Bridging The Gap Between Social Justice Theory and Practice: Addressing Sociopolitical Context in Trauma Therapy with Survivors.

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Abstract

A trauma-informed approach to therapeutic intervention has been adopted across mental health disciplines, including in work with survivors of sexual and interpersonal violence (Tseris, 2019b). However, trauma discourses have also been criticised for prioritising medicalised and psychiatric understandings and neglecting the historical, cultural and gender factors which enable and perpetuate violence (Peters, 2019; Reynolds, 2020). Feminist, decolonial and social justice-informed trauma frameworks highlight the need for the sociopolitical contextualisation of trauma within therapy (Goodman, 2015). Increasingly, mainstream ethical and trauma-informed care guidelines also demand that therapists are equipped to explore the sociopolitical factors involved with trauma and distress (Hailes et al., 2020). However, there is little research about therapists' experiences engaging in such conversations (Sutherland et al., 2016). To bridge the gap between theory and practice, more knowledge is needed about these conversations as they occur in trauma therapy (Pemberton & Loeb, 2020). In this study, a narrative inquiry approach was used to investigate ten therapists' (psychologists, counsellors and psychotherapists) stories of discussing the sociopolitical context of trauma in therapy with survivors of interpersonal violence. Interviewees told stories that explored how they navigate the inclusion of sociopolitical context in their therapeutic conversations, perceived therapeutic outcomes from these conversations, and what skills, tools and professional and personal learning have been involved. Narrative analysis showed how respondents who were committed to exploring sociopolitical context positioned themselves in resistance to more dominant medicalised trauma narratives, including in their professional training. They outlined the fundamental importance of a relational and power-aware approach, which includes witnessing, collaboratively externalising narratives and being actively non-neutral. Stories described ways in which clients transformed shame and increased their sense of agency through exploring broader social narratives impacting their experience of trauma and healing. Learning in the areas of intersectionality, personal privilege and power was highlighted as necessary to hold these conversations appropriately.

Recommendations and a reflective practice question framework are provided to inform practitioner practice and training.

Keywords: social justice, trauma-informed practice, trauma, interpersonal violence, therapy, intersectionality, liberation psychology

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Glossary of Te Reo Māori Words and Terms

For ease of reading, particularly for international readers, I provide a glossary of Te Reo Māori words or terms used in this thesis. I provide this with the acknowledgement that many of these terms carry complex lineages and multiple meanings and understandings.

Aotearoa: Te Reo Māori name for New Zealand, used throughout the thesis in place of New Zealand.

Kaupapa Māori: Kaupapa refers to a purpose, vision or principles. Kaupapa Māori may refer to a Māori approach, Māori philosophy or Māori agenda or principles.

Mana: A fundamental concept in Māori culture that relates to power, authority, prestige, integrity, status or spiritual power within a person, place or object. Mana is inherited at birth but may also be accumulated through life based on actions and achievements.

Manaakitanga: Relates to showing generosity, kindness, and respect for others, ensuring the mana of both parties is upheld.

Pākehā: Refers to people of Aotearoa who are of European descent.

Pepeha: A pepeha is a Te Reo Māori way of introducing yourself. It provides information on people, places and landmarks you are connected to so that others may learn how you are connected or where you diverge.

Whakapapa: Genealogy, lineage, line of descent to ancestors.

Te Reo: Aotearoa's officially recognised indigenous language.

Te Tiriti o Waitangi: The Treaty of Waitangi was signed by representatives of the British Crown and Māori chiefs in 1840 and is commonly regarded as the founding document of Aotearoa New Zealand as a

nation state. The document established ways of working together and the internationally recognised Te Reo Māori version protected Māori's rights to sovereignty over their lands and people. However, there are significant discrepancies between the English and Māori versions. The Crown has repeatedly failed to uphold and honour the relationship and agreements set out in Te Tiriti o Waitangi. Within healthcare settings, the principles of Te Tiriti are often acknowledged as partnership, participation and protection.

Tika: Refers to what is right and good in a situation.

Whakawhanungatanga: Describes a process of great importance in Māori culture of building relationships, emphasising connection, belonging and respect.

Chapter One - Background and Terminology

The purpose of this opening chapter is to situate myself in the thesis, outline the rationale for the terminology I use and to give the structure of the thesis. The aim of the present study was to explore therapist stories of engaging in therapeutic work which contextualises trauma within sociopolitical factors with survivors of interpersonal violence.

Situating Myself

My personal and professional background has greatly influenced my choices in this study, both in topic and theoretical leaning, and in my analysis and interpretations; therefore, situating myself and who I am at the outset of this thesis is important to me for transparency. I am a Pākehā cisgender women. Aspects of my identity have afforded me great privilege, particularly regarding my position as a European heritage white person living on stolen Māori land. I have grown to have a fascination with the ways that privilege impacts our ability to acknowledge and heal both personal and collective trauma. I also grew up in a working-class family, raised for the most part by a single mother. I have experienced and witnessed the intersections of gender and class-based marginalisation and trauma in my own life, and this has informed my understanding of these issues. In particular, it has informed a passion for ensuring that issues of power, oppression and marginalisation are considered within therapeutic work.

I have spent more than 15 years involved in activism and social change work in movements and campaigns related to climate and environmental justice, feminism, reproductive rights and anti-racism. I have worked in professional campaigning organisations around the issue of climate change and in advocacy and service delivery on issues of gendered violence. It was, in part, my own experiences with helping those who were experiencing distress related to their activism, as well as supporting those impacted by gendered violence, that led me towards a focus on psychology and therapy, and this research. I wished to see the links between individual and collective made more strongly. From my perspective, the world of collective struggle and the world of mental health still seemed disconnected, disjointed, and most of the time, not able to speak to each other effectively. When I read about liberation psychology, it

did not feel so much like a discovery as it was a relief. In it, I found a home within guiding psychological frameworks. I had read the heavily related work of Freire and Foucault, but here was work explicitly related to how I could find a home within psychology that spoke to my values. Therefore, I believe describing some key tenets gives some background to my own thinking, and therefore to the scope and framing of this study and the lens through which it was designed and data. Of course, my own thinking is influenced by many theories and frameworks. Still, in briefly describing liberation psychology, I hope to give a grounding to the explicitly liberatory values which inspire me.

Liberation Psychology

> ...to acquire new psychological knowledge it is not enough to place ourselves in the perspective of the people; it is necessary to involve ourselves in a new praxis, an activity of transforming reality that will let us know not only about what is but also about what is not, and by which we may try to orient ourselves toward what ought to be. (Martín-Baró, 1994, p.45)

Liberation psychology as a discipline was developed in the context of Latin American emancipatory movements, with Salvadoran Psychologist Ignacio Martín-Baró often cited as its key developer (Torres Rivera, 2020). However, movements and thinkers worldwide have independently been working with similar principles and concepts. As Torres Rivera (2020) notes, “Fanon, Foucault, Enriquez, Memmi, Biko, and Cabral, to name a few, are associated with the concepts and principles of liberation psychology that unknowingly were using the principles and methods of liberation psychology in different parts of the worl” (p. 42). Liberation psychology speaks back to the limitations of traditional Western psychology, which has often ignored the social and political conditions of people’s lives, particularly the most marginalised (Comas-Días & Torres Rivera, 2020; Montero, 2007). Instead, liberation psychology calls for reckoning with how the well-being of people is connected to the reality of oppressive systems, which makes well-being difficult, if not impossible (Afuape, 2012). Liberation psychology seeks to situate the psychologist's role within broader movements for liberation and social struggle. In doing so, it

prioritises understandings of distress and the world generally through the lens of those who are most oppressed and explicitly works toward collective social transformation.

Liberation psychology places anti-oppression at the core of its theory and practice. Afuape (2012) argues that oppression and injustice are often used interchangeably, and I use Afuape's definitions here. Oppression has been described as the use of power of one social group over another in a way that maintains social inequities (Afuape, 2012), while injustice refers to "coercively establishing and maintaining inequalities, discrimination, and dehumanising, development-inhibiting conditions of living ... imposed by dominant social groups, classes, and people upon dominated and exploited groups, classes and peoples" (Gil, 1998, p. 10). Liberation psychology acknowledges the role of oppression and injustice in the (lack of) well-being of people. It further argues that understanding the mechanisms of oppression and their role in a person's life is key to wellbeing and social transformation (Moane, 2003). It focuses on collective transformation but does not diminish the individual experience, prioritising how the collective and individual experiences interact and reinforce one another.

Liberation psychology proposes that part of a psychologist's role should be that of working alongside those developing critical conscientization. A term first developed by Freire (1970), conscientization refers to developing an awareness of the ways accepted realities of life are informed by structures of power and oppression. It is the process of moving toward an understanding of our own role in oppressive systems, of rejecting the ideas involved in oppression, and seeking collective change (Torres Rivera, 2020). It moves from a place of 'stuckness' to a place of seeing possibilities beyond what exists.

Liberation psychology and its core ideas were developed in the context of colonisation, an understanding of which is key to its goals (Afuape, 2012). Māori scholars have long heralded ideas similar to those of liberation psychology while also being unique to Aotearoa and having their own whakapapa. Kaupapa Māori theory has its unique lineage of calling for conscientization to realities for Māori (Eketone, 2008; Smith, 1997) as well as engaging in reflective praxis (Smith, 2021). Practice with liberatory aims within an Aotearoa context should be placed in our local context and history of colonial

violence. Psychologists within liberatory traditions have long pointed out the role of psychology and the 'psy' professions in the project of colonisation, and in further subjugating, pathologising and traumatising indigenous peoples (Martín-Baró, 1994; Reynolds & Hammoud-Beckett, 2017).

Involved in the conscientization process is exploring and uncovering the oppressive ideologies behind taken-for-granted truths and 'de-ideologising' everyday experience (Martín-Baró, 1994). This involves a questioning of social conditions as they has been presented through the dominant ideology. Also involved is a reframing of oneself and one's social groupings away from the way the oppressor group has presented them. Instead liberation psychology calls for seeing strengths or what Baro described as 'virtues of the people' (Martín-Baró, 1994, p. 47) This relates to strengths based practice and reorients from simply seeing negative impacts of oppression to seeing the various tools, values, resources and acts resistance which accompany those who have experienced oppression (Torres Rivera, 2020). The role of the psychologist in this process is to accompany people along it and make offerings of context, rather than to hold an expert role (Moane, 2003).

Three key areas which have been a focus of practice from a liberation psychology perspective include; 1) social analysis, 2) understanding community needs, and 3) developing liberatory therapeutic programmes which meet the needs of the most marginalised (Montero, 2007). This speaks to another idea core to liberation psychology, again originally put forward by Freire, of praxis. Action without reflection and analysis is unlikely to be liberatory or may be harmful. Conversely, intellectualising without action does not contribute to social transformation (Comas-Días & Torres Rivera, 2020). Instead, liberation psychology argues for an ongoing cycle of reflection and action to change social conditions.

While not a comprehensive exploration of liberation psychology, these key ideas have inspired my approach to practice and research. By contributing to knowledge about therapists who contextualise trauma within the sociopolitical alongside clients in therapy in Aotearoa, I hope that this study contributes to praxis and is a contribution to the efforts of many people working towards more liberatory mental health practice.

Terminology

Language often carries multiple definitions and meanings depending on the knowledge field, influencing theories, and the power held by those using them (Burr, 2015). It is, therefore, essential to be clear about choices and intended meanings when using important terms. For ease of reading, specific terms used repeatedly throughout this thesis are defined and explained below. These are not presented as objective definitions but rather my understandings and chosen use of these terms among many possibilities.

Interpersonal Violence (IPV). This study explores work with those who have experienced interpersonal violence. My aim in using this term is to be inclusive of various forms of violence. I use the definition taken up by Hollin (2016), who defines interpersonal violence as "the direct, often face-to-face, actions of an individual, including acts of neglect, which inflict emotional, psychological, and physical harm on other people" (p. 3). This definition is inclusive on purpose and includes physical violence, sexual violence, emotional and verbal abuse, harassment and stalking, and financial and economic abuse (Baylor College of Medicine, n.d.). Though this definition describes violence inflicted at an interpersonal level, individual and collective level violence are interconnected (Husso et al., 2017). Interpersonal violence occurs within specific cultural and historical contexts that shape the phenomenon of interpersonal violence and its responses, which will be explored more in the subsequent chapter.

