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"It's Like Drowning and You Can't Get Out"; The Influence of Intimate Partner Violence on Women with Chronic Low Back Pain

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Abstract

As intimate partner violence (IPV) can have a long-term impact upon physical pain and psychological distress, the lived experiences of six women with chronic low back pain (CLBP) who survived IPV were studied in order to deepen the understanding of how they have experienced CLBP and IPV. Two superordinate themes were identified from the findings; "psychological interface of IPV and pain" referring to the psychological impact and "pain as a symptom of IPV" reflecting the physical trauma responses that the women identified. This article identifies clinical implications for counselling psychologists to consider when providing therapy for people with CLBP. This study suggests that if issues associated with the trauma are not identified, treated or supported, pain experiences may be impacted, which could compromise therapeutic treatment. Questions need to be asked about trauma history when assessing for CLBP, and management treatments need to incorporate strategies for understanding and coping with the impact of IPV. Counselling psychologists need to be at the forefront of delivering training to medical colleagues who may not consider the significance of trauma upon CLBP experiences and responses.

Keywords

chronic low back pain, interpretative phenomenological analysis, intimate partner violence, trauma, counselling psychology

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Introduction

Chronic lower back pain (CLBP) is defined as back pain that is experienced consistently for a minimum of three months, which is beyond the time in which healing from an acute injury would be expected to take place, and therefore is not associated with tissue damage (British Pain Society, 1997; Cole, Macdonald, Carus, & Howden-Leach, 2010). Across England, one in eight people live with chronic pain daily, and annually, around one-third of the UK population will experience lower back pain (National Institute for Clinical Excellence (NICE), 2009). Nineteen percent of European adults experience moderate to severe chronic pain (Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006). NICE guidelines (2016) state that worldwide, low back pain is the most significant cause of disability. In addition to pain and potential disability, CLBP can also negatively influence personal and social relationships (De Souza & Oliver Frank, 2011), perceived social role (Bailly, Foltz, Rozenberg, Fautrel, & Gossec, 2015), activities, work, stigma, and outlook (Froud et al., 2014).

CLBP has been identified as one of the detrimental consequences of *intimate partner violence* (IPV) (Balousek, Plane, & Fleming, 2007; Campbell et al., 2002; Humphreys, Cooper, & Miaskowski, 2011; Wilson, Silberberg, Brown, & Yaggy, 2007). However, the psychological factors that explain how the abuse relates to the pain are poorly understood. It is important to understand the impact that living with such conditions has on the individual, to inform services so that they can better respond to the needs of the client in their care.

IPV is defined as physical, psychological, emotional, sexual, and economic abuse. These violations may be perpetrated together or separately by a current or previous intimate partner (Taket, 2004). According to Sanderson (2008), IPV also includes spiritual abuse and is characterised by controlling behaviour. The Crime Survey for England and Wales (2018) gathered data on partner violence within the previous twelve months via self-completed reports in which they included non-physical abuse (emotional or financial), threats, force, sexual assault, and stalking. For those between the ages of 16 and 59, women reported greater abuse rates than men since the age of 16 (24.9% and 10%, respectively). For those between the ages of 60 and 74, 18.9% of women and 9.1% of men reported having been victims on at least one occasion. This data does not include physical violence, and, due to under-reporting, is unlikely to present an accurate picture.

IPV has a profound impact upon a woman's psychological well-being on account of the fear, shame (stigma), anger, and powerlessness that is often engendered by the experience (Flinck, Paavilainen, & Åstedt-Kurki, 2005; Orzeck, Rokach, & Chin, 2010). IPV is usually hidden from those closest to the survivor, and repeated exposure can result in women losing a sense of their identity, which ultimately impacts upon their confidence and self-worth (Orzeck et al., 2010). Victims of IPV often live in a permanent state of hyper-vigilance, and evidence suggests that female victims are at a higher risk of being murdered by the perpetrator when they leave the relationship than at any other time (Flinck et al., 2005). Thus, survivors may experience and perceive the relationship as traumatic (Orzeck et al., 2010) and may experience symptoms of Post-Traumatic Stress Disorder (PTSD), which can continue long after the relationship has ended (Strigo et al., 2010). Pearlman and Saakvitne (1995, p. 60) define a traumatic experience as one where "The individual experiences (subjectively) a threat to life, bodily integrity, or sanity". For IPV relationships, there is the added impact of the trauma being interpersonal, where what might be perceived to be a loving relationship becomes one in which acts of danger such as sexual, physical or verbal behavior can "cause – or have potential to cause – harm to an intimate partner" (Heyman, Slep, & Foran, 2015, p. 64). The psychological impact of IPV on women includes experiences of constant fear and uncertainty, shock, fear of death, suicidal ideation, and self-blame (Scheffer Lindgren & Renck, 2008). Furthermore, various studies have highlighted the role that emotions can play in maintaining and increasing chronic pain and the impact that IPV and chronic pain can have on mental health, including depression and the risk of suicide (Wuest et al., 2008). Thus, there are physical and psychological impacts both in the short and longer-term.

