Greater Manchester. (2024) [Online]. Retrieved January 2025, <https://www.trgm.co.uk/>
- Trauma Informed Plymouth Network. (n.d.). An approach developed by the Trauma Informed Plymouth Network [Online]. Retrieved January 2025, <https://democracy.plymouth.gov.uk/documents/s96832/Trauma%20Informed%20Plymouth%20Approach.pdf>
- Treisman, D. (2004). Rational appeasement. *International Organization*, 58(2), 345–373. <https://doi.org/10.1017/S002081830458205X>
- Trevillion, K., Corker, E., Capron, L. E., & Oram, S. (2016). Improving mental health service responses to domestic violence and abuse. *International Review of Psychiatry*, 28(5), 423–432. <https://doi.org/10.1080/09540261.2016.1201053>

- Trevillion, K., Howard, L. M., Morgan, C., Feder, G., Woodall, A., & Rose, D. (2012). The response of mental health services to domestic violence: A qualitative study of service users' and professionals' experiences. *Journal of the American Psychiatric Nurses Association*, 18(6), 326–336. <https://doi.org/10.1177/1078390312459747>
- Trevillion, K., Oram, S., Feder, G., & Howard, L. M. (2012a). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. *PLOS One*, 7(12), Article e51740. <https://doi.org/10.1371/journal.pone.0051740>
- Trippany, R. L., Kress, V. E. W., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development*, 82(1), 31–37. <https://doi.org/10.1002/j.1556-6678.2004.tb00283.x>
- Tronto, J. C. (2005). An ethic of care. In A. E. Cudd & R. O. Andreasen (Eds.), *Feminist theory: A philosophical anthology*.
- Tronto, J. C. (2013). *Caring democracy: Markets, equality, and justice**. NYU Press.
- Tseris, E. (2019). Social work and Women's mental health: Does trauma theory provide a useful framework? *The British Journal of Social Work*, 49(3), 686–703. <https://doi.org/10.1093/bjsw/bcy090>
- Tseris, E. J. (2013). Trauma theory without feminism? Evaluating contemporary understandings of traumatised women. *Affilia*, 28(2), 153–164. <https://doi.org/10.1177/0886109913485707>
- Turner, E., Medina, J., & Brown, G. (2019). Dashing hopes? The predictive accuracy of domestic abuse risk assessment by police. *The British Journal of Criminology*, 59(5), 1013–1034. <https://doi.org/10.1093/bjc/azy074>
- Turner, W., Hester, M., Broad, J., Szilassy, E., Feder, G., Drinkwater, J., Firth, A., & Stanley, N. (2017). Interventions to improve the response of professionals to children exposed to domestic violence and abuse: A systematic review. *Child Abuse Review*, 26(1), 19–39. <https://doi.org/10.1002/car.2385>

- Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma*. Penguin UK.
- Van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, 1(5), 253–265. <https://doi.org/10.3109/10673229409017088>
- Van der Kolk, B. A. (2002). The assessment and treatment of complex PTSD. *Treating Trauma Survivors with PTSD*, 127, 156.
- Van der Kolk, B. A. (2010). *Developmental trauma disorder. PESI*.
- Van der Kolk, B. A., & Courtois, C. A. (2005). Editorial comments: Complex developmental trauma. *Journal of Traumatic Stress*, 18(5), 385–388. <https://doi.org/10.1002/jts.20046>
- Van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991). Childhood origins of self-destructive behavior. *The American Journal of Psychiatry*, 148(12), 1665–1671. <https://doi.org/10.1176/ajp.148.12.1665>
- Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, 18(5), 389–399. <https://doi.org/10.1002/jts.20047>
- Van Teijlingen, E., & Hundley, V. (2002). The importance of pilot studies. *Nursing Standard* (through 2013), 16(40), 33–36. <https://doi.org/10.7748/ns2002.06.16.40.33.c3214>
- Veysey, B. M., & Clark, C. (2004). Responding to physical and sexual abuse in women with alcohol and other drug and mental disorders: Programme building. Introduction. *Alcoholism Treatment Quarterly*, 22(3–4), 1–18.
- Vidale-Plaza, D. (2023). A survivor-centered and holistic ethics of care: A reflection on ethics of care in practice and within survivor groups. *Journal of Genocide Research*, 1–15.
- Vizenor, G., & Lee, A. R. (1999). *Postindian conversations*. Lincoln.

- Vizenor, G. (Ed.). (2008). *Survivance: Narratives of native presence*. U of Nebraska Press.
- Vidale-Plaza, D., & Djangala Fall, M. D. E. (2023). What are survivors of conflict-related sexual violence saying about care? *International Journal of Gynaecology and Obstetrics*, 163(2), 352–354. <https://doi.org/10.1002/ijgo.14958>
- Vila, A., & Pomeroy, E. C. (2020). Effects of violence on trauma among immigrant women from Central America. *Social Work Research*, 44(4), 221-232.
- Visser, I. (2018). Trauma in non-Western contexts. *Trauma and literature*, 1, 5-37.
- Voith, L. A., Logan-Greene, P., Strodthoff, T., & Bender, A. E. (2020). A paradigm shift in batterer intervention programming: A need to address unresolved trauma. *Trauma, Violence, & Abuse*, 21(4), 691-705.
- Voronka, J. (2016). Disciplines, difference, and representational authority: Making moves through inclusionary practices. *Philosophy, Psychiatry, and Psychology*, 23(3–4), 211–214. <https://doi.org/10.1353/ppp.2016.0020>
- Vrklevski, L. P., & Franklin, J. (2008). Vicarious trauma scale. *Traumatology*, 14(1), 106–118. <https://doi.org/10.1177/1534765607309961>
- Walby, S. (1989). Theorising patriarchy. *Sociology*, 23(2), 213–234. <https://doi.org/10.1177/0038038589023002004>
- Walby, S., Towers, J., & Francis, B. (2016). Is violent crime increasing or decreasing? A new methodology to measure repeat attacks making visible the significance of gender and domestic relations. *British Journal of Criminology*, 56(6), 1203–1234. <https://doi.org/10.1093/bjc/azv131>
- Walker, L. E. (1979). *The battered woman*. Harper & Row.
- Walker, L. E. (2009). *The battered woman syndrome*. Springer Publishing Company.
- Walker, L. E. A. (2002). Politics, psychology and the battered woman's movement. *Journal of Trauma Practice*, 1(1), 81–102. https://doi.org/10.1300/J189v01n01_05