Survivor/Client. Throughout this thesis, I use the terms 'survivor' and 'client' interchangeably to refer to those people who use the services of therapists and partake in therapy for trauma, including IPV. The term 'survivor' is one used often within sexual violence literature. The feminist movement began using this term in the 1980s to emphasise the strength, resilience and many possibilities of experience that exist for those who have experienced sexual violence (Jordan, 2013). They argued that 'victim' was an identity that not all who had survived violence wished to align with. Others say that the term survivor does not honour the levels of devastation which violence and the patriarchal system within which it occurs inflict (Harding, 2020). However, I take the position, as others have, that where no term is

identified as a preference, using the terms interchangeably and respecting the diversity of experiences within these terms is acceptable (Sexual Assault Kit Initiative, 2015). I use the term survivor within this thesis to emphasise my respect for those who endure sexual violence and as a form of respect for the lineage of resistance at both individual and collective levels to the social structures which enable it.

I also interchange the term 'client' in this thesis with 'survivor' due to the understanding that some people discussed in the respondents' stories may have experienced IPV while others may not have. There is a lively debate around terms for those who use therapeutic or broader mental health services. 'Patient' is still frequently used but has been criticised for its passive, pathological and medicalised implications (Costa et al., 2019). Service-user is also used as an alternative, which is argued to be more empowering, but has been criticised for its focus on the individual defined by its use of services (McLaughlin, 2009). The term 'user' has also been argued to suggest that the care always has a 'use' and is voluntary, despite evidence that psychiatric care is often not voluntary and may not always be desired or helpful (Priebe, 2021). The term 'client' has been criticised for its connection to a commodification of healthcare given the consumerist nature of the term. Others suggest the term entrenches the expert role of the practitioner (McLaughlin, 2009). I use the term within this thesis due to its likely origins in client-centred therapy and the hope that lies within this of a more collaborative relationship between the 'client' and the therapist (Costa et al., 2019). I also acknowledge the complexities behind the decision to use any one term. I hope that by using both 'survivor' and 'client' in this thesis, an inclusive tone is taken that encompasses many experiences.

Social Justice. Social justice is a loaded and nebulous concept, and scholars have devoted their entire professional lives to defining the term (Goodman et al., 2004). In considering its definition, it is helpful to consider what a socially just world looks like. While not comprehensive, Smith (2003, as cited by Goodman et al., 2004) describes such a world as one where people have:

> Adequate food, sleep, wages, education, safety, opportunity, institutional support, health care, child care, and loving relationships. "Adequate" means enough to allow [participation] in the world . . . without starving, or feeling economically trapped or uncompensated, continually

> exploited, terrorized, devalued, battered, chronically exhausted, or virtually enslaved (and for some, still, actually enslaved). (Smith, 2003, p. 167)

I would add to this that a socially just world is one where people can freely embody and live within their cultures and identities without restriction or fear of reprisal or marginalisation.

In light of this, social justice describes both a goal and the change process towards this goal (Cutts, 2013). It describes efforts and movements towards equity for all people. Equity relates to access to resources, freedom from oppression and the right to self-determination. Intrinsic to social justice is the balancing and redistribution of power among people and groups to make this equity possible (Fitzgibbon & Winter, 2023). Social justice includes efforts which resist or challenge injustice at interpersonal, organisational, community and structural levels (Fitzgibbon & Winter, 2023; Moane, 2003). For therapists, social justice includes scholarship, therapeutic practice and advocacy, which work towards change in aid of these goals (Goodman et al., 2004). This necessarily involves working alongside and to meet the needs of those most oppressed and with the least structural power (Vera & Speight, 2003).

Sociopolitical Context and Contextualised Practice. Sociopolitical context in this thesis describes the context of people's lives, distress and trauma, which is related to that which is broader than the individual or interpersonal. It represents the context in which people's lives occur, including trauma and distress, at the level of social groupings, power, and authority (Allen, 2011). It describes the norms, behaviours, laws, ideas, and resource allocations that follow power concentrations and dynamics at social and systemic levels. This context is closely linked to issues of injustice or social justice, as previously defined.

I use the term in a way closely related to that of ‘psychopolitical validity’, used within critical community psychology (Prilleltensky, 2003; Prilleltensky & Fox, 2007). This term describes the need for practice within psychology that links individual-level psychological processes with issues of power at social and structural levels. Practice that only occurs at the psychological level or only within the political will not adequately address issues of wellness and liberation. As Prilleltensky argues, "Power is never political or psychological; it is always both." (Prilleltensky et al., 2008, p.116). Sociopolitical context is

therefore intertwined with issues of power at both interpersonal and structural levels. Within the context of this study, I sometimes use the term ‘contextual practice’ or ‘contextualised practice’ to refer to therapeutic practice in which the therapist acknowledges the importance of sociopolitical context within clients' lives and discusses and explores this sociopolitical context as part of the therapeutic process. This occurs within a context of alignment with social justice principles and goals.

Thesis Structure

In this opening chapter, I have situated myself in this work and outlined some key terminology. Chapter two introduces the frameworks and concept of IPV and trauma. In chapter three, the landscape of research and calls for therapy to include exploring sociopolitical context are outlined, along with the complexities involved. The case for this study is then summarised, including relevant studies and the gap within the literature that this research seeks to address. Finally, the aims of this study are presented. Given the intersectional nature of the subject of this study, which conceivably touches on a wide array of subjects, the literature chapters are not intended to cover all literature subsequently raised and discussed in response to the results. Instead, the thesis follows a more narrative flow where these chapters provide context and justification for the study, and later discussion of results includes referring back to this literature as well as raising new literature where appropriate to what was raised in participant narratives. Chapter four outlines the methodology. Chapters five, six and seven are results and discussion split into three sections. Finally, Chapter eight is a summary chapter including limitations and future research.

Chapter Two - Literature Review: IPV, trauma and contested understandings

In this chapter, aspects of the sociopolitical environment in which IPV occurs are first examined. Then, trauma, its history as a concept, as well as critiques of trauma narratives and practices, are outlined. Finally, more politicised and sociopolitically contextualised understandings of trauma are described.

Sociopolitical Context of IPV

Sociopolitical conditions and structures play a pivotal role in creating and perpetuating IPV. Rates of violence are affected by issues of race, poverty and other and social locations, which also interplay with means and access to preventative or recovery-based support and education. Women in Aotearoa experience sexual and domestic violence at far higher rates than men (Ministry of Justice, 2021). Māori women are more likely to experience violence than Pākehā women (Ministry for Women, 2015).

A feminist lens of sexual and interpersonal violence provides a deeper understanding of the causes and functions of violence through the examination of gendered power inequities and patriarchal structures of power (Cockburn, 2004). Socially constructed gender norms provide specific and prescribed social roles which affect the way people relate to themselves and each other in society. Through this gendered relating, power inequities are reinforced and embedded. These roles and the power differential involved in them leave some more vulnerable to violence, and cisgender men are more likely to perpetrate violence (Hearn, 2012).

One conceptualisation of the intersections of gendered power inequities and sexual violence is the concept of rape culture (Gavey, 2018). Rape culture is broadly defined as “a pervasive ideology that effectively supports or excuses sexual assault” (Burt, 1980, p. 219), and exists when “rape, or sexual assault, is the normalised expectation” (Burnett, 2016, p. 1). Rape culture describes the multi-faceted ways in which male dominance is normalised and sexual violence is then regarded as expected or accepted. Rape culture purveys a fundamentally distorted and inequitable view of healthy relationships,

and therefore rape culture as a concept helps explain sexual violence as well as broader interpersonal violence (Winn, 2018).

Key aspects of rape culture include the prevalence of gender roles, oppression and discrimination, and an acceptance of violence within society (Johnson & Johnson, 2021). Gender roles describe the expectations, responsibilities, interests, and subjectivities made available to people based on dominant cultural narratives around gender, and specifically around a binary view of men and women. Traditional ideas around gender roles include ideas that men are dominant and women are submissive, men are strong and women are fragile, and men are sexual while women are pure. These ideas, while commonly regarded as outdated, still inform societal discourses and structures, and are linked to victim-blaming ideas about women being deserving of violence due to perceived defiance of such sexist gender roles and ideas (Abrams et al., 2003; Chapleau et al., 2007). Such ideas have been described as 'rape myths' and include ideas that a woman may have been 'asking for it' due to her appearance, that women often fabricate rape, that women who are raped are promiscuous, or that promiscuous women deserve to be raped, and that men can not help themselves (Winn, 2018).

Research shows young people in Aotearoa still witness or experience daily incidents of rape culture related sexism (Sills et al., 2016). Sexism may be described as discrimination and stereotyping based on the sex which someone is assigned at birth (Burt, 1980; Gaunt, 2013). At the root of sexism is a belief that men are superior to women. This belief leads to an objectification of women. Sexism is often prevalent when people behave in ways perceived to be outside of traditional gender roles. Likewise, sexism may occur at social or structural levels. In this sense, sexism has a role in policing gender roles and therefore perpetuating them, and thereby, gendered violence is an inevitable result of sexism (Guy, 2006).

Sexism has also often been described within two categories: overt sexism and benevolent sexism (Glick & Fiske, 1997). While overt sexism is more outright hostility and misogynistic acts and attitudes, benevolent sexism is the more subtle sexism which may appear to celebrate women while actually limiting them (Oswald et al., 2019). Benevolent sexism upholds the belief that women are weak and need

protection, resulting in a confining of women to strict gender roles. The link between overt sexism and violence is relatively clear, in that overt hostility towards women and views that place men as superior lead to a belief in women as deserving of violence and men as being justified in dominating women. However, benevolent sexism also legitimises hostile sexism and lays the groundwork for gender inequity which enable violence towards women and all those who do not fit strict gender roles (Glick & Raberg, 2018).

Intersectionality and Interpersonal Violence

Intersectional models of IPV expand upon earlier feminist models which prioritised gendered explanations of violence to explore and highlight the intersections of race, class, sexuality, gender, disability and other social positions, and how they contribute to the prevalence of rape culture, where some bodies are more vulnerable to violence (Armstrong et al., 2018). The term intersectionality was first put forward within academia by Professor Kimberlé Williams Crenshaw, who critiqued white feminist explanations of women's experience, explained primarily by and for white women, and instead described how black women's experience is uniquely shaped by racism and sexism, and how these experiences intersect and compound one another (Collins & Bilge, 2016; Crenshaw, 1991). However, though Crenshaw's work is seminal, intersectionality as an analysis of power across social locations was being advanced by black feminists and activists before this development in academia (Salem, 2018).

Within an intersectional understanding of power and oppression, every person's experience of privilege and oppression is unique due to the various social locations they hold within interlinked and connected systems of power. Systems of oppression give more power to some than others, and these power inequities intersect with experiences of violence (Hooks, 1989). Intersectional understandings of IPV acknowledge how these oppressions work together to perpetuate violence and dominance, and that the experience of IPV is different and intensified for people who experience layered and multiple oppressions (Guy, 2006). Research shows that women of colour, for example, not only experience quantitatively higher rates of violence, but that their experiences of violence are qualitatively different to white women's experiences (Waller et al., 2021). Systems of inequity based on race, class, gender,

sexuality and ability, and more operate at micro and macro levels to perpetuate this violence. Not only are those who hold multiple marginalised identities more likely to experience violence, but they are also isolated from positions and places of power where decisions are made, thus reinforcing these inequities (Collins & Bilge, 2016).

Intersecting oppressions contribute to rape culture, in part, through the ways different bodies are represented and constructed. People with bodies who fall outside the white, thin, male, cisgender, heterosexual and able-bodied norm are represented as defective and disposable in popular culture. Negative portrayals of people with disabilities, for example, contribute to rape culture in that society more readily accepts violence against less valuable bodies (Balderston, 2013). Elsewhere, scholars have pointed out the hypersexualisation of women of colour in popular culture as a contributor to rape culture (Gómez, 2023). An intersectional lens not only offers a way to explore how violence is understood and perpetuated, but also to explore how violence links these systems of colonisation, patriarchy, ableism, white supremacy and so on (Collins & Bilge, 2016).