There is a strong evidence base that links chronic pain with IPV (Balousek et al., 2007; Coker, Smith, & Fadden, 2005; Humphreys et al., 2011), whereby disability associated with chronic pain has been attributed to both the physical violence itself and/or the impact of psychological trauma as a result of long-term abuse (Coker et al., 2005). In a study looking at health needs and barriers of women who experienced IPV, Wilson et al., (2007) found that 32% of their participants ($n = 25$) reported chronic pain, and 16% reported back pain, with 16% indicating physical injury as a result of IPV. An earlier study by Coker et al. (2005) found that for 1,152 women attending family practice clinics, disability was associated with chronic pain. This had been attributed to both the physical violence itself and/or the impact of psychological trauma resulting from long-term abuse. In their research looking at women survivors of IPV and their chronic pain experiences, Wuest et al. (2008) found that from a sample of 292 women, over 50% had experienced back pain that was viewed as related to the abuse ($n = 187$). This suggests that pain may, in part, be a result of the physical harm caused to the woman from their violent partner. Additionally, Wuest et al. (2010) revealed that the reported psychological abuse severity by 309 women from a community sample who had experienced IPV was significantly correlated with chronic pain severity, suggesting that it is not only physical injury contributing to the experience of chronic pain.

More recently, links between post traumatic stress disorder (PTSD) and pain have been identified. Tiwari, Fong, Chan and Ho (2013) explored the experiences of Chinese women who have chronic pain and who have experienced domestic violence; it was found that the severity of PTSD influenced the severity of psychological abuse on the severity of chronic pain. Thus, suggesting that PTSD functions as a mediator, in particular, between severe psychological abuse and severe chronic pain.

Emotions of fear, anger, and sadness have been identified as more likely to be experienced by individuals with PTSD or those who experience chronic pain than a "healthy sample" (Finucane, Dima, Ferreira, & Halvorsen, 2012). This research was focused on five basic emotions; sadness, anger, fear, disgust, and happiness, and the researchers compared four groups; participants who were either healthy, depressed, had PTSD or chronic pain. This quantitative research provided evidence for the importance of emotion-focused interventions; however, the control group of healthy individuals consisted of university students who may not represent the general population and therefore lacked representation of diverse educational/socio-economic differences within and between groups.

These studies' methodology was quantitative, showing the associations between the variables but not the meaning of the experience for the abused women with pain. Nevertheless, research suggests that how survivors respond is paramount to their potential for recovery from pain-related disability (Dysvik, Natvig, Eikeland, & Lindstrøm, 2005) and trauma-related symptoms (Orzeck et al., 2010). For counselling psychologists who work with these women in pain services, adult mental health services, domestic violence services, and beyond, understanding the subjective experiences of survivors of IPV would contribute to enhanced care by informing effective assessment and treatment. Consequently, the aim of this exploratory investigation was to examine the lived experiences of women with CLBP who have survived IPV. Many authors have emphasised the need for clinicians to ask questions, specifically about their history of IPV (Scheffer Lindgren & Renck, 2008) and to discuss the health implications relating to IPV (Bonomi et al., 2009). Specifically, in assessing for the treatment of women with chronic pain, clinicians should be asking questions about IPV history in order to provide support for potential IPV-related PTSD (Balousek et al., 2007; Flinck et al., 2005; Humphreys, Cooper, & Miaskowski, 2010; Wuest et al., 2008). Equally, women who present with an IPV history need to be assessed for health implications (such as chronic pain) that may be linked to the IPV experience (Taft, Vogt, Mechanic, & Resick, 2007). Watson, Carthy, and Becker (2017) interviewed 17 psychological therapists who identified limited training in IPV for specific groups, including women over the age of 45 and a state of "prolonged therapeutic helplessness" that led to several unhelpful strategies, including boundary violations and treating the symptoms rather than the "root cause" (pp.227-228).