- Walker, L. E. A. (2006). Battered woman syndrome: Empirical findings. *Annals of the New York Academy of Sciences*, 1087(1), 142–157. <https://doi.org/10.1196/annals.1385.023>
- Walker, L. J. (2014). Sex differences in moral reasoning. In *Handbook of moral behavior and development* (pp. 355–386). Psychology Press.
- Walker, N., Beek, K., Chen, H., Shang, J., Stevenson, S., Williams, K., Herzog, H., Ahmed, J., & Cullen, P. (2022). The experiences of persistent pain among women with a history of intimate partner violence: A systematic review. *Trauma, Violence and Abuse*, 23(2), 490–505. <https://doi.org/10.1177/1524838020957989>
- Walker, P. (2018). Complex PTSD: From surviving to thriving. *Tantor audio*.
- Walklate, S. (2007). What is to be done about violence against women? Gender, violence, cosmopolitanism and the law. *British Journal of Criminology*, 48(1), 39–54. <https://doi.org/10.1093/bjc/azm050>
- Ward, J., McMurray, R., & Sutcliffe, S. (2020). Working at the edge: Emotional labour in the spectre of violence. *Gender, Work and Organization*, 27(1), 82–97. <https://doi.org/10.1111/gwao.12377>
- Ward-Lasher, A., Messing, J., & Stein-Seroussi, J. (2017). Implementation of trauma-informed care in a housing first programme for survivors of intimate partner violence: A case study. *Advances in Social Work*, 18(1), 202–216. <https://doi.org/10.18060/21313>
- Warnock, C. (2018). Too complex for “complex needs”? Learning from work with victims of domestic abuse, who also have multiple and complex needs. Final Report – November 2018. <https://www.vonne.org.uk/sites/default/files/files/resources/TooComplexEvaluation-Nov2018.pdf>
- Warsaw, C. (2014). Thinking about trauma in the context of domestic violence: An integrated framework. *Synergy: A newsletter of the resource center on domestic violence child protection and custody*. National Council of Juvenile and Family Court Judges.

- Warwick-Booth, L., & Coan, S. (2024). Trauma informed mental health support; qualitative evaluation findings from one voluntary and community sector programme for women experiencing DVA. *Journal of Gender-Based Violence*, 1–17. <https://doi.org/10.1332/23986808Y2024D000000023>
- Wathen, C. N., & Mantler, T. (2022). Trauma- and violence-informed care: Orienting intimate partner violence interventions to equity. *Current Epidemiology Reports*, 9(4), 233–244. <https://doi.org/10.1007/s40471-022-00307-7>
- Wathen, C. N., Schmitt, B., & MacGregor, J. C. D. (2023). Measuring trauma- (and Violence-) Informed Care: A Scoping Review. *Trauma, Violence and Abuse*, 24(1), 261–277. <https://doi.org/10.1177/15248380211029399>
- Wathen, C. N., & Varcoe, C. (2019). *Trauma-& violence-informed care: Prioritizing safety for survivors of gender-based violence*. Western University.
- Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993, October). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. In annual convention of the international society for traumatic stress studies, San Antonio, TX, 462.
- Welford, J., Moreton, R., Keast, M., Milner, C., & Roberts, J. (2022). Fulfilling Lives: Supporting people with multiple needs: A summary of programme achievements, evaluation findings, learning and resources. The National Lottery community fund [Online]. Retrieved September 25, 2024, <https://www.tnlcommunityfund.org.uk/media/insights/documents/Summary-of-programme-achievements-evaluation-findings-learning-and-resources-2022.pdf?mtime=20221128143121&focal=none>
- Welsh Government. (2021). *Review of Adverse Childhood Experiences (ACE)*. Policy Press [Report] [Online]. Retrieved November 26, 2024, <https://www.gov.wales/review-adverse-childhood-experiences-ace-policy-report-html>
- Wendt, S., Bastian, C., & Jones, M. (2021). Building collaboration with child protection and domestic and family violence sectors: Trialling a living lab approach. *The British Journal of Social Work*, 51(2), 692–711. <https://doi.org/10.1093/bjsw/bcaa206>

- Westwood, J., Baginsky, M., Hallett, S., Richardson Foster, H., Steils, N., & Stanley, N. (2023). Strengthening knowledge and awareness in family services of domestic abuse, foundations. Strengthening knowledge and awareness in family services of domestic abuse. *Foundations*.
- White, M. B. (1997). Jean-Martin Charcot's contributions to the interface between neurology and psychiatry. *The Canadian Journal of Neurological Sciences. le Journal Canadien des Sciences Neurologiques*, 24(3), 254–260. <https://doi.org/10.1017/s0317167100021909>
- Widom, C. S., Czaja, S. J., & Dutton, M. A. (2008). Childhood victimization and lifetime revictimization. *Child Abuse and Neglect*, 32(8), 785–796. <https://doi.org/10.1016/j.chiabu.2007.12.006>
- Wies, J. (2008). Professionalizing human services: A case of domestic violence shelter advocates. *Human Organization*, 67(2), 221–233. <https://doi.org/10.17730/humo.67.2.l43m2v5422171113>
- Wies, J. R. (2006). The changing relationships of women helping women: Patterns and trends in domestic violence advocacy. *Human Organization*. JR, 2008. Professionalizing human services: A case of domestic violence shelter advocates, 67(2), 221–233.
- Wies, J. R. (2009). Boundaries in carework: A case study of domestic violence shelter advocates in the USA. *Global Public Health*, 4(5), 464–476. <https://doi.org/10.1080/17441690902815470>
- Wild, J. (2023). Gendered discourses of responsibility and domestic abuse victim-blame in the English children's social care system. *Journal of Family Violence*, 38(7), 1391–1403. <https://doi.org/10.1007/s10896-022-00431-4>
- Williams, K. R., & Houghton, A. B. (2004). Assessing the risk of domestic violence reoffending: A validation study. *Law and Human Behavior*, 28(4), 437–455. <https://doi.org/10.1023/b:lahu.0000039334.59297.f0>.
- Woolf, B. (1957). The Log likelihood ratio test (the G-test); methods and tables for tests of heterogeneity in contingency tables. *Annals of Human Genetics*, 21(4), 397–409. <https://doi.org/10.1111/j.1469-1809.1972.tb00293.x>