In Aotearoa, like other settler colonial states, the context and effects of colonisation are inextricably linked to sexual and interpersonal violence (Cavino, 2016). Domestic violence was not tolerated in pre-colonisation Māori society, but the role and place of women and children within whānau and broader society for Māori has been denigrated through processes of colonisation (Pihama et al., 2019). Colonising violence and dispossession have not only imposed patriarchal views of women but also undermined Māori cultural practices, which help uphold healthy relationships (Wirihana & Smith, 2014). Māori scholars and practitioners argue that the terms ‘whānau violence’ and ‘family violence’ incorporate not only domestic and family violence that occurs within homes and family systems but also the state and colonial violence which has been perpetrated against whānau both in the present day and historically, and how these different sites of violence interact (Wirihana & Smith, 2014).

These connected structures of oppression intersect to construct what a ‘victim’ looks and acts like, and those who fall outside of this construction often experience being blamed for their own victimisation, as was described earlier in the description of gender-based rape myths. The ‘perfect victim’

is also constructed on the basis of race, class and ability. (Armstrong et al., 2018; Jordan, 2013). Historically, women of colour in colonised countries were seen by the law as noncitizens and correspondingly had no legal protection against violence (Armstrong et al., 2018). While this may have changed, modern ideas of what constitutes a 'perfect victim' still portray a young, middle or higher class, white, cisgender and able-bodied white woman who didn't know her attacker and fought back (Jordan, 2013). With regards to violence between partners, common misconceptions based on oppressive stereotypes continue to impact not only the prevalence and experience of this violence, but also the support received. For example, the Family Violence Death Review Committee in Aotearoa New Zealand (Family Violence Death Review Committee, 2020) found that agencies blame women for failing to protect children from violence from fathers while simultaneously failing to hold the male perpetrators to account. Such responses are based on patriarchal ideas that mothers have more responsibilities toward their children than fathers, and that male violence is 'natural' and difficult to control (The Auckland Coalition for the Safety of Women and Children, 2020).

Ecological and sociopolitical models of sexual violence recovery, drawing on empirical research, have demonstrated how societal level oppressions and victim blaming attitudes affect recovery through a multitude of factors, from reactions survivors receive upon disclosure, to the framing of their mental health challenges following violence (Ahrens, 2006; Anderson & Overby, 2021). Research with victim/survivors about their experiences following disclosure show that negative reactions, often due to rape myths or other discriminatory experiences, seriously hinder the recovery process (Ahrens, 2006). Men are also not sheltered from the effects of such myths, and those who do not conform to dominant ideas of masculinity are left more vulnerable to experiences of violence (Viki & Abrams, 2002). Research also suggests that rape myths contribute to men being less likely to report experiences of sexual violence (Reed et al., 2020).

In summary, the sociopolitical context is vital in understanding the prevalence, maintenance and recovery process from interpersonal violence. An intersectional lens allows a view which incorporates not

only a gendered analysis but expands this to all sites of power inequity and illuminates how intersecting oppressions contribute to which bodies become subject to violence.

Trauma

The term trauma is now used across the field of mental health. Broadly, trauma can be described as events, hardships or circumstances which have a lasting negative impact on mental, physical, and emotional wellbeing (Sweeney et al., 2016). Acknowledging the impact of environmental/social causes for distress is now commonplace and marks a turn away from a focus on only the intrinsic, intrapsychic, and individual processes involved in mental distress. It is now broadly accepted across mental health disciplines that it is important to both identify and work to ameliorate the effects of trauma with clients (Sommers-Flanagan & Sommers-Flanagan, 2017). Like the experience of trauma itself, the history and theories around traumatic events and their impacts on mental health have always been influenced by societal, historical, and political context (Goodman, 2015).

Sigmund Freud may have been among the first to present evidence in Western academia of the impacts of traumatic events in his work studying women experiencing so-called 'hysteria'. Freud found that rather than these symptoms being personal flaws of women, they were instead a result of widespread experiences of sexual abuse (Herman, 1997). After facing controversy and critiques for these findings, which were shocking for their time, Freud later withdrew and changed his theory to suggest instead that these symptoms were a result of women's sexual dysfunctions and desires. The broader scientific community and Freud himself could not comprehend that women were facing widespread sexual abuse. Freud stopped validating the accounts of his female patients and instead decided these accounts of sexual abuse were fantasies, a theory which has caused significant harm to survivors (Herman, 1997). Goodman (2015) highlighted how this historical example of trauma theory development calls attention to the fact that defining what is and isn't traumatic has been shaped by the interests of those with power. Those with the power to define what is traumatic can also determine which experiences, and what responses to experiences, are 'normal' and which are 'abnormal'.

Research about the distress experienced by veterans and survivors of sexual violence was influential in further developing the field of trauma and in its eventual inclusion within psychiatric diagnoses (Herman, 1997). Partly as a result of lobbying by advocates for trauma survivors, Posttraumatic Stress Disorder (PTSD) was first introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980 (American Psychiatric Association, 1980). Trauma theory and practice have been heavily influenced by the development of the diagnosis of PTSD and the inclusion of this trauma-related disorder within the DSM (Tseris, 2019b). The definition of a traumatic event involved in the diagnosis of PTSD has come to influence what is considered traumatic, and the diagnostic criteria has influenced what is commonly understood as the effects or symptoms of trauma. The DSM-5-TR, in its criteria for PTSD, defines a traumatic event as exposure to actual or perceived threat of death, serious injury or sexual violence, which may be directly experienced or witnessed or indirectly witnessed (American Psychiatric Association, 2022). This definition has been broadened since earlier DSM editions, now allowing for repeated indirect exposure, such as being repeatedly exposed to details of trauma. Recent research related to adverse childhood experiences, a broad range of experiences including violence, neglect and exposure to substance abuse or poverty, has also increased the popularity of a focus in trauma (Sheffler et al., 2020). Studies in this area have provided evidence of the link between adverse early events and a vast array of later life challenges, including mental health, social, substance abuse and medical problems (Felitti et al., 1998).

Commonly accepted and widely researched examples of traumatic experiences are those involving interpersonal violence, such as rape, domestic violence or violence in war and combat. Childhood and developmental trauma include experiences such as sexual abuse, neglect, family conflict, parental abandonment, and bullying (Van der Kolk, 2009). Natural disasters, car crashes and other physical accidents where serious injury or threat of death or death/injury to others are also commonly accepted as potentially traumatic events. While the DSM definition focuses on trauma as a single event, a developing field of research recognises the impacts of repeated and prolonged exposure to trauma and the effects of such ongoing and/or confounding trauma has led to the development of the diagnosis of

Complex PTSD (CPTSD), which is recognised in the International Classification of Diseases (World Health Organisation, 2022).

Trauma-Informed Care

The widespread acknowledgement of the effects of traumatic experiences on people has led to the development and adoption of trauma-informed practice across human service provision, but particularly within mental health services. The terms trauma-informed care (TIC), trauma-informed practice, and trauma-informed approaches are often used interchangeably to describe a strategy or practice which incorporates an acknowledgement and incorporation of trauma theory into its design and practice. Broadly speaking, trauma-informed practice equates to a focus and acknowledgement of trauma and its effects, education of service staff about the traumatic experiences which may have impacted the life experiences of service users, and a commitment to provide services in such a way which does not trigger traumatic responses as much as possible (Wilson et al., 2015). A common factor across trauma-informed approaches within service delivery is also routine screening for trauma history (Harris & Fallot, 2001).

The adoption of trauma-informed frameworks for service delivery has become popular across a broad range of Government, clinical and community sectors and agencies in Aotearoa (Atwool, 2019). However, the extent to which TIC principles have migrated to practice is unclear. Research suggests that there is a lack of understanding on implementing trauma-informed care in service settings (Dyer & Chisnell, 2023). Many of the TIC approaches advocated have been adapted from the US-based Substance Abuse and Mental Health Services Administration's TIC principles of safety, empowerment, trust, choice, peer support, and cultural, historical and gender sensitivities (Te Pou, 2024). However, there has been very little recognition of the role of culturally appropriate care for Māori within such approaches, indigenous models of trauma and healing, or the cultural, historical and social context of trauma (Pihama et al., 2019; Wirihana & Smith, 2014). More will be explored in this context in the subsequent section.

Contested Understanding: Critical Responses to Trauma

The rising use of trauma-informed practice and trauma-related research has emerged alongside more attention being paid to marginalised groups, and the effects of marginalisation and systemic

oppressions and their relation to mental health. It is widely accepted that members of marginalised social groups are at more risk of facing adverse and potentially traumatic events and are less likely to have the resources and access to care and environments to support recovery (Matheson et al., 2019). Because of the link between trauma discourse and a focus on causal factors as opposed to purely symptoms, it is no surprise that trauma and trauma-informed care are sometimes viewed as inherently advancing social justice and equity (Tseris, 2019a). The development of PTSD as a diagnosis, and its eventual inclusion in the DSM in 1980, was seen as a victory for its further acknowledgement of the devastating impacts of violence (Peters, 2019). It was the first diagnosis in the DSM-III, which focuses on the causes of distress rather than purely symptoms (American Psychiatric Association, 1987), and prompted research about the symptoms of trauma-related stress and distress that has led to advances in treatment and therapeutic responses (Goodman, 2015; Herman, 1997).

PTSD also provides an alternative to other diagnoses, which have often been given to women with a trauma history, such as Borderline Personality Disorder (BPD) and Histrionic Personality Disorder (though one could be diagnosed with both PTSD and a personality disorder). Borderline Personality Disorder has been widely critiqued by feminists for its gendered, pathologising, and some argue outright misogynistic construction and application, which invisibilises gendered violence (Berger, 2014; Ekhtman, 2025; Shaw & Proctor, 2005; Tseris, 2019b). People who are diagnosed with BPD are much more likely to be women and are very likely to have a history of trauma and abuse (Shaw & Proctor, 2005; Wagner & Linehan, 1994). Despite this well-documented link, the description of the diagnosis in the DSM is devoid of any social and trauma context, describing people with the disorder as displaying a pervasive pattern of impulsivity, unstable relationships, extreme sensitivity to abandonment, unstable affect and self-image, paranoia, suicidal behaviour and self-harm and difficulty controlling anger (American Psychiatric Association, 2013). Feminists have highlighted how the symptom list associated with BPD reflects common constructions of femininity and have highlighted how patriarchal ideas of ‘madness’ have been linked to traditional notions of femininity (Ussher, 2013). Further, research has shown how people with this diagnosis are stigmatised and treated poorly within health services, and seen as attention-seeking,

manipulative, and not really ill (Klein et al., 2021). Tseris (2019) highlights how people with this diagnosis then face double oppression, experiencing the stigma of a psychiatric diagnosis while not receiving the support and sympathy that other diagnoses may elicit.

Unlike BPD, PTSD and trauma-focused diagnoses offer a more contextualised diagnosis which has an explicit focus on societal and/or violent causes of distress, and therefore arguably could lessen associated stigma and pathologisation. Feminist academics and advocates also advocated for the changes in the diagnostic criteria and definitions of trauma, which have seen the definition broadened in the DSM (Burstow, 2003). Other trauma-related diagnostic conceptualisations have emerged and been advocated for, such as that of CPTSD, which accounts for ongoing and multiple experiences of violence (Briere & Lanktree, 2011). Many argue that the PTSD diagnosis and associated research has contributed to a view of trauma symptoms which sees them as normal responses to unacceptable events, and helps focus on the events themselves, such as rape or war violence, as the problem, the societal factors which enable them. While such changes to understandings of both trauma and the heightened awareness of violence have made a significant impact, a growing body of literature has been exploring trauma theory, discourse and practice from critical, feminist and indigenous perspectives and raising important questions and critiques (Burstow, 2003; Summerfield, 2004; Visser, 2015).

The emergence of PTSD as a diagnosis has been argued to be the ultimate medicalised response to gendered and political violence (Burstow, 2003). Summerfield (2004) suggests that the rise of trauma discourse has been "The most spectacular facet of the globalisation of Western trends towards the medicalisation of distress" (p. 234). Criterion A of the diagnostic criteria for PTSD, which defines a traumatic event, has been one successful target of changes by feminist and other advocates. The DSM-III-R edition included as criteria that the traumatic event was outside the usual range of human experience and would be very distressing to almost anyone (American Psychiatric Association, 1987). Feminists argued that such an understanding of trauma is not applicable when considering the high rates of violence which women experience. Such a description may further obscure the fundamentally pervasive nature of violence against women in society. This stipulation of the traumatic event as 'outside the range of normal

experience' was eventually removed after lobbying efforts by feminists (Brown et al., 1995). Feminists have also pointed to the high rates of diagnosis of PTSD in women who have experienced sexual assault, for example, and questioned the applicability of the diagnosis. Rates of lifetime prevalence of PTSD in survivors of sexual assault are between 24% and 58% (Walsh et al., 2012). High rates of the disorder may point to 'diagnostic drift', or the problem of defining common experiences of distress as symptoms, resulting in inflated numbers of diagnoses (Moynihan et al., 2013).