The Present Study

The above literature review demonstrates quantitative links between CLBP and IPV; however, there appears to be a lack of qualitative studies that explore women's lived experiences of CLBP in the context of surviving IPV. Wilson et al. (2007, p. 1497) emphasise the importance of using qualitative methods in future health and IPV related research "given the sensitivity, complexity, and subjectivity of the subject matter". If counselling psychologists can understand the experiences of women who have survived IPV and have CLBP, then therapeutic assessment, treatment, and training of colleagues can be tailored to enable women to cope with both their CLBP and the trauma of IPV. The research question which is central to this exploratory study is;

What are the lived experiences of women with CLBP who have survived IPV?

Method

Methodological Approach

Interpretative phenomenological analysis (IPA) was used based upon the method outlined by Smith, Flowers, and Larkin (2009) to ensure a rigorous approach. This is an interactive process between researcher and participant for which "the researcher is trying to make sense of the participant trying to make sense of what is happening to them" (Smith et al., 2009, p. 3). This is also known as a double hermeneutic, whereby the researcher can only interpret the participant's experience, albeit influenced by "the researchers own view of the world" and the relationship between researcher and participant, as stated by Willig (2013, p. 87).

This design allowed for the open exploration of the individuals' experience of "something", in this case, CLBP and IPV. Thus, the process enabled the participant to develop an increased awareness while the researcher "makes sense" (Smith et al., 2009, p. 49) of the participants' experience. This approach places emphasis upon engaging with the participants and their experience through a process in which the power is shared by both researcher and participant. This is particularly significant for participants for whom lack of power is likely to have been a feature of past relationships (Howard, Trevillion, & Agnew-Davies, 2010). It has the added feature of analysing the findings "to shed light" on CLBP and IPV phenomena, thus linking personal experience with practical application (Smith et al., 2009, p. 36). Willig (2013) provides a rationale for why phenomenological research is used so widely within counselling psychology research, which is based on the humanistic philosophy that underpins counselling psychology. In particular, she identifies that the core conditions of person-centered counselling specifically align well with the interview process in which the researcher "listens to the client's account of their experience empathically, with an attitude of unconditional, positive regard and without questioning the external validity of what the client is saying" (Willig, 2013, p. 16).

The ideographic focus allows the researchers to "concentrate on specific individuals as they deal with specific situations or events in their lives" (Larkin, Watts, & Clifton, 2006, p. 103) grounded within a relativist ontology which focuses upon their experiences of those events (Willig, 2013). Finally, IPA allowed for the exploration of more than one phenomenon (Smith et al., 2009), and the question posed to participants gave them the opportunity to explore both experiences while acknowledging that IPV was the historical situation and CLBP was the ongoing process.

Sample

Six adult women were recruited from a National Health Service (NHS) pain service in the north east of England. All participants had received a comprehensive physical assessment for their chronic pain conditions. Inclusion criteria included adult women who had experienced IPV and experienced CLBP for a minimum of three months. The abuse must not have occurred within the last 12 months, removing the risk of "endangering or unsettling women who might not have other supportive contacts" (Enander, 2011, p. 32). This approach is supported by previous research (Enander, 2011; Humphreys et al., 2010, 2011).

All participants were of White British ethnicity and were aged between 26 and 65. Five of the six were unemployed, yet four had gained educational achievement. For all participants, the abusive partner was male. Four of the six had experienced violence from one partner and two from at least two partners, whom they had been in a relationship with between 3 and 32 years. Four of the six women reported having experienced child abuse with physical and emotional ill-treatment being the most common, followed by subsequent sexual violence and neglect. Finally, the source of pain included lower back pain for all women, with additional pains mentioned throughout their bodies.

Data Collection

Ethical approval from a university ethics committee and the research and development ethics committee of the NHS Trust and NRES (National Research Ethics Service) committee was granted. Participants were identified by the pain service and provided with detailed information about the research. All participants had a brief introductory telephone meeting with the researcher. This process provided an opportunity to develop a rapport, provide transparency about the research, and create an ambience that reflected equality with the potential participant as a co-researcher (Kasket, 2012). Dates and times were arranged and audio recorded and face-to-face interviews took place. Interviews lasted between sixty and ninety minutes. The interview began with the focused question, "As a survivor of intimate partner abuse and living with chronic back pain, please can you tell me how these experiences have been for you?" followed by further prompts as open questions to elicit as much rich and subjective data from participants as possible. Participants assigned themselves a pseudonym, used so that completed forms could be cross-referenced with transcribed interview data.