- Williams, K. S. (2016). Victims and the voluntary sector: A torrid affair. In A. Hucklesby, M. Corcoran (Eds.), *The voluntary sector and criminal justice* (pp. 211–240). Palgrave Macmillan UK. https://doi.org/10.1057/9781137370679_10
- Williams, W. I. (2006). Complex trauma: Approaches to theory and treatment. *Journal of Loss and Trauma*, 11(4), 321–335. <https://doi.org/10.1080/15325020600663078>
- Wilson, A., Hurley, J., Hutchinson, M., & Lakeman, R. (2021). ‘Can mental health nurses working in acute mental health units really be trauma-informed?’ An integrative review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 28(5), 900–923. <https://doi.org/10.1111/jpm.12717>
- Wilson, A., Hutchinson, M., & Hurley, J. (2017). Literature review of trauma-informed care: Implications for mental health nurses working in acute inpatient settings in Australia. *International Journal of Mental Health Nursing*, 26(4), 326–343. <https://doi.org/10.1111/inm.12344>
- Wilson, A. E., Calhoun, K. S., & Bernat, J. A. (1999). Risk recognition and trauma-related symptoms among sexually revictimised women. *Journal of Consulting and Clinical Psychology*, 67(5), 705–710. <https://doi.org/10.1037//0022-006x.67.5.705>
- Wilson, C., Pence, D. M., & Conradi, L. (2013). Trauma-informed care. In *Encyclopedia of social work*. NASW Press and Oxford University Press. <https://doi.org/10.1093/acrefore/9780199975839.013.1063>
- Wilson, C. K., Samuelson, K. W., Zenteno, C. B., & Sorsoli, L. (2012). Relationships between past trauma exposures and PTSD among survivors of intimate partner violence. *Journal of Aggression, Maltreatment and Trauma*, 21(5), 540–554. <https://doi.org/10.1080/10926771.2012.680575>
- Wilson, J. M., Fauci, J. E., & Goodman, L. A. (2015). Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches. *The American Journal of Orthopsychiatry*, 85(6), 586–599. <https://doi.org/10.1037/ort0000098>

- Wilson, J. P., Droždek, B., & Turkovic, S. (2006). Posttraumatic shame and guilt. *Trauma, Violence and Abuse*, 7(2), 122–141. <https://doi.org/10.1177/1524838005285914>
- Wilson, N. C. (2013). *An exploration of accredited learning for the domestic violence sector in Ireland* (Master's thesis, National University of Ireland, Maynooth (Ireland)).
- Wilton, J., & Williams, A. (2019a). *Engaging with complexity: Providing effective trauma informed care for women*.
- Witt, L., & Diaz, C. (2019). Social workers' attitudes towards female victims of domestic violence: A study in one English local authority. *Child and Family Social Work*, 24(2), 209–217. <https://doi.org/10.1111/cfs.12604>
- Women's Aid (n.d.) *Research integrity framework on domestic violence and abuse*. <https://www.womensaid.org.uk/wp-content/uploads/2020/11/Research-Integrity-Framework-RIF-on-Domestic-Violence-and-Abuse-DVA-November-2020.pdf>
- Women's Aid. (2021). *The Impact of Less Funding for Domestic Abuse Services* [Online]. Retrieved November 27, 2024, <https://www.womensaid.org.uk>
- Women's Aid. (2022) *Are you listening? 7 Pillars for a survivor-led approach to mental health support*. Women's Press Aid.
- Women's Aid. (2024). *National Quality Standards – Women's Aid* [Online]. Retrieved January 2025, <https://www.womensaid.org.uk/what-we-do/national-quality-standards/>
- Women's Aid and SafeLives (2016) *Shared Roadmap for System Change: Jointly endorsed evidence-based recommendations to change policy, practice and funding in our sector and to transform women and girls' lives*. <https://www.womensaid.org.uk/wp-content/uploads/2016/11/Shared-Roadmap-for-System-Change-1.pdf>
- Wood, D., & Madigan, R. (2022). Exploring trauma-informed care in Plymouth's domestic violence services [Online] Available at: [Insert URL here] Retrieved November 27, 2024.

- Wood, L. (2015). Hoping, empowering, strengthening: Theories used in intimate partner violence advocacy. *Affilia*, 30(3), 286–301. <https://doi.org/10.1177/0886109914563157>
- Wood, L., Clark, D., Cook Heffron, L., & Voth Schrag, R. (2020). Voluntary, survivor-centered advocacy in domestic violence agencies. *Advances in Social Work*, 20(1), 1–21. <https://doi.org/10.18060/23845>
- Woodcock, J., & Woodcock, J. (2022). Social systems that promote attachment versus systems that create trauma. In *Families and individuals living with trauma: A guide for therapists, relatives, and friends* (pp. 123–139). Springer International Publishing. https://doi.org/10.1007/978-3-030-79039-4_9
- World Health Organization. (1992). *The ICD-10 classification of mental and behavioral disorders: Clinical descriptions and diagnostic guidelines*. Author.
- World Health Organization. (2014). *Global status report on violence prevention 2014*. World Health Organization. Retrieved September 2024, <https://www.who.int/publications/i/item/9789241564793>
- World Health Organization. (2018). *ICD-11: International classification of diseases* (11th revision). Retrieved September 2024, <https://icd.who.int/en/>
- World Health Organization. (2019). *ICD-11: International classification of diseases* (11th revision) [Online]. Retrieved January 2025, <https://www.who.int/standards/classifications/classification-of-diseases>
- World Health Organization. (2024) [Online] Available at: *Understanding and addressing violence against women*. Retrieved January 2025, https://iris.who.int/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf
- Yatchmenoff, D. K., Sundborg, S. A., & Davis, M. A. (2017). Implementing trauma-informed care: Recommendations on the process. *Advances in Social Work*, 18(1), 167–185. <https://doi.org/10.18060/21311>
- Yazan, B. (2015). *Three approaches to case study methods in education*. Yin, and Stake.