The current DSM-5-TR definition of trauma involves defining what constitutes a traumatic event which could lead to PTSD as 'Exposure to actual or threatened death, serious injury, or sexual violence' (American Psychiatric Association, 2022). Lobbying efforts have meant that witnessing such events, learning about them being experienced by a 'close family member or close friend', or repeated exposure to details of such events, are now also included as valid events leading to PTSD (American Psychiatric Association, 2022). While such a diagnostic description may validate and legitimise those who fall within its specifications, such a narrow description also creates boundaries about what is and what is not traumatic, which has politicised implications. A focus on an individual understanding may come at the expense of community and collective understandings of the processes of trauma, and their political context and may reduce or hinder efforts to address broader societal change targeted at the political level (Afuape, 2012). For example, longstanding microaggressions experienced by people of colour are not included within PTSD criteria, nor are the transgenerational trauma of war or collective traumatic experience of people with marginalised identities on the basis of, for example, sexuality or colonisation. Likewise, a focus on people's parents as perpetrators of trauma without sociopolitical context can obscure from the justice which may have been lacking in the lives of those parents, and the political and social influences which led to their behaviour or supposed inadequacies as parents (Reynolds, 2020).

Decontextualising and Pathologising Violence?

Despite the link between social location and violence, standards and modes of treatment and recovery are generally delivered with a focus on resolving trauma pathology, devoid of political context.

It has been repeatedly highlighted that within the colonised context of Aotearoa, for example, that mental health care for Māori continues to be delivered within a diagnositic, medicalised and deficit based model which must urgently be changed if Māori needs are to be met within mental health care (Government Inquiry into Mental Health and Addiction, 2018; Kopua et et., 2021). Focusing on intra-individual factors of violence and recovery which ignores sociopolitical factors may not suit individuals from marginalised populations whose experience of violence is heavily political and may reduce or hinder efforts to address broader societal change targeted at the political level (Reynolds, 2020). However, such a pathological model of trauma and treatment is likely to be unsuitable for many beyond any specific marginalised population (Stevenson, 2023).

Trauma discourse, particularly in regard to therapeutic responses, involves heavily medicalised language, such as 'treatment', 'symptoms', 'risk', and the development of manualised therapeutic responses which must be implemented by trauma 'experts' (Briere & Spinazzola, 2005; Cohen et al., 2012; Kretschmar et al., 2018). It has been highlighted that the evolution of the term trauma to mean both causal events and resulting distress means that terms like violence or rape are sometimes replaced with the term trauma, which may have depoliticising effects (Tseris, 2019). A medicalised trauma response, which may focus on and help alleviate individuals' distress through a focus on understanding symptoms and developing coping skills, may carry many benefits, but may also lack a crucial element of contextualisation. Such contextualisation can be critical in limiting internalisation of blame. Feminist trauma-informed frameworks argue that contextualising the social and political context is vital in a woman's understanding and meaning-making of the violence she has experienced (Wilkin & Hillock, 2014)). Many feminist scholars and activists have argued that a pathologising focus on symptomology contributes to the location of deficit within the survivor of violence (Burstow, 2003; Gómez, 2023; Goodman, 2015). Research supports that elements of consciousness raising and understanding politicised aspects of domestic violence, for example, have been an important element to healing and therapeutic change for many women survivors of violence (McGirr & Sullivan, 2017; Scoglio et al., 2021).

Along with a construction of distress after violence as deficit and individually located, therapeutic discourses around trauma and gendered violence may place the responsibility for 'fixing' such pathology and dysfunction on survivors individually (Egan, 2020). In this sense, despite its well-intentioned goals of empowering women and recovery after violence, therapy can serve a function of social control. Some scholars argue that a focus on pathology and symptomology in women after violence and abuse is a form of neoliberal dominance and a tool to enforce associated ideals (Peters, 2019; Tseris, 2019b). These might include an overemphasis on self-responsibility over collectivity and viewing behaviours which interfere with capitalist productivity as pathology (Peters, 2019). Within these pathologised views on survivor distress, there may be little room for alternative understandings of behaviours and experiences as everyday acts of resistance to oppression (Wade, 1997).

The diversity of experiences and responses related to gendered violence may not be captured in trauma discourses that suggest universal symptom profiles. While linking violence and abuse to many devastating mental health consequences has been validating for many, some have argued that such discourses also create notions of inherently broken, weakened, or vulnerable victims, and trauma as an inherent trait (Grondin, 2011). Gavey and Schmidtt (2011) explored discourses around the 'trauma of rape'. They found that while positive advances have been made in negating rape myths, there are also complex discourses regarding trauma in everyday discourse which may essentialise survivors as permanently scarred, or frame women who claim to have experienced less psychological damage than others following rape as 'in denial'. Medicalised understandings of trauma may also damage survivors' abilities to construct their own understandings, which may differ from these dominant ideas.

Commonly described symptoms of trauma include distorted thinking about the world and others (Herman, 1997). Many trauma-informed therapies for those recovering from violence include working to restore trust in others and a sense of safety to a 'normal' level (Cohen et al., 2012). Such therapeutic goals rest on the problematic assumption that the world is essentially safe, and that people who have been traumatised have a less realistic picture of the world than others (Burstow, 2003). In these assumptions again lies a notion of normalcy based on those who hold the most power and have the privilege of safety.

For people who live in and through marginalised and oppressed bodies, including women, people of colour, indigenous people, queer, and disabled people, a mistrust in the world and the motivations behind systems and processes of oppression may be appropriate, and indeed may be a precursor for resistance and social change (Afuape, 2012; Tseris, 2019).

Politicised Understandings of Trauma

Transgenerational, collective and oppression trauma are often overlooked in therapy and mental health assessment, thus missing vital information about the origins and nature of current distress (Kira, 2001). Even intergenerational contexts of trauma are often overlooked, such as focusing on a child's symptoms following sexual abuse without exploring parental histories of trauma (Frazier et al., 2009). Not contextualising distress and trauma within these politicised, intergenerational contexts may result in less effective therapies. In discussing the context of the global COVID-19 pandemic as a collective trauma, Muldoon (2020) raises evidence which suggests a sense of collectivity and shared narrative about a collective trauma may act as a protective factor and increase feelings of efficacy and agency. Such arguments are also supported by research, which suggests that a sense of shared-ness in the face of trauma works to counter anxiety and distress in response to it, and aids collective narratives which build resilience (Kearns et al., 2017). Transgenerational, historical and discrimination (or oppression) trauma are examples of perspectives of trauma and trauma processes which include an explicitly sociopolitical and more collective perspective, and these are outlined below.

Transgenerational Trauma

Transgenerational trauma refers to the passing of trauma from one generation to the next, and it's mechanisms and effects have been described and studied at individual, family, community and societal levels (Salberg & Grand, 2024). Western academic study of transgenerational trauma was heavily influenced by studies in the 1960s involving the children of Jewish holocaust survivors, who displayed symptoms of trauma despite not having directly experienced the trauma their parents did (Barocas & Barocas, 1979; Freyberg, 1980). Markedly higher than average rates of distress, which meet diagnostic

thresholds for depression, PTSD, ADHD, anxiety disorders, and other diagnoses, have also been found in children of survivors of torture and/or genocide, such as those in Rwanda, Yugoslavia, and Cambodia (Braga et al., 2012).

Domestic and sexual violence and abuse have been studied specifically for the ways they affect the subsequent generations. The intergenerational transmission (IGT) framework for understanding intimate partner and family violence has gathered much empirical support since its inception in the 1980s (Bellack et al., 2013). Stemming from social learning theory, theorists argued that witnessing interparental violence created social scripts and grew habituated responses through learning processes, with the family being a primary site of such learning for children. Empirical research has provided extensive evidence that violence and aggression are passed down or repeated intergenerationally, even in the absence of direct witnessing or experience of violence (Cordero et al., 2012). Research suggests that a correlation exists not only between the witnessing of violence and later perpetration of violence across generations, but also later victimisation (Kwong et al., 2003). Feminist theorists have also highlighted the need to examine the effects of patriarchy intergenerationally, and that trauma such as gendered violence, should be examined through the perspective of intergenerational patriarchal trauma (Atkinson, 2018). Mother-daughter relationship dynamics, along with gendered roles young girls are socialised into, which prioritise empathy and the needs of others, have also been discussed for decades by feminist scholars as processes of intergenerational patriarchal trauma (Rich, 1977; Vogel, 1994; Webster, 2020).

The process of transmission of transgenerational trauma should not be viewed solely through a purely deficit perspective. Alongside trauma and its adverse effects, intergenerational transmission of resilience and resistance can also occur in the face of oppression. Scholars have argued for more research and trauma interventions focusing on exploring and emphasising these strengths (Danieli, 2007). Collective memories, or shared practices of remembering such as storytelling involving past disasters or challenges, may enable people or communities to better overcome new or present-day disasters or traumas (Goodman & West-Olatunji, 2008). Danieli (2007) also pointed out the learnt flexibility of increasing and relaxing protections and defences according to levels of threat that are often involved in

collective oppression-based trauma. A vast and diverse history of social movements led by oppressed peoples demonstrates the creative resilience and survival which is also part of the transgenerational story of trauma, and which also instills positive traits which are passed from one generation to the next.

Other theorists and researchers argue that the attachment bonds within the family create the necessary environment where trauma and unhealthy relationship bonds enable the lasting and cyclical nature of repeating abusive behaviour or victimisation (Alexander, 2015). Webster (2020), in her work identifying what she calls 'The Mother Wound', describes how women experience ongoing symptoms of low self-confidence, poor boundaries, a sense of abandonment, and relationship difficulties due to the transmission of patriarchal wounds passed down through mothers to daughters. She suggests that it is within this relationship that the biggest wounding takes places, due to the need for the daughter to attach and relate to her mother for survival, but this wounding exits within the context of pervasive patriarchal messaging and impacts. Atkinson (2018) highlights how the transgenerational trauma of patriarchy, including that of gendered violence, is still depoliticised and confined to the relational and individual level attachment space, whereas it needs to be seen as transgenerational, politicised misogyny to understand and contend with it.

Psychoanalytic theorists have provided further concepts and frameworks for the understanding of transgenerational transmission of trauma, with Bakó and Zana (2020) providing the concept of the 'transgenerational atmosphere'. They describe how the first generation of collective or historical trauma survivors creates this transgenerational atmosphere through a process of splitting off the unbearable pain of the trauma, creating an atmosphere of projected, unspoken pain. Through this splitting, a boundaried 'me' is lost, and an intrasubjective space is created, and subsequent children are drawn into this atmosphere of unspoken trauma:

> The transgenerational atmosphere is an unconscious way of preserving and transmitting the trauma and the related experiences and memories when there is no narrative remembering or intentional passing on of the experience… For the following generations the atmosphere is alien (yet somehow familiar), a sum of experiences and feelings that

> cannot be comprehended on the basis of their own life-story, or only with difficulty. It is a shared we experience in which several generations are deeply involved, the life-worlds merge together and exist in a common field (Bakó & Zana, 2020, p. 30).

In summary, there are multiple areas of understanding and research regarding transgenerational trauma, including interpersonal violence. What these theories share, to varying degrees, is an acknowledgement that trauma and distress do not occur devoid of sociohistorical context. Instead, these theories link individuals with their place in time, community, and culture to explain their experiences.

Historical Trauma and Colonisation

Indigenous scholars and practitioners have long called attention to the transgenerational, collective, and historical nature of trauma experienced by people who have experienced colonisation, often broadly referring to this as historical trauma (Lawson-Te Aho & Liu, 2010; Wirihana & Smith, 2014). Initially drawing on early work on the transgenerational trauma of holocaust survivors, indigenous scholars asserted how similar ongoing processes of trauma transmission were occurring due to the genocidal acts of colonisation (Smallwood et al., 2021). However, the historical trauma of colonisation is not defined by a singular act or even a series of acts, but the historical and ongoing processes of colonisation and white supremacy-based violence (Heart & DeBruyn, 1998). Trauma, as defined by indigenous scholars, is both collective and intergenerational in nature, and thereby differs from some descriptions of transgenerational trauma, which could potentially be passed down through individuals or single families (Pihama et al., 2019).