Within four weeks of the interview, the participants were invited to engage in member checking, which lasted, on average for one hour. Recommendations set out by Carlson (2010) were followed to avoid traps in member checking. This was achieved by providing participants with summary statements and quotes rather than the full transcript, and choices and clarity about the process and reassurance about the usefulness of their data. All participants stated how they had benefited from sharing information during the experience of member checking. This process ensured that the findings closely represented participants' lived experiences.

Analysis

The analysis process followed Smith et al.'s (2009) IPA approach for a sample size of up to six participants. The process was divided into stages, beginning with the first author immersing herself in the findings after each interview. Interviews were listened to several times, then transcribed verbatim. Transcripts were also read several times. Notes were written based upon descriptive, linguistic, and conceptual comments, and then emergent themes were recorded. Following final member checking, the researcher began to identify connections across the emergent themes. Through abstraction and polarisation, superordinate themes were developed in the first instance for each participant, followed by the group as a whole. An additional researcher validated the selected themes; the interpretation of findings was then carried out.

Throughout the research process, the first author engaged in ongoing personal and epistemological reflexivity. A journal was utilised when ideas about the research first emerged and throughout the stages of data collection, analysis, and interpretation. The aim was to identify and recognise presuppositions, personal and professional experiences linked to the phenomenon, and maintain a critical stance towards the limitations of the research question, design, and methodology. The awareness of thoughts and feelings were particularly important when making sense of the lived experience from descriptive analysis to phenomenological interpretation. This required a process of detecting and separation from personal experiences and those identified by participants while allowing deeper reflections to "uncover subtle and nuanced insights" that would not have been possible without this level of reflexivity (Goldspink & Engward, 2019, p. 296). Reflecting upon this process and analysing the data with the second author was a fundamental part of the reflexivity process and vital in ensuring that the epistemological position was not compromised.

Results

The research aimed to understand the experience of CLBP within the context of having experienced IPV, and as participants were invited to share their experiences of both phenomena, they explored them together and interchangeably. The experiences where IPV and CLBP were considered to be linked have been reported here.

The two superordinate themes that capture the participants' IPV and CLBP experiences are "psychological interface of IPV and pain" and "pain as a symptom of IPV". The first theme represents the impact that IPV has had upon the psychological self, as triggered by current, physical pain while the second theme represents the impact that trauma has had upon the physical self, including CLBP.

Psychological interface of IPV and pain

The psychological impact of IPV has continued for all participants beyond the ending of the relationship. In particular, there is evidence of experiences of helplessness during IPV and beyond, in addition to shame, which is characterized by embarrassment and self-blame. Experiences linked to CLBP trigger cognitive and emotional responses that serve as reminders of IPV, while memories of IPV result in feelings of helplessness and shame as well as physical responses. Participants refer to the emotional distress of the trauma as experienced in the body as pain or illness. In this way, their pain is linked to their emotions and becomes an expression of how they feel.

Helplessness

This subtheme of helplessness summarises the powerlessness referred to by five of the six participants. The experiences of not having control over their lives because of IPV and CLBP were evident, resulting in the participants feeling unable to do anything to change their experiences. For some participants, their CLBP appeared to trigger feelings of helplessness that were initially experienced when living with IPV. During member checking, one participant said that when her pain is at its worst, she can "picture myself on the floor, curled up with me hands above me head" ("Julia"). Therefore, the memory of violence is triggered by the pain experience and, in some cases, influences present behaviours. This level of vulnerability seems like a risky place for the women to return to as it previously signaled danger.

When the women experience pain or others trying to take care of them when they are in pain, this appears to result in them believing they have lost control resulting in feeling overwhelmed and helpless. This helplessness is a reminder of the IPV and leaves the women feeling vulnerable and fearful.

"Stacey" desribed the role that others are taking by looking after her when she is in pain and how this level of perceived control by others leaves her feeling out of control. She uses the word control five times, and it appears that she is trying hard to grasp hold of it yet feeling fearful that others will take it from her. Her perception that help from others indicates a loss of control appears to increase her feelings of vulnerability. However, she also appears to feel vulnerable because she finds it difficult to trust the good intentions of others based upon the IPV she has experienced:

> The more I lose, yeah, the more things people helping or, you know, taking away from me, the more I feel less in control. I feel more vulnerable, I feel... more... I can understand it, I can't understand why people would want to, like, help me still.

"Mia" also illustrates the helplessness she encounters when her pain is intolerable and how this impacts her sense of how little mastery she has over her own life and has had in the past: "Well it's awful because then I feel like I'm losing control like". The future is also perceived by "Emily" to be out of her control as she considers that she will never have what she wants (less pain, less isolation, and a loving partner): "It is what it is, isn't it? I can't change anything. You can change the future, you, right now but... what will be, will be".