- Yeater, E., Miller, G., Rinehart, J., & Nason, E. (2012). Trauma and sex surveys meet minimal risk standards: Implications for institutional review boards. *Psychological Science*, 23(7), 780–787. <https://doi.org/10.1177/0956797611435131>
- Yehuda, R., & LeDoux, J. (2007). Response variation following trauma: A translational neuroscience approach to understanding PTSD. *Neuron*, 56(1), 19–32. <https://doi.org/10.1016/j.neuron.2007.09.006>
- Yin, R. K. (2009). How to do better case studies. *The SAGE handbook of applied social research methods*, 2, (254–282).
- Yoon, R. (2021). *Programme domains of trauma-informed practice associated with client perception of care and staff perceived organizational support: A study of women's substance use programs utilizing qualitative comparative analysis* (Doctoral dissertation, University of Toronto (Canada)).
- Youansamouth, L., Ruston, R., & Clarke, S. (2020). Lancashire violence reduction network: Outcomes framework. Lancashire Violence Reduction Network [Online]. Retrieved January 2025, <https://lancsvrn.co.uk/wp-content/uploads/2020/10/Outcomes-Framework-Lancs-Violence-Reduction-Network.pdf>
- Youssef, N. A., Lockwood, L., Su, S., Hao, G., & Rutten, B. P. F. (2018). The effects of trauma, with or without PTSD, on the transgenerational DNA methylation alterations in human offsprings. *Brain Sciences*, 8(5), 83. <https://doi.org/10.3390/brainsci8050083>
- Yu, B., Ndumu, A., Mon, L. M., & Fan, Z. (2018). E-inclusion or digital divide: An integrated model of digital inequality. *Journal of Documentation*, 74(3), 552–574. <https://doi.org/10.1108/JD-10-2017-0148>
- Zahar, R. (1974). *Frantz Fanon: Colonialism and Alienation* (Vol. 19). NYU Press.
- Zhu, J., Exner-Cortens, D., Dobson, K., Wells, L., Noel, M., & Madigan, S. (2024). Adverse childhood experiences and intimate partner violence: A meta-analysis. *Development and Psychopathology*, 36(2), 929–943. <https://doi.org/10.1017/S0954579423000196>

APPENDICES

Appendix A Practitioner Interview Schedule



Before the interview

- My name is Rachel Close and I am a PhD research student from the University of Central Lancashire. I am part of the research team working on the Roadmap for change that lasts evaluation.
- I would like to ask you about the work you have done using the VOICES framework and assessment tools - including aspects of the work you found most helpful and any areas for improvement.
- I am specifically interested in learning more about 'trauma informed approaches' (see definition of a trauma informed approach below).
- Some questions I will ask are about how you support women accessing WWIN and other questions are about how WWIN supports you to do that work with survivors.

A Trauma-Informed Approach is a model for organizational change in front line human services that promotes resilience in staff and service users. Key principles of this approach include safety, trustworthiness, transparency, cultural sensitivity, collaboration, and empowerment among and between staff and service users. This approach recognizes the role trauma plays in the lives of service users and staff and seeks to shift the clinical perspective from “what’s wrong with you” to “what happened to you” by recognizing and accepting ‘symptoms’ or ‘certain behaviours’ as strategies developed to cope with trauma.

The questions I will ask are about gaining a sense of the use and usefulness of a trauma informed approach in relation your work in domestic violence service provision. You do not have to answer any questions you do not want to. Your

answers will not be identifiable (anonymous) and are not related to workplace performance measures.

Introduction questions:

How long have you worked for Women's aid?

What is your professional background?

What drew you to this kind of work?

Workforce Development questions

Have you/your colleagues all received formal training around psychological trauma?

Are you familiar with the term trauma informed? What does it mean to you?

Do you regard your work as trauma informed?

Have you heard of secondary or vicarious trauma? How would you define in your own words

How would you/your service prevent this happening to your staff?

Does your service provide any resources for your practitioners i.e. information about trauma and or secondary trauma?

What structures are in place to support learning, best practice and support around working with people who may be traumatised?

Trauma Focussed Service questions

Are you familiar with the principles of trauma informed care?

(if no, provide the list: Safety , Trust , Empowerment, Choice, Control and a sense of Partnership working/Collaboration)

How do you apply the following principles of trauma informed care within your work with survivors?

Safety:

Trust:

Empowerment:

Choice:

Control:

Partnership working:

Do you record outcomes or make case notes which allude specifically to the trauma informed principles?

Do you use trauma screening tools? i.e trauma symptom checklist

Who would you refer to for specialist trauma practitioners? What are the links/pathways with psychotherapists and mental health services?

Are trauma histories recorded within your care plans/assessments?

*After they have answered the question in their own words, optional prompt:
any information regarding previous traumatic experiences or relationship based trauma that the person your working with has previously experienced*

Service Delivery questions

Do you know of any info sharing around trauma informed practice (TIP) within your agency?

In consultation with other agencies?

What does your organisation do to ensure risk reduction around re-traumatisation?

What input does your service get from service users in developing trauma informed systems?

Prompt: this could be getting service user feedback about referral route, accessibility of the service, multi agency working and sharing information about trauma histories etc

Would you say that your interventions are strength based? Please describe how?

How do you provide safe and positive environment for your service users?

Is there any inclusion of TIP in written policy?

Do you have an appointed leadership/job role specifically related to trauma informed care in your organisation?

What does your organisation do to ensure risk reduction around re-traumatisation?

Additional questions

I will read aloud this definition of repeat victimisation:

Repeat victimisation- someone who has repeatedly been the victim of domestic abuse (or indeed any other abuse of maltreatment), with their current partner or other previous partners.

Does your work involve helping women understand their situation where repeat victimisation is an issue?

Do you think that a trauma informed approach helps you to reduce the shame or stigma some survivors carry if they :

Return to an abuser?

Have multiple experiences of domestic abuse by different perpetrators?

Endings:

How do you know when it is time to stop working with a service user?

How is the effectiveness of VOICES therapeutic intervention measured?

If they do not understand the question, prompts could include, outcome measures, observations, service user feedback etc.

Are any of the following factors considered when assessing the effectiveness of therapeutic intervention (provided through VOICES framework)

I read through this list

- The survivors stress levels (prompt if needed: anxiety or aggression) and stress related behaviours (i.e. alcohol use);
- The survivors emotional wellbeing (prompt if needed: feeling more upbeat, less frightened, sad or anxious)
- The survivors self-esteem (prompt if needed: confidence, feeling of being in control);
- The survivor's social life (prompt if needed: spending more time with loved ones, getting along better with other people, creating stronger connections with people around you etc);

- The survivor's family relations (prompt if needed: improved relationship with your children, speaking with your own family members more often, feeling supported by your family);
- The survivor's victimisation (prompt if needed: have they experiences more/ less incidents of being a victim of abuse or violence?)

Close and Debrief

What would you want other people to realise about domestic abuse?

Prompts: Dispelling any myths, more awareness about the prevalence of domestic abuse, more understanding and compassion shown to survivors?

How do you look after yourself? Either professionally or personally

Prompts- clinical supervision, support from colleagues, hobbies outside of work, mindfulness

What are the most rewarding aspects of your job?

Is there anything we have not discussed which you think is important?

Was this conversation okay for you? If not, what could we do better?

Do you need any support following this discussion? If yes, ask if they would like to be referred back to staff member or provider or other support signposting

Would you like a summary of the findings sent to you? If yes, what is the safest way to do this?

If you no longer wish to take part in this research or would like any specific answers you have provided to be omitted from (left out of) publication, please do not hesitate to contact myself or my academic supervisor, Rachel Robbins.