The concept of the ‘soulwound’ was coined by Duran and Duran (Duran & Duran, 1995) to describe the transgenerational and collective wounding of colonisation inflicted on indigenous American Indians. This concept describes the spiritual nature of the wounding and distress described in native communities. In addition to the wounding as a result of physical, cultural and psychological violence, Duran (2006) explained how elders described that this wounding extended to the natural environment and people’s relationship with it:

> In addition, they explained how the earth had been wounded and how, when the earth is wounded, the people who are caretakers of the earth are also wounded at a very deep soul level. Earth wounding speaks to the process whereby people become destructive to the natural environment and disturb the natural order (Duran, 2006, p. 16).

In Aotearoa, the continued disparate health and wellbeing outcomes of Māori are directly attributable to colonisation and the ongoing processes of cultural and resource loss and systemic racism (Pihama et al., 2016; Reid et al., 2019). As well as direct violence and massive loss of life through war and disease, Māori culture, identity and practices were profoundly affected by colonisation, and continue to be despite struggle, resistance and the ongoing reclamation movements of Māori. The ongoing occupation of Māori land continues to deprive Māori of reconnection to whenua (land) and culture, and deprives Māori of resources, and the state continues to be a force of institutional white supremacy (Wirihana & Smith, 2014). The ongoing dominance of the colonial state, what Pihama et al. (2019) describe as 'legal imperialism', also forces assimilation and a rupturing of the indigenous systems which protected the wellbeing of Māori. This also involves a rupturing of relationships between people and the environment, and between men and women.

Kruger et al. (2004) note how understandings of whānau violence in the mainstream are framed "using an analytical process that is punitive, reductionist and individualised" (Kruger et al., 2004, p. 11), and instead call for understandings of these present-day acts of violence within the context of historical and ongoing trauma of colonisation. Wirihana and Smith (2014) argue that acknowledging historical trauma is a necessary step in the healing of individual and collective soul healing. The ongoing dominance of medicalised and diagnostic views of mental health continues to subjugate Māori knowledge and approaches, hindering efforts for such an ecosystemic view of Māori trauma and whānau violence to occur or for kaupapa māori approaches to be resourced (Balzer et al., 1997).

Other colonised and racially marginalised and oppressed groups around the world have also documented and explored the mechanisms and processes by which trauma has been transmitted through generations, how it connects to current day acts of family violence, and how these processes are

compounded by current day experiences of continued marginalisation (DeGruy Leary, 2005; Hoffart & Jones, 2018). The term 'Posttraumatic slave syndrome' was coined by DeGruy (2005) to describe the ongoing individual and collective effects of institutional racism and the legacy of slavery for African Americans and has since been used to explore how this historical trauma has created legacies of gendered violence and a denigrated relationship between women and men (St. Vil et al., 2019). Research around colonial, racist and abusive residential schools, which Native American children were sent to, has revealed how the abuse experienced in these schools led directly to the normalising of domestic violence (Hoffart & Jones, 2018).

Oppression/Discrimination Trauma

Oppression/discrimination trauma describes the adverse effects on well-being, often similar to posttraumatic symptoms but not limited to them, which occur because of the day-to-day experiences of discrimination and oppression (Goodman, 2015). This daily experience and transgenerational and historical trauma are inextricably linked for many who experience them. Many groups and cultures that have been exposed to historical and collective traumas, which may have been passed through generations, continue to face various forms of systemic and individual marginalisation and discrimination today. A validating and mirroring societal atmosphere can be important to healing in the aftermath of collective trauma (Bakó & Zana, 2020). However, aspects of structures and institutions within society itself can be the perpetrator of collective trauma, and marginalised groups are less likely to find such trauma acknowledged and validated by dominant discourses and institutions when this is the case. Therefore, transgenerational passing of trauma is even more likely when society itself is the perpetrator of trauma and therefore impedes collective healing.

The cumulative stress of discrimination or being part of a group with less social power has been theorised to have an impact on many facets of wellbeing, which is in turn linked to many mental health problems, including traumatic stress-related problems such as PTSD, anxiety, and depression (Gill & Matheson, 2006). Empirical studies support such theories and have found evidence for the impact of daily experiences of discrimination (including but not limited to sexism, heterosexism, and racism) on health

and wellbeing, even when other social and economic factors are controlled for (Benner et al., 2018; Deitch et al., 2003; Swim et al., 2009). Research focusing on racism has found that its subtle and pervasive nature results in lowered emotional wellbeing (Ferdinand et al., 2015; Huynh & Fuligni, 2010), while studies have found that daily experiences of sexism and gender discrimination are related to the severity of psychological symptoms in women in a range of areas (Klonoff et al., 2000; Stepanikova et al., 2020). Aspects of psychological well-being which have been linked to the negative outcomes associated with discrimination include shame, self-esteem, emotional regulation, perceived control, and personal mastery (Greene & Britton, 2015; Wilson & Gentzler, 2021). Chronic shame has been highlighted as a common experience for those facing ongoing oppression and marginalisation in daily life (Dolezal, 2022)

Discrimination, shame and violence. Shame has long been associated with the effects of trauma (Herman, 1997). Unlike guilt, which is a negative emotion related to behaviour, shame arises through a negative evaluation of the self as a whole, a sense of the self as being fundamentally flawed, worthless or 'bad' (Seah et al., 2023). This shame is closely linked to beliefs about being to blame for their trauma (Bhuptani & Messman-Moore, 2019). Studies exploring shame and trauma-related 'disorders' such as PTSD have found that shame is characteristic of the distress associated with trauma (López-Castro et al., 2019; Seah et al., 2023). Shame is often focused on as a key target of trauma therapy for survivors, who develop a deep sense of shame in part out of the experience of violation and a loss of dignity and sense of self that is involved with the traumatic events, particularly sexual assault (Herman, 1997).

Shame is also a social emotion and therefore arises in relation to the perception of other people and social norms (Bhuptani & Messman-Moore, 2019). Researchers have highlighted how the shame and self-blame involved with sexual assault and IPV survivors' experience are increased or even created by the consistent environment of stigma and blame associated with narratives around survivors being responsible for their own assault (Kennedy & Prock, 2018). These beliefs exist within the wider cultural scaffolding of rape culture and patriarchy, the broader cultural environment which excuses and enables sexual violence, particularly against those with marginalised identities such as women, gender minorities,

people of colour, indigenous people and disabled people (Gavey, 2018). Victim blaming narratives work to minimise rape by focusing on the victim's behaviour instead of the perpetrator (Gavey & Schmidt, 2011). There is research which supports the fact that experiencing stigma and victim blaming when disclosing sexual assault, and internalising victim blaming narratives, increases shame and psychological distress after sexual assault (Kennedy et al., 2012; Kennedy & Prock, 2018). In this regard, the narratives people face after violence related to rape culture and the marginalised people it targets directly link to the shame that is such a core component of the effects of violence.

The discrimination people experience following violence often occurs within the context of daily and lifelong experiences of identity-based discrimination and marginalisation (Eshelman et al., 2024). Considering those who are most susceptible to interpersonal violence and associated victim-blaming narratives are marginalised people, it follows that those who experience this victim-blaming are those who have already experienced discrimination trauma in other forms. A sense of internal shame has been highlighted as a prevalent outcome of discrimination, oppression, and marginalisation (Dolezal, 2022). Discrimination based on aspects of a person's identity such as gender, sexuality, race, or ability, is arguably distinct from other life stressors in its targeting of someone's identity. Discrimination is inherently demeaning and personal, given that it is the result of an ideology of superiority of a powerful group over certain aspects of members of a marginalised group's identity (Klonoff et al., 2000). Shame, because of ongoing discrimination and oppression, has been described as distinct in that it is pervasive and enduring, and becomes what feminist researcher Bartkey (1990) described as a 'pervasive affective attunement'. She and others have described chronic shame as a more appropriate term for those who come to experience and expect shame in their daily life, both at individual levels and via structural levels of oppression (Bartky, 1990; Dolezal, 2022).

The argument that existing discrimination trauma compounds the effects of trauma for those who experience violence is supported by research. Experiences of racism and homophobia, for example, have been positively linked to the severity of trauma symptoms after experiences of violence (Eshelman et al., 2024; Gold et al., 2007; Harb et al., 2023). Studies, particularly those with LGBTQI survivors, have

repeatedly found that a mediating factor in such outcomes is the role of shame (Cabral & Pinto, 2023; Salim et al., 2023; Straub et al., 2018). For example, in a study exploring the experiences of 326 trauma-exposed sexual minority women, internalised heterosexism was found to positively predict the severity of PTSD symptoms (Straub et al., 2018). This relationship between internalised heterosexism and PTSD experiences was found to be mediated by shame-related withdrawal tendencies.

In summary, people experience discrimination in the form of victim blaming, which directly impacts recovery as well as the perpetuation of violence. Further, existing lifelong experiences of discrimination and oppression, such as racism or homophobia, negatively impact wellbeing and compound these experiences. Shame, due to trauma, rape culture narratives around victim blame, and identity-based discrimination, exacerbate the psychological effects of trauma. These intersections show the importance of the sociopolitical context in the experience of interpersonal violence, not only directly surrounding the violence, but also how existing experiences relate to violent trauma and its aftermath.

Chapter Three - Literature Review: Bringing The Politicised Context Into Therapy

In this chapter, the reality of the current practice and literature around bringing sociopolitical context into trauma therapy and therapy generally will be explored. Firstly, the broad calls for including sociopolitical context in TIC and therapy will be outlined, highlighting that such calls are not niche within social justice literature, but instead now cross disciplines and contexts. Then, examples of models of assessment and therapy which include sociopolitical context will be given. Barriers to and complexities involved in effectively exploring sociopolitical context in therapy will then be explored, followed by an overview of issues in training for such practices. Finally, the case for this study will be summarised and research aims will be outlined.

Calls for Including Sociopolitical Context in Therapy Go Mainstream

The need for therapists, both trauma-informed and otherwise, to be aware of and include sociopolitical context in their case conceptualisations and therapeutic discussions has been widely discussed and acknowledged. In Aotearoa, ethical guidelines for therapists, including psychologists, psychotherapists, and counsellors, increasingly highlight the need to attend to sociopolitical factors within therapeutic practice. The Code of Ethics for psychologists working in New Zealand has a section dedicated to social justice and responsibility to society (Code of Ethics Review Group, 2012). While the wording may be somewhat broad, this section calls for ‘addressing and challenging unjust societal norms and behaviours that disempower people at all levels of interaction’ and demands that ‘‘Psychologists are sensitive to the needs, current issues, and problems of society and take account of these needs in their work” (Code of Ethics Review Group, 2012, p. 25). Core competencies for Clinical Psychologists, for example, include having skills in ‘Integration of the concepts of stigma, discrimination and social exclusion into assessment and treatment processes’ (New Zealand Psychologists Board, 2018). The New Zealand Association of Counsellors' Code of Ethics (New Zealand Association of Counsellors, 2020) also promotes social justice as a core principle, and calls for counsellors to “support their clients to challenge

the injustices they experience" (p. 5) and to "promote social justice through advocacy and empowerment" (p. 5).

Apart from emerging and highly important research which explores cultural safety and issues (eg. Waitoki et al., 2023, Waitoki et al., 2024), there is to date no research on the application of these social justice, ethical and competency obligations specifically in practice in the Aotearoa context. However, of relevance, Stevenson's (2023) Aotearoa-based doctoral research explored service users' views of Clinical Psychologist competencies, comparing and contrasting these views to existing competencies as set out by the New Zealand Psychologist's Board (NZPB). It consisted of a survey (n = 73) and individual interviews (n =12) and asked adults who had used the services of Clinical Psychologists how they viewed competence. Among the findings and of most relevance to this study, service users reported greater emphasis on cultural issues, knowledge and competence than are emphasised in existing NZPB competencies. Findings suggested that competencies must include moving from knowledge to action in practice, such as intervention about intergenerational and cultural loss. The study highlighted issues of stigma, discrimination and power repeatedly by participants, leading Stevenson (2023) to suggest that more specific competencies should be developed around working alongside clients facing these issues. Participants also repeatedly highlighted the harms of the medical model for all people, marginalised and otherwise, suggesting that Clinical Psychologists must be adept at working with less pathological models to be competent. Stevenson (2023) recommended that, to meet expectations of competence around issues of power and non-pathologising language, more specific expectations of competence in alternative models, such as the Meihana model of assessment and the Power Threat Meaning Framework (outlined in the subsequent section), would be beneficial.