This external locus of control that "Emily" perceives is likely to be a self-fulfilling prophecy that exacerbates her isolation and low self-worth as what she wishes for does not materialize (without her taking some responsibility for change). The concept of external locus of control was first identified by social learning theorist Rotter (1966), who suggested that life is governed by external forces, a belief that undermines the individual's capacity for autonomy. The self-fulfilling prophecy indicates false belief systems that become true because of how the individual interacts with their environment. Thus, the belief that nothing will change leads to ineffective coping strategies, resulting in the lack of change that was predicted. This then results in poor psychological and physical health (Wurm, Warner, Ziegelmann, Wolff, & Schüz, 2013).

"Stacey" identifies experiencing isolation on account of CLBP that reminds her of the IPV and helplessness she experienced: "I'm more isolated again, and I don't like that feeling of being isolated. I like to be able to know what I'm doing". She uses the word "they're" when referring to her CLBP, yet it could be considered that she is also referring to her violent partner here who caused the back pain in the first instance.

> I'm isolated because of my pain, and my back and, and because, you know, of, I don't know how to describe it. My back, my pain controls my life where I'm not in control of my life anymore; they're controlling me.

Feelings of helplessness were demonstrated when participants reflected upon attempts to make sense of what has happened to them as illustrated by "Emily": "It's something (sigh)... yes, you, it, I suppose I'm over it, yes, but it still pops in, it's the reason why... why did it happen? And why, why me?".

"Emily" referred to the benefits system in terms of feeling disbelieved and, therefore, having to prove her existence, something that can be experienced as a further aspect of systemic trauma. Systemic trauma is identified as the "contextual features of environments and institutions that give rise to trauma, maintain it and impact posttraumatic responses"-(Goldsmith, Martin, & Smith, 2014, p. 117), resulting in a sense of helplessness:

> So, I mean, you've got to go for medical interviews and you've got to go against a board to, and I think, you know, it's, it hurts. Why would I sit and say I'm in pain when I'm not in pain? What benefit would I get out of that?

"Mia" refers to drowning as a metaphor for the level of suffocation that she experiences as a result of her situation. She identifies the ongoing impact of living with IPV and CLBP that she cannot rescue herself or be rescued from, illustrating a bleak future fraught with fear: "It's like you're drowning and you can't get out".

Shame

Most women described shame as embarrassment and self-blame that they had ever experienced IPV. One participant, during member checking, described it as "a stench that doesn't go" and how the shame can "erode personal identity" ("Pollyanna"). It appears that the need to continuously defend or prove themselves to others (e.g., perpetrators of IPV and clinicians/assessors) concerning their CLBP has further enhanced their sense of shame.

Here, "Emily" identifies the shame connected to having to prove to others something that cannot be seen. She later describes this as a form of abuse from benefits assessors, who have so much control over her life with the decisions that they can make: "Well, I worked ,and it's, it's like you say with the pain, to prove you're in pain, to people that are not with you every day, that don't see what pain you go through, it's degrading". This emphasizes how others can be pivotal in either systemically re-traumatising/re-abusing or providing survivors with a focus for survival. She later links the shame of having to prove herself to others to earlier abuse: "And that's the thing throughout my life". It seems here that although "Emily" expresses (during various points within the interview) that she wants to be loved by others, she also appears to be afraid of being seen and therefore, her isolation is further compounded by the fear of somebody seeing her for all that she is which would result in shame:

> ”Emily”– I'm getting to the point now where I'm frightened to go out.
> "Researcher" – Right
> "Emily" – And I was like that with the abuse, with him.
> "Researcher" – Right, right. And what's the fear of going out now?
> "Emily" – The fear of going out now is in case I fall and the embarrassment and the people looking at me. If they look at me and when they

> do look at me, I think, what are they looking at me for? Is there something wrong with me, you know, erm, and it was the same with that.

"Pollyanna" describes how she feels about lying to the doctor about how she sustained injuries when she was pregnant. The lie was a cover-up for injuries incurred as a result of IPV and the subsequent pain that she experienced: "There's a, there's a guilt, there's like erm, when I go back, it's almost like I wish I hadn't said it, almost like that lump in my throat".