Thank you

rclose@uclan.ac.uk

RRobbins1@uclan.ac.uk

Appendix B Practitioner Information Sheet



Shared Roadmap for System Change

Transforming the response to women and girls who have experienced domestic abuse

INFORMATION SHEET FOR PRACTITIONERS TAKING PART IN TELEPHONE OR FACE TO FACE INTERVIEWS

Who is this information for?

This information sheet provides information about the interviews being carried out with practitioners at Wearside Women in Need service (WWIN), specifically those using the VOICES assessment and intervention framework.

Why is this research being carried out?

This research forms a part of the independent evaluation of the Wearside Women in Need services. The research is taking place from 2018 to 2021. This specific part of the evaluation research will specifically seek to understand if a 'Trauma Informed' approach (TIA) to domestic violence service provision can better serve the needs of survivors, practitioners and organisations.

Who is doing the research?

Researchers at the Connect Centre, University of Central Lancashire, are undertaking an independent evaluation of services provided by Women's Aid and SafeLives, funded by the Big Lottery. This is known as the 'Roadmap' study. This PhD research is part of the 'Roadmap' evaluation. My name is Rachel Close and I am a PhD student with the University of Central Lancashire. My research is focused on the VOICES intervention which has been designed to help respond effectively to survivors of domestic abuse with 'complex needs'. VOICES is described as a 'framework and set of associated tools which will enable expert independent women led services to provide services to women that is: Needs led, Strengths Based and

Trauma Informed'. The focus of my research will be to understand how a 'Trauma Informed approach' (TIA) is being used at this particular site, to better serve the needs of survivors, practitioners and the organisation as a whole. In order to do this, I will use Hanson and Lang's schema (2016) which consists of three elements: workforce development trauma-focused services and organisational delivery:

- Workforce Development: Staff training on trauma, measure staff knowledge proficiency, prevent secondary trauma in staff, info/access to TFT for staff
- Trauma Focussed Services: evidence-based trauma assessments (history and symptoms), include trauma history in care plan, availability of trauma practitioners (trained)
- Organisational Delivery: info sharing around TIP in agency, with other agencies, risk reduction around re-traumatisation, input from service users in developing TI system, interventions that are strength based/promote positive development, provide safe and positive environment, inclusion of TIP in written policy, leadership/job role specifically related to TIC

What would we like you to do?

We would like this pre-interview information sheet to given to all WWIN practitioners before they take part in a semi structured interview.

Practitioners as Gatekeepers

In addition to taking part in the research as a participant, your role as keyworker will be essential to help us make contact with survivors of domestic abuse you work with. We understand that women will be nervous and potentially nervous or suspicious of us and the forms we are asking them to complete. We will listen to their concerns from you and provide further information to increase their confidence.

At the beginning of the evaluation, we will need written consent from women to agree to sharing their data and completing the forms.

- Give the information sheet to all workers and survivors who will be taking part surveys and in face to face or telephone interviews
- Assist with keeping consistent data e.g. ID numbers
- Help researchers to communicate with clients/ service users and assess any needs or barriers that may affect their participation in the research

- Discuss any concerns or queries you may have with the research team

September/November 2020:	All staff/practitioners will be sent the information sheet and consent form to read. Please take time to go through it and clarify anything they don't understand. Please inform us of any specific requirements e.g. language, learning difficulty etc. so that we can provide information in an appropriate format.
November/December 2020	Surveys and Interviews (face to face or telephone) will be carried out with staff/practitioners. At the end of the interview they will be asked to invite at least one service user they have/are currently working with to take part in the survivor interview phase
January/February 2021	Interviews to be carried out with survivors/service users at a Wearside Women In Need appointed safe location.

Points to note

- Please assure your service users that this research study is separate to the care they will receive as part of the WWIN service, and their participation will not affect the service they receive from you.
- Participants can withdraw their data from the study with two weeks of completing the questionnaire.

What happens to the information you provide?

We will give everyone who takes part a code number. The privacy of all those participating in the research will be protected and you will not be identified in any reports or material produced.

If service users tell us that they, an adult or a child/young person is at risk of serious harm then we will have to tell their **WWIN support worker** but I will talk to them about this first. We will keep all transcripts of audio recordings secure and they will be destroyed five years after the end of the project.

What protection measures are in place?

Participation in the research is voluntary and participants will be asked for their consent every time they complete an interview. Participants can choose to withdraw their research data up to two weeks after completing the Interview. If this happens, their data will be destroyed within 48 hours and no further data will be collected.

We understand the sensitive nature of the research and great care has been taken to address any ethical concerns. The research has been reviewed by the Psychology and Social Work Ethics Committee at the University of Central Lancashire.

Information containing names and identifying information will be kept according to the UCLan Data Storage and Protection policy and will be stored in files separate to the research data collected. All documents will be stored electronically, and password protected. The identity of staff, clients and all data will be anonymous. Participants will be known by an ID number. Coding systems will be stored separately and accessed only by the evaluation team. Identifying features of participants will be removed.

Who has approved the study?

The project has been approved by the University of Central Lancashire's Ethics Committee. If you wish to contact them you can email them at ethicsinfo@uclan.ac.uk

How will the results be used?

The report on services in five areas of England will be published in 2021. The results will be used to improve and develop services for women and girls experiencing domestic abuse.

What if I want more information?

Please contact the Research Team if you have any questions. Their contact details are:

Helen Richardson Foster, Research Associate, Connect Centre, UCLan

Email: hrichardsonfoster@uclan.ac.uk Tel: 01772 895121 ~ 07870 835316

Kelly Bracewell, Research Associate, Connect Centre, UCLan

Email: kbracewell1@uclan.ac.uk Tel: 01772 893667 ~ 07870 835306

In case of complaint contact details:

Nicky Stanley, Professor of Social Work, UCLan

Email: nstanley@uclan.ac.uk

Tel: +44 (0) 1772 89 3655

Appendix C Practitioner Consent Form



PRACTITIONER INTERVIEW CONSENT FORM

Please read the following statements and tick the boxes if you agree:

I have read the research information sheet and I have had the opportunity to ask questions. ☐

I agree to this interview being recorded. ☐

I agree for you to talk with my worker/my client about our work together at WWIN. ☐

I understand that information which suggests that there may be serious risks to me or a child cannot be kept confidential and I have had this explained to me. ☐

I understand that my participation will be anonymous and any details that identify anyone will not be included in reports or other publications produced from the research. ☐

I agree to take part in the research ☐

Please sign below to give your consent

Name (PRINT):	_____	
Signature:	_____	Date: / /

Name of researcher (PRINT):

Signature of researcher : _____

Date: / /

Appendix D Survivor Interview Schedule



Before the interview

Go through consent and make sure they understand each point clearly especially around not having to answer a question and can stop the interview at any stage without giving a reason. Explain that the interview is expected to last between 40 minutes to an hour.