Social justice-focused and intersectional feminist frameworks of trauma-informed care and psychological therapies internationally highlight addressing sociopolitical context as a key component of care (Audet & Paré, 2017; Prilleltensky & Fox, 2007). Following from liberation psychology traditions, Prillitensky (2008) has argued for the concept of psychopolitical validity, arguing that psychological approaches to assisting people with mental health should be assessed on their ability to attend to wellness

within sociopolitical context. This includes conceptualising wellness within an understanding of the suffering of oppression and assisting people to not only adapt to their societal conditions but to challenge and resist them. In bringing the language of 'validity' to this conversation, often used in 'evidence-based' literature around mental health and therapy, Prillitensky demonstrates how the evidence for the sociopolitical context in conceptualising and understanding wellbeing is so clear, efforts to address wellbeing must include this context to be truly evidence-based, or 'valid' (Prilleltensky, 2003).

A common theme amongst social justice-oriented frameworks for therapeutic trauma practice is the rejection of the idea of the neutral therapist (Goodman, 2015; Linklater, 2020; Reynolds, 2020; Tseris, 2019b). This is because in siding with the traditional aims of being a 'neutral' therapist, dominant and status quo ideologies are often left unexamined or perpetuated (Tseris, 2019b). Social justice-oriented practitioners argue that a therapist must actively work against the deeply rooted and ideologically driven claims to neutrality and side with those who have been marginalised (Linklater, 2020; Prilleltensky, 2008; Reynolds, 2020). Many people, particularly those who have experienced oppression or colonisation, such as Māori, Rigby (2018) argue, do not experience the therapy space as neutral. Instead, it is a space inherently filled with the narratives, ideas, beliefs and norms of Westernised white therapy. Therefore, as therapists seek an actively liberatory stance, an anti-neutrality stance is necessary to counter the pathologising and individualistic ways of thinking that have formed therapeutic modalities (Reynolds, 2020).

Despite scholarship and research around incorporating sociopolitical context into therapy being most developed within social justice-focused literature, it is not confined to it. In fact, the calls for bringing sociopolitical context into therapy are well and truly mainstream. Internationally, the Substance Abuse and Mental Health Services Administration (SAMHSA) is a US-based TIC framework which has been broadly influential, including within Aotearoa. SAMHSA has adapted earlier TIC models and suggested six trauma-informed principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and understanding cultural, historical and gender issues (SAMHSA, 2014). This last principle explicitly calls for recognising and addressing

historical trauma, gender and culturally responsive services and moving past biases and stereotypes. The guidelines note that these principles should be reflected in intervention and treatment. Such principles are reflected across similar guidelines elsewhere and across disciplines. New Zealand TIC guidelines, such as those published by Te Pou (a national workforce centre for mental health and addiction) also highlight the need for uniquely place-based understandings of trauma-informed care which take into account the processes of colonisation and dispossession which impact experiences of trauma for Māori (Donaldson et al., 2018). As previously mentioned, however, despite such calls, the reality is that TIC in Aotearoa is often still devoid of this context (Atwool, 2019; Pihama et al., 2019; Wirihana & Smith, 2014).

Calls for sociopolitically contextualised care are also made within guidelines for TIC for survivors of IPV in Aotearoa. The New Zealand Ministerial Group on Family Violence and Sexual violence has highlighted the need to address rape myths, harmful gender norms, historical trauma and gendered elements of violence as a key part of working with survivors of violence (Ministry of Social Development., 2017). Likewise, guidelines produced by Te Ohaaki a Hine National Network Ending Sexual Violence Together highlight the critical importance of acknowledging and building knowledge to work with those who hold marginalised identities, in countering rape myths perpetuated within a patriarchal system and in acknowledging historical trauma and colonisation (Wharewera-Mika et al., 2016). Internationally, in the discussion of trauma-informed care for survivors of sexual and interpersonal violence across disciplines, practitioners are called to both consider and often ask directly in assessment about how systemic oppression has impacted the survivor's experience (Herman, 1997; Kulkarni, 2019).

In summary, calls for the inclusion of a sociopolitical context into work within TIC, TIC with survivors and therapy generally have been made across disciplines and areas of literature and have now reached the mainstream.

Existing Assessment and Therapy Models Which Include Sociopolitical Context

Many therapeutic frameworks which are commonly used within trauma-based approaches include elements which aim to analyse structural and oppressive influences and contexts involved in trauma and

distress. Indigenous Māori models of wellbeing used in therapeutic assessment, such as Te Whare Tapa Whā (Durie, 1998) and models of assessment, such as the Meihana model, include an exploration of the impacts and influences of experiences of social marginalisation, including colonisation and racism (Pitama et al., 2007). The Meihana model, for example, takes the shape of a Waka Hourua (traditional Māori sailing vessel) and includes exploring clients' lives holistically, including the context of environmental, social cultural supports and connections, connection to land, and relationships to services and biases and barriers within those services (Pitama et al., 2017). It also includes *Ngā Hau e Whā*—the four winds of Tāwhirimātea—which represent key sociopolitical forces that impact Māori lives: colonisation, racism, migration, and marginalisation (Pitama et al., 2017). Many techniques and practices involved in feminist therapy, including collaboratively exploring societal beliefs and expectations such as those associated with rape culture, have been incorporated into models of therapeutic work with survivors (Evans et al., 2005; Williams & Barber, 2004).

There are many mechanisms by which therapists incorporate sociopolitical context into therapeutic discussions. As outlined above, some include this in collaborative formulation and assessment. This may involve elements of consciousness raising, where therapists may share information or suggest ways in which sociopolitical factors are involved with trauma and have been a focus of research about work with survivors of SV/IPV (McGirr & Sullivan, 2017). In discussing meeting trauma-informed standards of therapy with survivors of violence, Pemberton and Loeb (2020) suggest that carrying out a gender, cultural and historical analysis in therapy with survivors is important, highlighting how exploring gendered labour, roles, and allocation of resources can be empowering for trauma survivors. They concluded that more research is needed on how this is being carried out in practice in trauma therapy with survivors of violence (Pemberton & Loeb, 2020).

Explicitly reflecting on intersecting identities and social location shared, and not shared, between practitioner and client has also been utilised by therapists as a way to both build trust and open conversations about sociopolitical influences (PettyJohn et al., 2020; Watts-Jones, 2010). ‘Broaching’ is a term used to describe “the counsellor’s ability to consider the relationship of racial and cultural factors

to the client's presenting problem" (Day-Vines, 2007, p. 404). Given sociopolitical issues such as culture are often left unexamined if not broached, some have argued that therapists should explicitly broach such matters in the beginning, relationship-building phases of therapy, in order to create trust and openness for such discussions (Day-Vines et al., 2007; Ertl et al., 2019; Pettyjohn, 2020). In the Aotearoa context, discussing positionality and culture of the therapist as part of 'declarative dialogue' has been described as part of a practice of cultural humility, and a way to express openness to conversations about broader contextual issues and model vulnerability (Tohiariki, 2024).

D'arrigo-Patrick et al.'s (2016) research examining therapist social justice perspectives in practice also concluded that a key social justice practice is 'countering', where therapists may highlight an oppressive or discriminatory self-belief, and then collaboratively counter such beliefs and build counter-narratives. Therapists have highlighted how they often represent powerful institutions for many marginalised clients, and that validating is a powerful form of advocacy within therapy, where a therapist acts as a witness in hearing stories of how power has been wielded against clients, and validates the injustice of this experience (Afuape, 2012; Kozan & Blustein, 2018).

Narrative Practices as Sociopolitically Contextualised Stories

Narrative-based understandings of distress and treatment have long been popular with those who wish to practice using a social justice lens (Combs & Freedman, 2012). In narrative therapy, for example, work with clients often involves exploring narratives which may have been adopted to understand their life, including dominant and oppressive social discourses (Miller et al., 2007; Ricks et al., 2014). Narrative therapy was developed in Australia and New Zealand over 30 years ago by Michael White and David Epston, and draws on ideas from poststructuralism for its practices, which attend to power and societal discourses (Combs & Freedman, 2012). It is based on the understanding that stories influence how people make meaning of themselves, their lives and society, and that it is the stories people adopt that influence what they know of themselves and what options are available to them (White & Epston, 1990).

Narrative practices are influenced by Foucauldian notions of modern power, in which oppressive power over people's lives is no longer instrumented solely or even predominantly through centralised power but is also carried out via discourses which operate at every level of social life. Those who hold the most power and privilege have the most influence over these discourses, and without examination, most of us attempt to live up to these powerful discourses which shape our ideas about what is normal, acceptable and worth aspiring to. In assisting people to re-author the story of their lives and selves, the goal is for people to live a life more of their own making, rather than one constrained by the dominant societal discourses which may be influencing their story (Monk et al., 1996). As Combs and Freedman (2012) state, "narrative therapists seek to continually develop ways of thinking and working that bring forth the stories of specific people in specific contexts so that they can lay claim to and inhabit preferred possibilities for their lives"(p. 1039).

One important tool used in narrative therapy, which assists in this examination of sociopolitical influences and re-authoring, is externalisation. This tool is linked to a core assumption in narrative therapy which is that *the person is not the problem, the problem is the problem* (White, 2007). Therapists engage in externalising conversations, which aim to help people see their own identity as separate from the struggles they have faced. This externalising also offers a chance to explore what oppressive discourses may be at work within the stories people hold, and the problems they face. This work helps externalise oppressive experiences and break down limiting beliefs and understandings, and is better able to see how people still exhibit agency and resistance in response to problems, even amongst oppressive circumstances (DeKruyf, 2008).

Re-authoring narratives is not confined only to narrative therapy and has been taken up in other therapeutic frameworks for working with trauma and distress. Writing down and exploring narratives about a survivors' life and experience of trauma, and an exploration of oppressive discourses which may help shape those narratives, has also been incorporated into guides for other trauma modalities such as trauma-focussed-CBT (Cohen et al., 2012). The Power Threat Meaning framework (PTMF) is another example of narrative-based models emphasising sociopolitical context (Johnstone & Boyle, 2018).

Developed in the UK, it has garnered significant attention as a model of conceptualising distress and the context in which it occurs (Gallagher et al., 2024). It aims to move away from psychiatric, diagnostic conceptualisations of people's problems towards a narrative contextualised understanding, focusing on how power operates in our lives, including interpersonal, economic, social, cultural, ideological, coercive, embodied and legal power (Johnstone & Boyle, 2018). The framework explores how people have come to experience threats due to the negative use of this power and how they develop survival responses and distress as a result. In exploring what happened to someone (how power operated in their lives), what meaning they made from this, and how they had to respond to survive, a person develops a story which is contextualised and non-pathological.

In summary, there are many models of assessment and therapy and therapeutic tools in which sociopolitical context has been incorporated into practice. The next section explores the reality of this incorporation and the barriers to implementing in practice.

Complexities Involved in Incorporating Sociopolitical Context Into Therapy

Despite the growing calls for integrating sociopolitical contextualisation and awareness into trauma-informed work and therapeutic intervention outlined above, many scholars and practitioners argue that this is not yet a widespread practice. Some argue the trend is towards a less politicised and more individualised approach (Audet & Paré, 2017; Gold, 2017; Reynolds, 2020). There is still a long list of popular modalities for therapy where the sociopolitical is still not prioritised or, where it is included, it is as an ‘add on’ which is often not then carried out in practice (Tseris, 2019b).