Shame appears to be experienced as a form of self-punishment as "Mia", and "Jo" consider that they are being punished with pain for their past experiences. "Mia" identified that her pain and physical health problems act as a punishment for leaving her husband for a violent partner: "But then I think as well, I know it's stupid, but that's how I think, I think God punished me for leaving my husband heart-broken, so that's my punishment, like, sort of thing. That's how I think of it".

"Jo" viewed that her choice to have a relationship with a man who was violent has resulted in pain. Therefore, she described her pain as a life sentence for the "mistakes" that she has made in her life: "That maybe that's what's caused me to be in pain or because I'm being… erm, sort, what's the word, I'm being punished for… for sort of going to live with this man".

Pain as a symptom of IPV

This superordinate theme pays attention to specific physical trauma responses. Despite the abusive relationship ending, the trauma is re-experienced repeatedly through pain and as the cause of pain in the first instance. Participants are, therefore, making sense of their pain in the context of IPV. "Pollyanna" makes a link between the rape and her pain; "The spinal pain has been a lot worse since that last rape, yeah". Similarly, "Stacey" makes direct links too:

> I think it's probably because of the abuse, to be honest because where I've got my pain, is, it, I think it's linked...My bottom area, my back, that is where I was kicked and punched a lot so I think it's linked physically with my pain, I think it could've been one of the causes of my pain because I haven't got a definite cause of why my back is bad.

"Jo" questions IPV as a potential cause of her pain, although her use of the words "you know" and her difficulty in naming IPV but instead referring to it as "this" shows evidence of some hesitation: "Yeah, yeah. I, some days I'm in agony and I think… is it because, you know, this has happened to me or is it just… you know the way things are?"

Participants shared how their IPV pain is experienced in their present pain and how this link has been a more recent discovery, illustrating that women will not necessarily make conscious or immediate connections between IPV and pain.

> I never used to think it was because of that but where I get the pain the most is everywhere he used to hurt us and everywhere where it hurts, I can feel his fist or his foot in that exact place and what it felt like then ("Julia").
>
> Yeah, erm, my legs, the top of my legs, my thighs, I get a lot of pain there and I think it is linked with… I feel,… lately, the more… I've looked back at my past, I can tell my pain increases ("Stacey").

As "Emily" describes her experience of anticipatory death, she displays some physical symptoms indicating that the trauma of the event is being experienced in her body as well as her memory:

> I mean he was, I was in with (son) and he came home one night early and he was saying I do love you and I do… .and I thought, aw God, what's he going to do now, I was getting, like, frightened and erm [moved with pain], he said, er, I do love you and I said yeah I know.

Discussion

The research aimed to explore the experiences of women who have survived IPV and who live with CLBP to deepen the understanding of the relationship between the two phenomena. Throughout the hermeneutic process, participants formed links between IPV and CLBP in terms of physical and psychological impacts. All participants showed or described symptoms of trauma responses due to IPV, the most prevalent being linked to somatic responses. This is in line with previous research (Coker et al., 2005; Strigo et al., 2010; Taft et al., 2007; Tiwari et al., 2013; Wuest et al., 2008). In addition, the current findings showed that for some participants, CLBP is a direct result of IPV, but for others, there was tentative hesitation in making this link in a face-to-face interview. Dysregulation of appropriate pain perception (Keeshin, Cronholm, & Strawn, 2012, p. 46) has been used to explain this form of hesitation. Further support for this concept has been found within psycho-neurological literature (e.g. Noll-Hussong et al., 2010). Explanations for tentative responses have also been found in psychodynamic theory (Sanderson, 2008). Thus, participants are tentative because they doubt themselves, especially as the links between IPV and CLBP have usually not been confirmed by an external source such as a physician or a police officer. This unique finding that women are tentative in their commitment to linking this abuse and their pain provides insight into what might maintain trauma responses and unhelpful coping strategies and warrants further research.