- My name is Rachel Close and I am a PhD research student from the University of Central Lancashire.
- I would like to ask you about the work you have done with (key worker), including aspects of the work you found most helpful and any areas for improvement.
- I am specifically interested in learning more about women's experiences of 'trauma informed care' (see definition of trauma and trauma informed care below) and how/if your worker has been able to help you recover from traumatic experiences
- Some questions I will ask are about how your worker/MSP works with other services and advocates for your needs.
- Voucher.

Introduction Questions

Age:

Gender:

Parenting Status:

Nationality:

Ethnic Origin:



Level of educational attainment (i.e. secondary school, college, undergraduate, postgraduate):

1. You and MSP

How long have you been using the service? Have you accessed different parts of the service (i.e. counselling, IDVA, outreach, refuge)

What other services (if any) have you received help from in relation to domestic abuse?

How long have you been working with your key worker?

Have you heard of the term psychological trauma? If so what does it mean to you?

Has anyone ever used it in relation to your experiences of domestic abuse?

2. The support/intervention you have received

The principles of trauma informed practice are: Safety , Trust , Empowerment, Choice, Control and Collaboration

Has your worker made you feel safe? How?

Has your worker-built trust with you? How?

Has your worker made you feel more empowered? How- Could you give an example?

** Empowered means : stronger and more confident, especially in controlling your own life and claiming your rights.*

Has your worker helped you to feel more in control? How- Could you give an example?

Has your worker offered you choices? Could you give an example?

Has your worker worked in partnership/collaborated with you? How- Could you give an example?

Have you noticed that any of these difficulties have increased, decreased or stayed the same since you started work with MSP?

Did your worker ever ask you directly about any of these difficulties you were experiencing? *For example, did your worker ever ask you about having 'flashbacks' or having nightmares.*

Has your worker asked you about your life history?
This could include major events, Important relationships, memories from your childhood

Do you feel that your worker plans the work around your needs?
For example, meeting a time and a place that is comfortable and convenient for you.

Would you feel confident to discuss any mental health issues with a MSP worker?

3. Putting your needs first (within MSP & other services you work with)

How do you decide what to talk about during your time with your worker?



Does your worker do anything in particular that makes you feel more comfortable or more at ease?

Does your worker speak to other professionals in your life? Do they talk to one another?

Do you feel that other professionals understand you and your experience of domestic abuse?

Can you tell me more about that?

Are there any other professionals in your life who understand you and your experience of domestic abuse well?

Can you tell me more about that?

Has your MSP worker helped the other workers to understand your difficulties and your needs? How?

Have you ever had to miss or reschedule an appointment with your MSP worker? If yes how have they responded?

Are you ever asked by your worker to contribute to a service evaluation or asked to fill in questionnaires about your experience of working with the service?

Do you feel you can give feedback if something doesn't work for you?

Does your worker point out or highlight your strengths? Could you give an example?

Have you ever noticed the work 'Trauma' or 'Trauma informed practice' in any paperwork you have signed/read during your work with this agency?

Have there been any things that made it difficult for you to work with MSP?

Practical (location/work/housing)	Location / accessibility Work commitments Housing issues Financial
Identity (religion/sexuality/culture)	Gender Ethnicity Religion Culture Sexuality Disability
Your feelings about using the service	Fear of punitive action by social services (i.e. if I talk about my partners abusive behaviour, I fear that my children may be taken away) Issues around privacy or consent (e.g. I am afraid my information will be shared with other agencies without my consent)
Other difficulties	Lack of support system Stigma Emotional distress Mental health issues Substance or alcohol use Familial relationships/ obligations/loyalty

Do you talk about any of the following topics?

Which topics do you speak about the most with your worker ?

Prompt if needed- i.e. safety planning, risk, child protection issues, experiences of abuse, etc

Are there any topics you wish you spoke about more with you worker?-

Prompt if needed- i.e. how you feel, goals for the future, family support, etc

5. Changes

Would you say you started working with MSP because you wanted something to change?

Did you set goals/aims or targets you wanted to work towards with your MSP worker?

Through working with MSP, would you say any of these areas have been impacted upon?

- Your stress levels (i.e. anxiety or aggression) and stress related behaviours (i.e. alcohol use);
- Emotional wellbeing (feeling more upbeat, less frightened, sad or anxious)
- Self-esteem (confidence, feeling of being in control);
- Social life (spending more time with loved ones, getting along better with other people, creating stronger connections with people around you etc);



- Family relations (improved relationship with your children, speaking with your own family members more often, feeling supported by your family);
- Being a victim of crime or abuse (more or less incidents of being a victim of abuse or violence)

Have you or your worker discussed any changes in your life in any of the areas listed here?

What would you say has been the most helpful thing about the support you have received from MSP?

How would you describe MSP/your worker to a friend or family member who was ever in need of support?

6. Close and Debrief

Is there anything we have not discussed which you think is important?

Was this conversation okay for you? If not, what could we do better?

Do you need any support following this discussion? If yes, ask if they would like to be referred back to staff member or provider or other support signposting

Would you like a summary of the findings sent to you? If yes, what is the safest way to do this?

If you no longer wish to take part in this research or would like any specific answers you have provided to be omitted from (left out of) publication, please do not hesitate to contact myself or my academic supervisor, Nicky Stanley.

Thank you

Appendix E Survivor Information Sheet



SURVIVOR Participant Information Sheet

1. Title of Study

How does a 'Trauma Informed' approach (TIA) impact on domestic abuse (DVA) service provision: for survivors, the practitioners, and the organisation?

2. Version Number and Date

Version 1- 15.10.21

3. Invitation Paragraph

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your WWIN worker or other people you know and trust while deciding if you would like to take part. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

This information sheet provides information about the interviews being carried out with survivors who are working, or have worked, with the Wearside Women in Need service (WWIN).

Who is doing the research?

My name is Rachel Close and I am PhD student with the University of Central Lancashire. Researchers at the Connect Centre, which is part of University of Central Lancashire, have undertaken a large, national evaluation of services designed to support survivors of domestic abuse. This evaluation is known as the 'Roadmap' study. The study you are being invited to take part in is a small PhD study which is part of this. My research is focused on the trauma informed approach adopted by Wearside Women In Need, which has been designed to help respond effectively to survivors of domestic abuse with 'complex needs'.