Historically, scholars have pointed to ideological interests which align with maintaining the status quo within mental health professions as one reason why sociopolitical context has been slow to be effectively incorporated into therapy (Chantler, 2005; Comas-Días & Torres Rivera, 2020). While this no doubt plays a part, there are complexities involved in bridging the gap between theory and practice when it comes to sociopolitically contextualised practice in therapy. Some reasons explored in research include a lack of knowledge of sociopolitical issues and how to integrate them effectively, practitioner discomfort

and privilege, the dominance of the medical and individualised model and training gaps (Burnes & Singh, 2010; Esmiol et al., 2012; Goodman, 2015; Treichler et al., 2020). These issues will be explored below. It is worth noting that these issues do not occur in a vacuum. Larger, structural issues, such as the ideological interests of those who hold power within the mental health professions, are interlinked and perpetuate the following issues.

Lack of Knowledge on Issues and Models of Integration

Research around exploring Psychologists' and Psychotherapists' views of the DSM has suggested that many have been dissatisfied with the medical model for decades and want to work more contextually, but that they often feel unfamiliar with alternative ways of working (Raskin, 2019; Raskin et al., 2022). Some research has explored therapists' practices of discussing specific sociopolitical issues, such as race or class, in therapy. In Cohen's (2016) United Kingdom (UK) based qualitative exploration of 12 therapists across different disciplines and how they incorporated social class into discussions with clients, results suggested that therapists rarely broached social class discussions, mostly only discussing this when clients explicitly raised it. They also found that clinicians did not share their own identity or experience about class when it was discussed, which has been suggested as necessary as part of broaching issues of identity and social location (Day-Vines et al., 2007; PettyJohn et al., 2020). Cohen (2016) concluded that helping professions need greater emphasis on building skills for broaching aspects of identity and sociopolitical location alongside more knowledge of theory on social class in education. Such a conclusion likely extends beyond only the issue of class.

A lack of knowledge about how sociopolitical factors are involved in clients' lives and distress has been cited in multiple studies as a possible reason for poor integration of social justice principles into practice (Goodman et al., 2004; Treichler et al., 2020). As Allen (2011) also raises, a further barrier beyond lack of knowledge may be the internalisation of harmful narratives by therapists themselves, making it even less likely they could identify how these are operating for clients.

Winter (2021) conducted a UK-based qualitative survey of 32 trainee and qualified practitioners in psychotherapy, counselling, and psychology to explore their understanding of politics in their work.

Results showed that despite a broad understanding that politics greatly influenced the lives and distress of clients, it was rarely discussed directly, and if so, largely only when raised by the client. This was discussed partly due to wanting to be client-led and not removing client autonomy. This echoes what some have cited as the dangers of liberation psychology practitioners' work. Afuape (2012) suggests that there are risks that practitioners could further harm clients if they take on an 'expert' role related to issues of social justice or define oppression for clients. Indeed, a participatory and collaborative way of discussing sociopolitical context is needed to avoid such pitfalls (Afuape, 2012; Comas-Días & Torres Rivera, 2020; Linklater, 2020; Reynolds & Hammoud-Beckett, 2017). It is possible that practitioners who have not developed such skills may feel or indeed are ill-equipped to discuss such issues appropriately.

It has been noted that a neglect of social and political factors within formulations with a client and in therapy can come from a desire to focus on factors which the therapist can have some influence over in the therapeutic process (Winter, 2019), despite this positive intent often leading to an overemphasis on the problems residing within the individual. Such a reason for avoiding the political suggests therapists may not have an understanding of the therapeutic benefits to exploring and validating sociopolitical context. Such benefits could include creating alternative stories less focused on self-blame, feeling validated and heard, and creating possibilities for resistance to harmful narratives and situations rather than adapting to them (Burstow, 2003; Goodman, 2015; Reynolds, 2020).

Researchers in the area of intersectionality, multiple marginalised identities and therapeutic practice have highlighted that research on discussing sociopolitical context in therapy continues to focus on single factors of identity or experience primarily (Hays, 2024; Moodley, 2007; Zimmerman & Catsronova, 2021). This means that the practice of discussing the more complex intersecting identities and experiences involved in a person's sociopolitical context is often not studied. Lack of knowledge around issues of power, sociopolitical context and intersectionality also means assumptions about sociopolitical factors for people based on stereotypes are more likely to occur (Cabral & Smith, 2011; Day-Vines et al., 2007; Israel & Selvidge, 2003; Watts-Jones, 2010).

Discomfort and Privilege

Some literature has highlighted the issue of practitioner discomfort as a key issue involved in integrating discussion about issues of race, class, and other politicised experiences (Allen, 2011; Al-Murri & Childs-Fegredo, 2023; Esmiol et al., 2012; Morrison et al., 2022). In a rare study which explored the inclusion of sociopolitical factors in therapy across issues (rather than only one issue), Allen (2011) interviewed or held focus groups with counsellors and clinical psychologists to explore how they included sociopolitical factors in their practice. Results suggested that practitioners experienced significant discomfort around raising sociopolitical issues in practice, particularly early in their careers. It also meant they experienced a significant feeling of dissonance related to this. The conclusions included that a focus on discomfort and dissonance in training may highlight important areas where further development and reflection are needed for practitioners to be competent in holding such discussions. This finding echoes those of many in the field of social justice in therapy, who have highlighted that it is a lack of development of knowledge about one's own power, identity and privilege, as well as experiences of oppression, that contribute to the discomfort involved in holding discussions about these issues (and therefore, in avoiding holding them) (Ertl et al., 2019; Morrison et al., 2022; PettyJohn et al., 2020; Watts-Jones, 2010).

In a meta-analysis of multi-cultural competency, results suggested that white trainees are often aware of their whiteness when working with non-white clients, but still often avoid or minimise conversations about race (Tao et al., 2015). Privilege plays a significant role in a therapist's ability to avoid conversations about political experiences (Afuape, 2012; Audet & Paré, 2017; Reynolds, 2020). In the Aotearoa context, Rigby (2018) argues that Pākehā practitioners desires to remain focused on internal factors and to attempt to remain 'neutral' or less engaged with sociopolitical factors may be more an issue of being 'unable to bear full self-knowledge' (p. 129) within a cultural encounter when working with Māori. In other words, discussing the sociopolitical may be difficult and uncomfortable due to the avoidance of knowing Pākehā culture, identity and history in a fully embodied way. The ability to avoid this is linked to the power and privilege of being part of a dominant group.

The Dominance of the Medical Model

Some research has explored therapists' experiences navigating medicalising or pathologising discourses or diagnostic discussions. This research suggests that many therapists struggle to align conflicting frameworks as they acknowledge the importance of sociopolitical context and attempt to incorporate politicised understandings, while also engaging in discourses which medicalise and pathologise the trauma and distress of survivors of violence (Peters, 2019; Sutherland et al., 2016; Tseris, 2019a).

In Tseris' (2014) Australian-based study, which involved interviewing social workers about their negotiation of trauma and psychiatric discourses with women who had experienced violence, she found that they indeed traversed both contextualised and more pathologising discourses in their work. Organisational restraints, such as the demand for individualised therapy or having limited time with clients, also influenced their ability to provide a more politically contextualised approach (Tseris, 2019a). In research exploring newly registered therapists' experiences, therapists reported feeling isolated if they prioritise social justice in their work, with few colleagues or supervisors with whom they can discuss social-justice focused practice (Kozan & Blustein, 2018). Some research has suggested that social justice-related work may be deprioritised due to a need to be taken seriously in a workplace and context dominated by the medical model of mental health (Winter & Hanley, 2015). A narrative review of studies exploring the implementation of TIC (Sweeney et al., 2016) and a qualitative study exploring Psychologists' experiences of implementing the PTMF (Omur, 2023), both found that practitioners easily reverted to the more dominant medical model to explain distress. Psychologists found the more sociopolitical PTMF to be a stark change from usual models of practice, and therefore difficult or requiring more effort to implement (Omur, 2023).

In summary, despite the many calls for sociopolitically contextualised practice, this often does not occur in practice. The complexities involved are multifaceted and include an ongoing lack of appropriate knowledge about issues and models of integrating these issues into practice, discomfort

involved in discussions and a lack of exploration of power and privilege, and the ongoing dominance of more individualised and pathologising approaches.

Training As A Gap Between Theory and Application

A growing body of literature explores the necessary multicultural and social justice competencies for therapists across disciplines and training models to meet such competencies (Cohen et al., 2021; Mallinckrodt et al., 2014; Ratts et al., 2010). Therapists highlight a continued lack of emphasis on social justice in their training programmes in research exploring the area (Treichler et al., 2020). Counselling Psychologist trainees' perceptions of how supportive their training was of social justice have also been found to be predictive of how committed they were to social justice in their work (Beer et al., 2012). While literature highlighting the role of sociopolitical factors in trauma is now widespread, scholars and practitioners argue that the widespread adoption of such a perspective meaningfully within training programmes has been slow to occur (Brubaker et al., 2010; Gazzola et al., 2018; Vera & Speight, 2003). Research suggests a high degree of commitment to social justice principles amongst new psychologists (Treichler et al., 2020) and psychotherapists (Arczynski, 2017), but ongoing significant gaps in training remain.

In Aotearoa, research released in 2024 about psychology training in Aotearoa suggested vast improvements are needed to address issues of power and oppression. Focusing on racism and oppression, the survey conducted by the WERO (Working to End Racial Oppression) research team and the University of Waikato yielded responses from 293 psychologists, training staff, and psychology trainees in Aotearoa (Waitoki et al., 2024). Unfortunately, 64% of respondents rated their training as 'poor' in addressing issues for Māori, while 46% of trainees had witnessed racism in their training in the last 12 months (Waitoki et al., 2024). Addressing broader issues of power and oppression, 14% of trainees had been subject to verbal bullying in their programmes, and 67% agreed that traumatic training experiences were normalised in psychology. With such significant issues of racism and normalisation of traumatic experiences in training, it is all but impossible to assert that there are no significant gaps and problems

with meaningful adoption of social justice-informed content and practices within psychology training in Aotearoa.

In another Aotearoa-based study, Tan et al (2024) explored psychology training directors' opinions on the integration of queer-related content in training programmes. Results showed that queer-related content and content aimed at working appropriately with queer people was often an 'add-on', such as guest lectures, and that there was a significant gap in training related to the meaningful threading of this content throughout training (Tan et al., 2024). Indeed, the problem of issues related to social justice and sociopolitical factors being included as an 'extra', rather than a core thread of training, has been noted as an ongoing problem (Burnes & Singh, 2010; Pearrow & Fallon, 2020; Treichler et al., 2020). In Winter's (2021) study, participants described having had 'diversity' training but little that covered a broader sociopolitical context, and they relied on knowledge from former careers or training in this area.

Social justice and diversity aspects of training programmes are often content driven, focusing on teaching culturally specific mental health information and information about discrimination of certain groups of people, for example (Esmiol et al., 2012; Morrison et al., 2022). One problem noted with this is that when training focuses more on content about other marginalised peoples but not about a therapist's own identities and experiences of both privilege and oppression, then this perpetuates 'othering' of these groups of people (Clausen, 2025). To meaningfully engage with the complex way that power and sociopolitical factors are involved with a person's life, therapists need training which emphasises process and reflection about the therapist's own position concerning intersectionality and ongoing curiosity and cultural humility (PettyJohn et al., 2020). Training programmes must include an in-depth exploration of therapists' own place in the world and position of privilege to equip them with the skills they need to incorporate understandings of power and oppression into practice (Collins et al., 2015). Likewise, as explored above, an intersectional approach is needed which explores issues across intersecting identities, in order to gain more nuanced understandings of how power operates in people's lives and to avoid generating stereotyped ideas of people's lives (Ertl et al., 2019; Zimmerman & Catsronova, 2021). Ongoing self-reflection on power and privilege, and intersectionality, has been highlighted as often

missing in training (Morrison et al., 2022; Treichler et al., 2020; Zimmerman & Catsronova, 2021). Ideally, training must highlight these processes as ongoing rather than a competency that can be 'achieved'.