Participants also experienced pain triggered by the memories associated with the abuse. For some participants, this was related to the original fear associated with anticipating what was about to happen next within the abusive relationship. The finding supports the previous work of Rothschild (2000, p. 56), who states that "emotions, though interpreted and named by the mind, are integrally an experience of the body" although previous research has not explored the experiences of women who have survived IPV and are living with CLBP. Therefore, CLBP can be framed as, in some way, a consequence of IPV and the associated memories. This form of re-experiencing the actual violence (flashbacks) or having an awareness of images associated with the brutality is supported by Cerulli, Poleshuck, Raimondi, Veale, and Chin (2012), whose participants also reported that physical pain triggered memories of the abuse, which led to them feeling overwhelmed. Therefore, counselling psychologists who work in pain services need to assess for IPV and childhood abuse when attempting to treat the pain most effectively and train others to do the same. For example, Flinck et al. (2005) argue that women are only likely to talk about the abuse if asked about it. The need for assessment of abuse is also highlighted by earlier researchers (Humphreys et al., 2011; Wuest et al., 2008). Perhaps, given the findings of this current study and previous research, it is not surprising that the participants focused far more on their prior experiences of violence rather than their pain (something that they are currently accessing treatment/support for). This raises concerns that women who are currently being treated by a pain service who have survived abuse are likely to have trauma symptoms that could interfere with the treatment of their CLBP, thus demonstrating the importance of screening and assessment for abuse. Counselling psychologists with their emphasis upon assessment and formulation are vital to incorporating this into their work and working with multidisciplinary teams to do the same.

Feeling helpless was a common theme for participants within this study. This subtheme provides an important link between IPV and CLBP as participants recounted that when they feel out of control (because of their pain), they are reminded of when they did not have any control (when they experienced IPV). The feelings of helplessness and beliefs that they cannot regain or maintain control may result in a passive approach to their pain, which, in turn, can increase the levels of pain if they resort to avoidance and withdrawal as a way to cope. Braams, Blechert, Boden, and Gross (2012) focused upon the role of suppression (a form of avoidance and emotional withdrawal) in pain and asserted that in the long term, suppression is more likely to lead to an increase in pain. Thus, strategies that focus upon increasing acceptance and a sense of mastery are likely to be effective forms of psychological treatment that align with the phenomenological stance of counselling psychology (Milton, 2016).

The links between a lack of control over IPV and pain have not been explicitly made until now; therefore, the theme of helplessness in this context is a new finding and one that is very relevant to counselling psychologists seeking to engage clients with change processes. This issue of maintaining control for survivors of IPV and CLBP would benefit from further exploration as it could be a feasible conduit to enabling survivors to develop their self-efficacy.

Four out of six participants for this study reported having experienced childhood abuse. It has been identified that feelings of shame that emerge from IPV experiences are often exacerbated by early life abuse (Cerulli et al., 2012). However, shame was not only triggered by IPV but also appeared to be further exacerbated by having to justify their pain to others in order to receive appropriate treatments or financial support. The participants were willing to talk about such experiences and feelings contrary to research by Thomas, Moss-Morris, and Faquhar (2006), who suggested that patients with chronic pain and a history of IPV tend to repress or suppress their emotions.

Punishment was a feature for some participants. This can be explained by Sanderson (2008), who refers to the process of re-enactment, at which point the survivor of IPV has become so familiar with punishment that it becomes re-enacted in the form of self-punishment or a perception of being punished by others. Perhaps, pain is then viewed by some survivors as part of this "trauma re-enactment" in which they are being punished for previous choices or, indeed, for existing (Sanderson, 2008, p. 182). Such cognitive misinterpretation, which is likely to arise during times of stress, can further worsen pain experiences (Wuest et al., 2008).

Self-preservation was apparent and referred to the way in which women were holding on to their dignity in the context of being judged or assessed by others. There was also the suggestion of them treasuring something much deeper within themselves, as though holding tightly on to a small flame while all hope, joy, and possibilities of a meaningful life was being painfully extinguished around them. However, unequivocal links to self-preservation have not been highlighted elsewhere for those who have survived IPV and are living with CLBP. It appears that holding on to self-preservation may be equally as important for those who have survived IPV and live with CLBP due to the challenges to identity, independence, control, and choice that they face as a consequence of both experiences. Some participants talked of the role of medication in limiting their sense of self-preservation as they lost their sense of coherence, while for others, the focus was upon maintaining their identity or valuing their roles in life. Therefore, supporting women to find ways to maintain self-preservation may be one feature of many coping strategies that they can adopt as part of their recovery.

Scheffer Lindgren and Renck (2008) concluded from their research that social support that is perceived to be at a high level is likely to improve the physical health of women who have experienced IPV. Within this study, this can be explained by women experiencing that others believe them, which then provides them with the opportunity to talk about their feelings (rather than suppress them). This may be enhanced by feelings of safety as they feel protected from reprisal by the perpetrator by people they know and by the criminal justice system. It is likely that when women feel supported by someone, for example, their counselling psychologist, they are less likely to experience physical tension that may exacerbate their pain.