My PhD study seeks to understand 'How does a 'Trauma Informed' approach (TIA) impact on domestic abuse (DVA) service provision: for survivors, the practitioners, and the organisation?'

4. What is the purpose of the study?

What is a trauma informed approach? A trauma informed way of working is about understanding that the experiences that survivors have lived through have been traumatic, in the sense that these experiences may have been so frightening or overwhelming that they have had a damaging impact on your physical and/or emotional health as well as your social life and relationships. A 'trauma informed' approach to supporting people who have lived through such experiences, prioritise safety, trust, collaboration, choice, control and empowerment in all their work with survivors.

Wearside Women in Need have stated that they work with survivors in a trauma informed way. This research is about asking staff providing support and survivors receiving support, about their experiences of a 'trauma informed' approach

5. Why have I been invited to take part?

As a survivor of domestic abuse, who is currently accessing support from Wearside Women in Need, your voice is important. My research is interested in finding out your experiences, particularly your experiences of trauma informed support.

More generally, learning about the views and experiences of survivors helps professionals and policy makers to not lose sight of your needs and continue working to improve and increase the support available women and girls experiencing domestic abuse.

6. Do I have to take part?

Participation in this research is voluntary and it is important that you understand that should you not wish to take part, you will not incur any disadvantage or disruption to the support you are currently receiving at WWIN.

If you do wish to take part:

- Taking part in this research study is separate to the care you will receive as part of the Wearside Women in Need service, and the answers you provide will not affect the service you receive.
- You can withdraw your consent at any time before or during the research and within two weeks of completing the research questionnaire and interview by contacting me on Rclose@tees.ac.uk

7. What will happen if I decide to take part?

The first stage of my research involving survivors will be inviting you to complete a trauma impact scale which your worker will print out and give to you. (this can be completed alongside or with the support of your worker if you wish). The scale draws from the trauma symptom inventory (TSI) and the trauma symptom checklist (TSC) to provide a way of learning about the presence and impact of trauma experienced by each survivor. This scale will ask you to look at a series of statements about psychological and physical impacts of trauma. You are required to tick a box to rate your level of experience or agreement, for example:

I experience memory problems 0 (never) 1 (occasionally) 2 (sometime) 3 (often)

On completing the scale, your WWIN support worker will scan the form and email it to me via a secure email system. The next stage is inviting all those who completed the impact scale to take part in a semi-structured interview, via telephone or Microsoft Teams in which I will ask you about some of your experiences working with the organisation.

You can also discuss with your worker if you would like them to be present during the conversation or if you would like to arrange to contact them following our conversation.

The interviews will be around 45 mins to an hour and will be carried out by me.

No additional persons will be present unless you have requested the presence of your WWIN worker or someone else who can support you. At the start of our conversation, I will ask you

if you are happy for me to record the call and I will talk briefly about consent and remind you of your right to withdraw from the research process check out with you that you are comfortable to proceed.

I will then ask you questions about your experiences of support at WWIN. There are no 'wrong' answers, I will be asking about your views, experiences, feelings, and thoughts. Any information you are able to provide will be greatly appreciated and valued.

What will happen to the information you provide?

Following our interview, I will save the audio recording of our conversation under a specific code number. The privacy of all those participating in the research will be protected and you will not be identified in any reports or material produced.

If you tell me that you or another adult or a child/young person is at risk of serious harm, then we will have to tell another responsible adult but will talk to you about this first. We will keep all completed questionnaires and interview data secure, and the data will be destroyed five years after the end of the project.

All documents will be stored electronically, and password protected. The identity of staff, clients participating, and all data will be anonymous. Participants will be known by an ID number. Coding systems will be stored separately and accessed only by the evaluation team. Identifying features of participants will be removed. Information containing names and identifying information will be kept according to the UCLan Data Storage and Protection policy and will be stored in files separate to the research data collected.

We understand the sensitive nature of the research and great care has been taken to address any ethical concerns. The research has been reviewed by the Psychology and Social Work Ethics Committee at the University of Central Lancashire.

8. How will my data be used?

The final PhD theses will be completed in 2024 and shared with you if you would like to receive a copy, before being published. The results will be used to improve and develop services for women and girls experiencing domestic abuse

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

Further information on how your data will be used can be found in the table below.

How will my data be collected?	<i>Short scales and Semi structured interviews with staff and managers working for a domestic abuse charity, Women's Aid</i> <i>Semi structured interviews with adult female survivors accessing support from this domestic abuse charity</i> <i>Demographic data provided by participants during interview</i> All interviews will take place over the phone or using Microsoft Teams. I will record the audio from these conversations (not video) to an mp3 file which will be safely and securely stores on the university One Drive that is password protected.
How will my data be stored?	<i>Paper copies of consent forms stored in filing cabinets</i> <i>Audio files stored securely on password encrypted hard drives.</i> At collection, data will be stored on encrypted devices. Electronic data will only be accessible via a secure connection. Non-electronic data will be stored in locked cabinets and will not be left unattended or in view of unauthorised people
How long will my data be stored for?	5 years after completion of the study
What measures are in place to protect the security and confidentiality of my data?	<i>Data gathered will be stored on password protected computers as per GDPR requirements.</i> <i>Research staff have successfully completed online GDPR training.</i> <i>I will be transcribing my own data. Transcriptions will also be stored on password protected computers as per GDPR requirements.</i> <i>This is in line with the UCLAN Data protection check list. Data will be destroyed 5 years after the project ends (i.e. 2026).</i>

Will my data be anonymised?	Yes The identity of staff, clients participating, and all data will be anonymous. Participants will be known by an ID number. Coding systems will be stored separately and accessed only by the evaluation team. Identifying features of participants will be removed. Information containing names and identifying information will be kept according to the UCLan Data Storage and Protection policy and will be stored in files separate to the research data collected.
How will my data be used?	<i>I will be looking at how a Trauma informed approach (TIA) can better serve the needs of survivors. practitioners and organisations. Consequently, I will be asking participants about their learning, practices, awareness, and experiences of working with and addressing trauma symptoms.</i>
Who will have access to my data?	<i>The University of Central Lancashire research team, including my academic supervisory team Nicky Stanley & Helen Foster Prior</i> <i>No data processor is being used (no third party person or organisation will have access to personal data).</i>
Will my data be archived for use in other research projects in the future?	Yes
How will my data be destroyed?	<i>This is in line with the UCLan Data protection check list. Data will be securely destroyed 5 years after the project ends- all information will be deleted from all UCLan data storage systems.</i>

[Transferring data outside the EU](#)

N/A

Contact Tracing

Only use this section if you will be conducting face-to-face participant interactions. The template COVID-19 Research Participant Pre-Visit Check form provides a section to collect the participants name and contact number. This information should be stored securely on the University network and in separate folder to where the research data is stored. You must destroy this information 21 days as per [UK Government guidelines](#)

[please check relevant authority guidelines if non-UK] after your final in-person face-to-face contact with the participant.