Limitations and Future Research

This exploratory investigation was successful in achieving its aims. It was enhanced by the qualitative approach, which allowed the participants to share their subjective experiences of IPV and CLBP, in contrast to previous quantitative studies. Although the low participant numbers are considered a limitation, the findings highlight some important links between CLBP and IPV in addition to considerations for assessment and treatment. These findings emphasise the need for a trauma-focused treatment approach, the outcomes of which could be further explored using a qualitative methodology. This is supported by Noll-Hussong et al. (2010), who recommended further research into the influence of psychotherapy on pain processing in patients with a history of abuse. A further consideration is that participants were recruited via a pain clinic and had received or were in the process of receiving therapy in relation to CLBP. Therefore, future research should consider those women who have not received any therapeutic intervention.

Although it is acknowledged that men are also impacted by IPV (Migliaccio, 2001), this study only included women because of higher rates having been reported than for men (Humphreys et al., 2010; Migliaccio, 2001) (although this might be due to under-reporting rather than limited incidence); and to obtain a homogenous sample. This is a limitation of this research, and future research should also consider the lived experienced of men with CLBP who are survivors of IPV.

The participants not reflecting the broader range of cultural and ethnic backgrounds found in the general population also limits the research. Ward profiles for the area within which the research took place suggest that the area is home to a Black, Asian, and Minority Ethnic (BAME) population that forms a larger proportion of the community than similarly-sized areas across England. However, the self-selecting participants did not reflect this. This could be explained by low numbers of BAME patients accessing the pain service from where participants were recruited, suggesting wider systemic issues regarding referrals into the service or alternative pain management support accessed by this population. Alternatively, potential BAME participants may have felt unable to take part in the research due to shame associated with IPV or the ability to access the researcher due to language barriers. Whatever the explanation, this is a limitation of this study.

Participants in this research were tentative about their perceived links between IPV and CLBP, yet there is research evidence to support this association. Therefore, future research could measure the physical and psychological benefits of educating patients with CLBP about the impact of IPV upon pain and coping (e.g., challenging misconceptions of punishment) to enable them to regain control over their lives. From a counselling psychology perspective, the need to ask women with chronic pain questions about a previous history of IPV or childhood abuse has been emphasised by a number of researchers (Balousek et al., 2007; Flinck et al., 2005; Humphreys et al., 2010; Wuest et al., 2008). However, Boucher, Lemelin, and McNicoll (2009) suggest that careful language should be used to ask about sexual violence as an association with IPV which appears to have been contradicted by the participants of this study. Women did use their own words or metaphors to describe sexual violence and volunteered this quite readily. They appeared to need to talk about their experiences and, in doing so, receive some support in the form of simply, being heard. Perhaps as voluntary participants of the research, they had prepared themselves and were, therefore, fervently anticipating this opportunity to share. However, participants within this study also referred to health professionals and benefits assessors in relation to their pain as well as how being believed (for both pain and IPV) is vital towards their recovery and, ultimately, their self-efficacy. It is likely that that potential isolation (and subsequent withdrawal) will perpetuate the experiences of pain and trauma if women feel unable to talk about what has happened to them. Counselling psychologists are very well placed to support their clients in training non-psychology colleagues to ask questions that could enable such disclosure. This study is the first to focus upon the experiences of survivors of IPV who are living with CLBP, and the findings are directly applicable to counselling psychology training, research, and practice.

Summary and Conclusion

The aim of the study was to explore the lived experiences of women with CLBP who have survived IPV. The study was successful in identifying these experiences and demonstrates a key link between CLBP and IPV, contributing to the developing qualitative literature within this area. The findings reveal the psychological interface of IPV and pain and the role of trauma upon CLBP.

As women identified that CLBP triggers feelings and memories associated with IPV, it is important that counselling psychologists and other healthcare practitioners who work with clients with pain are aware of this link during assessment and treatment. Asking about IPV history and considering how trauma can influence their responses to CLBP may impact upon how they engage in treatment and enable them to acknowledge any links that exist. If helplessness and shame can be addressed within a safe, therapeutic setting, clients may feel more able to manage their pain experiences and begin to challenge beliefs and assumptions regarding the abusive experience. Furthermore, the recognition that IPV as a physical and/or psychological trauma may have caused or contributed to CLBP can provide women with a sense of control over their understanding of it’s aetiology and management and help them find more helpful ways of coping. The findings emphasise the need for trauma-focused therapeutic approaches when working with clients who have survived IPV and are experiencing CLBP and highlights ways in which counselling psychologists can work with multi-disciplinary teams and individual clients to enhance the psychological and physical health of this population.

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Conflict of Interest

The authors declare that they have no competing interests.

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