As well as your research data which we have described above, we will also collect your contact information through the [COVID-19 Research Participant Pre-Visit Check form]. This is for the sole purpose of facilitating contact tracing by the NHS [/health authority name if non-UK] as part of efforts to control the coronavirus. Your contact information will not be accessed or shared with anyone other than the researcher, their supervisor (as a safeguard in the event of the researcher becoming unwell) and, only if required, an contact tracer. This information will not be used for any other purpose and no other data collected as part of this research will be shared in this way.

Your contact information, which is fully identifiable, will be stored separately, and with no obvious link, to the research data described above, in a secure encrypted and password protected file on university servers.

Your contact information will be destroyed 21 after our last in-person face-to-face contact. Your contact information can only be withdrawn if we have not yet had in-person face-to-face contact.

9. Are there any risks in taking part?

The interview is asking about how you have been supported by WWIN and your feelings and thoughts about your experience. You may find the topic of the interview or some the questions upsetting and if you wish to, you are free to stop the interview at any point and you do not have to answer any questions you do not wish to. We will make sure there is someone for you at WWIN to speak to after the interview if you need to and will provide you with information of other helplines and places you can seek support. I will ask you how you are feeling and if you would like to contact your WWIN worker following the interview. This could also be discussed during the interview If anything arises that causes distress or upset. Care has also been taken to make sure that focus of the questions is less around traumatic experiences and more around experiences of being supported by WWIN.

Whilst there will be a risk of a participant being identified from published data, I intend to anonymise their data and prevent this from occurring wherever possible, i.e. not stating names, or precise geographic locations such as addresses.

At collection, data will be stored on encrypted devices. Electronic data will only be accessible via a secure connection. Non-electronic data will be stored in locked cabinets and will not be left unattended or in view of unauthorised people

10. Are there any benefits from taking part?

In accordance with the [Research Integrity Framework on Domestic Abuse](#) (WA, 2020) researchers need to be 'accountable to each other, to survivors, and to the DVA sector in being as transparent as possible about the benefits and limitations of their work' (2020 p 4). While for some the benefits of contributing to research studies through sharing their own personal experiences may be derived from a sense of helping others, seeking justice and contributing to improvement of services, others may be driven to take part in order to have their voices heard. All too often research about domestic abuse does not include the views and lived experience perspectives of survivors.

Research often seeks to identify gaps or improvements that need to be made in service provision while also highlighting good practice that we can build upon. Your voice as a survivor is crucial because your views should be at the heart of the way in which any support service is designed and delivered.

While there may be no immediate or direct benefits for you on an individual basis as a result of taking part in this research, the wider goal of this research, and including survivor participants voices is to improve domestic abuse services for women and girls.

11. Expenses and / or payments

All Participants will be given a £15 shopping voucher as a gesture of gratitude for taking part in the study.

12. What will happen to the results of the study?

Anonymous data will be used in my PhD thesis, and in other reports resulting from this such as journal articles and conference presentations.

Your data will be anonymous, and your name will not be used in any publications.

I would like to offer any female survivors of domestic abuse who have contributed to this study the opportunity to help me present the findings at conferences or training events, should the opportunity

arise. This is by no means an obligation of taking part in a research interview. Should any woman wish to be involved in presenting the findings of this research we would have further conversations around how that person wishes to be identified and acknowledged within this continued engagement with the research process. Each woman's need for safety, comfort and choice would be prioritised in this decision-making process.

You will be asked at the end of your interview if you would like to receive a copy of the research thesis when it is completed. If you have stated that you would like a copy, I will ask you about how I can get that information to you safely. This could be through your support worker or through a safe and secure email address that you are happy to share with me (please see information below about how I store any personal information you provide).

13. What will happen if I want to stop taking part?

Informed consent is an ongoing process, not just something that occurs at the start of a study. You can withdraw their consent at any time before or during the research and within **two weeks** of completing the research questionnaire and interview. This is because data will be anonymised with this two-week time frame, afterwards it will not be possible to tell which results belong to which person. To do this email me on the contact details below:

r.close@uclan.ac.uk

14. What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting

Nicky Stanley, Professor of Social Work, UCLan

Email: nstanley@uclan.ac.uk

Tel: +44 (0) 1772 89 3655

If you remain unhappy, or have a complaint which you feel you cannot come to us with, then please contact the Ethics, Integrity and Governance Unit at OfficerForEthics@uclan.ac.uk.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

15. Who can I contact if I have further questions?

What if I want more information?

Please contact me if you have any questions, my details are:

r.close@uclan.ac.uk

Appendix F Survivor Consent Form



Shared Roadmap for System Change

Transforming the response to women and girls who have experienced domestic abuse

EVALUATION OF Wearside Women In Need INTERVIEW CONSENT FORM

Please read the following statements and tick the boxes if you agree:

I have read the research information sheet and I have had the opportunity to ask questions. q

I agree to this interview being recorded. q

I agree for you to talk with my worker/my client about our work together at WWIN. q

I understand that information which suggests that there may be serious risks to me or a child cannot be kept confidential and I have had this explained to me. q

I understand that my participation will be anonymous and any details that identify anyone will not be included in reports or other publications produced from the research. q

I agree to take part in the research q

Please sign below to give your consent

Name (PRINT):	_____	
Signature:	_____	Date: / /
Name of researcher (PRINT):		
Signature of researcher :	_____	Date: / /

Appendix G Survivor Ethical Approval



University of Central Lancashire
Preston PR1 2HE
01772 201201
uclan.ac.uk

09 November 2021

Rachel Close / Nicky Stanley
School of Social Work, Care and Community
University of Central Lancashire

Dear Rachel / Nicky

Re: BAHSS Ethics Review Panel Application

Unique Reference Number: BAHSS2 0143 CA Amend 13 10 21

The BAHSS Ethics Review Panel has approved your proposed amendment to your application 'To understand how a 'Trauma Informed' approach (TIA) to domestic violence service provision can better serve the needs of survivors, practitioners and organisations'.

Yours sincerely

Richard Davies
Deputy Vice-Chair
BAHSS Ethics Review Panel