Most training-related research has focused on social justice knowledge and content in training rather than specific training for effectively holding conversations with clients about broad sociopolitical issues. Again, where this occurs, it has generally been about training that includes how to work with one group of people, rather than with a broader lens of power awareness and sociopolitical context (Ertl et al., 2019; PettyJohn et al., 2020; Zimmerman & Catsronova, 2021). Such content has a cognitive focus, while there is often a lack of training focused on moment-to-moment relational and power awareness within the therapeutic encounter, which is needed to attend to issues of power and oppression (Esmiol et al., 2012; Morrison et al., 2022). Limited research has focused on the training of therapists explicitly aimed at building skills to hold conversations about sociopolitical issues and attending to power in therapy, or building a 'contextual consciousness' (Esmiol et al., 2012; Morrison et al., 2022). These studies concluded that a focus on personal reflection, power awareness, and privilege was important in building skills for discussions. They also highlighted that a crucial element was both actually practising such conversations in training and then holding group reflection on these conversations. Doing this helped reveal areas for further development, including those that raised feelings of discomfort. Similar suggestions have been made elsewhere, including that well-facilitated group discussions in training about issues such as race were important to development of competency in discussing these issues (Chung et al., 2018; Goodman et al., 2004; Treichler et al., 2020).

Research Rationale

As outlined above, sociopolitical factors, including issues of gender, race, and socioeconomic status, are linked to experiences of trauma, including the experience and aftermath of SV/IPV (Gavey, 2018; Hearn, 2012; Winn, 2018). A growing body of literature is exploring perspectives on trauma which emphasise sociopolitical context, including experiences of discrimination and oppression (Danieli, 2007;

Goodman, 2015; Linklater, 2020; Pemberton & Loeb, 2020), but many argue that trauma practice is often decontextualised and pathologising in reality (Burstow, 2003; Linklater, 2020; Reynolds, 2020; Summerfield, 2004; Tseris, 2019b; Wirihana & Smith, 2014). Therapeutic models and ethical guidelines call for including sociopolitical and collective context in assessment and intervention (Combs & Freedman, 2012; Hailes et al., 2020; Tseris, 2019b).

More research is needed about trauma-informed approaches as they are currently being practiced in Aotearoa (Donaldson et al., 2018). Within trauma-informed approaches with survivors of SV/IPV, there is still little research on how incorporating issues and awareness of cultural, historical and gender issues is being implemented in practice (Pemberton & Loeb, 2020). Despite the research noted above about the challenges therapists may face in navigating medicalising discourse and the issues within social justice in training programmes, little research has focused more specifically on actual discussions within therapy which address sociopolitical context, including with survivors of sexual and interpersonal violence. There is also a lack of research which focuses on practice across sociopolitical issues, rather than exploring therapeutic practice in relation to one specific sociopolitical issue. Finally, research regarding social justice-informed practices is largely based in the UK and US, with very little exploring such practices and related therapeutic conversations in Aotearoa. In order to grow and foster the adoption of socially just practice within therapy that includes sociopolitical context in appropriate ways, more research is needed about these conversations, complexities, skills and tools involved, and outcomes for clients. This research joins a wider pool of critical research concerning the adoption of socially just and feminist-informed practices within trauma work. My intention is to focus on these conversations as one important site where therapists may adopt and use contextualised definitions of trauma and enact social justice-aligned praxis. With the demands for such an approach noted above, more knowledge about clinicians' experiences of facilitating and navigating these discussions will help inform therapists adopting such an approach. It may also help inform researchers and practitioners to incorporate such a focus into training programmes.

Research Aims

The *aim of the present study was to explore therapists' stories of engaging in conversations in therapy which contextualise trauma within sociopolitical factors with survivors of IPV.* Using a thematic narrative inquiry methodology described in the subsequent chapter, participants shared stories of conversations with survivors of violence about the historical, political, cultural, and gender factors related to trauma. This exploration included *exploring what learning, tools and skills therapists use in holding these conversations, what outcomes they feel survivors experience from these sociopolitically contextualised discussions, and the complexities of holding them.*

Chapter Four - Methodology

This chapter outlines the knowledge assumptions behind this study, research design and the methods used for data collection. The chapter also discusses reflexivity, ethics and data analysis processes.

Social Constructionism

Social constructionism, and broader poststructural ideas around power and knowledge, informed my project, because it was appropriate to the project and its aims, one that centres history and context. Originally described as a term by sociologists Peter L. Berger and Thomas Luckman in 1966, social constructionism has developed into a broad multi-disciplinary movement (Berger & Luckmann, 1991). Linked in origin with postmodernism, it has its roots in the resistance to positivist and essentialist claims to knowledge and an objective reality which can be observed and described (Gergen & Davis, 1985).

Modernism is a relatively broad range of ideas which gained prominence in the Enlightenment, or the 'scientific revolution' (Sarup, 1993). At this time, people began to develop the view that the universe, world and everything in it function according to underlying laws or structures, which can be observed and discovered using scientific methods. As a result, scientific methods were developed which aimed to discover these laws and structures as reliably as possible. Along with these beliefs came other ideas which became deeply influential in Western thought, including the inevitability of progress through the ongoing discovery of 'truths' (Gergen & Davis, 1985). Positivism is a more specific term which refers to an approach to knowledge which asserts that there are 'facts' which can be discovered using scientific standardised procedures, and that this is how knowledge is accumulated (Berger & Luckmann, 1991). A positivist approach to research focuses on eliminating bias and values that may contaminate the research process and, therefore, reduce the chances of finding the 'truth' or 'facts'.

Poststructuralist theories, which were first articulated and developed in the 1960s by a range of mostly French philosophers and theorists, critiques modernist claims to absolute truths (Williams, 2005). Instead, they asserted that any claims to knowledge are context-bound. Poststructuralists are sceptical

about any theory or knowledge claims which are said to be objective, and instead argue for exploration of the many different positions to knowledge and 'reality' which occur according to different perspectives and positions to power (Williams, 2005). It should be noted here that social constructionism and poststructuralism are closely linked, and while there are different arguments about how these theories are linked or differ, I take the position in this thesis, as has been argued elsewhere (Drewery & Monk, 1994), that social constructionism is grounded within the varied range of poststructuralist approaches.

According to social constructionism, the process of knowledge creation is inherently contextual and cannot be disconnected from its social, cultural and historical links (Burr, 2015). Instead of seeing knowledge as something 'out there' to be discovered, social constructionism sees knowledge as shared, negotiated and contested through relationships and social interaction (Schwandt, 2003). As social species, we create knowledge and what is deemed 'truth' through social exchanges. Social constructionism does not ignore or dismiss observable or biological differences and realities, but its emphasis is on the meanings that we assign to these things through our social worlds. Scholars using social constructionist approaches are interested in the categories people in societies create, how they are made through language and interaction, and, importantly, who these categories serve. In this sense, social constructionism is inextricably linked to exploration of use of power, in that it is generally power within social society and interactions which determines whose constructions of knowledge are accepted (Burr, 2015).

Power, Knowledge and Discourse

I was influenced in my project by Foucauldian ideas around language and power, and how power and what is deemed knowledge is perpetuated in through everyday relationships. Poststructuralist approaches share an approach to knowledge which argues that what is considered truth is political (Burr, 2015). Involved in this process are the production and propagation of powerful 'discourses' which shape our view of the world. According to Michel Foucault, discourses are ways in which people make sense of the world and shape the ways we act in the world (Foucault, 1977). Discourses are "systems of thoughts composed of ideas, attitudes, courses of action, beliefs, and practices that systematically construct the subjects and the worlds of which they speak" (Lessa, 2006, p. 285). Foucault argued that dominant

discourses, those created and serving powerful groups according to socio-historic location, become so powerful and enmeshed within us that they are thought of as 'natural' or beyond critique (Foucault, 1989).

Foucault also argued for a change in the way we understand the use of power and knowledge production from that of sovereign power to that of governmentality. Whereas punishment was once used by sovereign powers to dominate citizens actively, Foucault argues that a shift has taken place and that power and control are maintained through a form of self-monitoring and self-policing (Foucault, 1977). As the nature of government and societal power shifted to one where people could be monitored more thoroughly, dominant discourses, which include social and behavioural norms, are not just absorbed by those in society, but are maintained and spread by those in society. Here, Foucault referred to the idea that power is everywhere, that it circulates amongst society and that the population are not simply a target but also "elements of its articulation" (Foucault, 1977, p. 98). People discipline themselves and others in order to align with dominant discourses and avoid the negative consequences of resisting or countering them. In other words, power and knowledge are not just created by those who hold the most structural power, but what is seen as 'true' or moral is perpetuated in our everyday conversations and relationships. Discourse is never inherently negative or positive but, rather, is tied to context. They are relational in that they are created and reinforced through interactions, and their effects depend on who they serve. I believe this view of power aligns with this project, in that I take the view that in therapeutic conversations, dominant discourses may be perpetuated or subverted, and in doing so, these small acts of conversation contribute to wider power structures in society or may challenge them.

Social Constructionism and This Study

As a novice researcher delving into the world of academic language and epistemological positions, I had earlier been wary of social constructionism due to a frustration with what I had seen as a view of knowledge that could lead to inaction and inertia. I am not alone in such criticisms. Some scholars have suggested that social constructionism is less likely to contribute to meaningful change because it lacks anything against which to judge its findings (Bury, 1986). If all accounts of knowledge

are legitimate, how can social constructionism provide any meaningful contribution to social change? How can it 'get off the fence' and take a position when it comes to inequity and marginalisation if everything is socially constructed, including social constructionism itself?

Such arguments have been refuted by researchers taking a social constructionist approach, who suggest that presenting findings as one of many discourses, and not relying on any claims to objectivity, encourages a debate with the research, which can, in fact, be more compatible with genuine social change than positivist-based findings (Burningham & Cooper, 1999). Contrary to some misconceptions, social constructionism does not dismiss the possible existence of an objective reality or biological influences on reality, as it is ultimately a theory of knowledge rather than ontological theory. However, it suggests that any such objective reality cannot be simply observed and described to create knowledge, because what we perceive as knowledge is a product of our own unique perception of the world and our social interactions. Any *meaning* we assign to realities is a process of social and cultural practices. In other words, the world cannot be known independently of our experience of it (Schwandt, 2003).

Social constructionism is often political in its approach. It is well suited amongst Western academic traditions of knowledge to attend to the power dynamics and claims to superiority which shape the oppressions to which this project speaks. Social constructionist scholars argue against essentialist claims to knowledge and reality, which have been used, both transparently and in invisibilised ways, in the claims of superiority which lie at the root of oppressions and the degradation of people based on their identities and social location (Gergen & Davis, 1985) Social constructionism is one way of viewing knowledge that can help us unpack commonly accepted truths to reveal the social practices that create them and, therefore, explore how power and who holds dominance impact what we see as truth.

Social constructionism informed my views on defining the terms of this project. In describing what interpersonal violence means, universal definitions that contain all people's experiences do not exist (Muehlenhard & Kimes, 1999). Relying on legal definitions around violence would involve marginalising other, equally valid, views and experiences. The construction of trauma is contested and linked with power and psychiatric claims to knowledge. Rather than choosing a definition of trauma, I have explored

different ways of knowing and understanding the term. This social constructionist approach advocates holding ambiguity, uncertainty and multiple views, rather than fixed ideas or ways of doing this (Freedman & Combs, 1996). As will be explored, these ideas arise multiple times in my discussion of narratives by participants.

Therapeutic approaches based on modernist ideas, which continue to be influential, focus on a search for the 'inner self' or deep structures, which are the 'real' person or fixed identity (Drewery & Monk, 1994). A modernist therapeutic approach is in line with psychiatric discourses, which assert that within an individual, certain disorders must be 'found' or revealed. Social constructionist approaches demand an exploration of how our identities, problems, and qualities have been shaped within context and how our understanding of our identities and lives are 'constantly created in relationship with others, with institutions and with broader relations of power' (Thomas, 2002, p. 87). The therapy room is not a neutral or objective space; within it, there lie layers of power and negotiations of knowledge, not only between therapist and client but with broader social structures and ideas of 'truths' (Drewery & Monk, 1994). This approach informs my view of the therapeutic process and the research question, which seeks to hear the stories of therapists who explore this political context in their work.

Narrative Inquiry

Narrative inquiry is ideally suited to a social constructionist epistemological view, and to my critical positioning, which centres an exploration of power. Narrative inquiry is in the same sense suited to social justice research and aligned with social action and movements, with Riessman (2008) highlighting that "personal narratives can also encourage others to act; speaking out invites political mobilization and change as evidenced by the ways stories invariably circulate in sites where social movements are forming" (p. 8).

What is Narrative?

Within the broad range of qualitative research approaches available, narrative inserts itself by offering up the opportunity to explore narrative as the process and form through which humans make

sense of the world (Murray, 2021). Narratives combine the past, present and future to form meaning, contextualised by social and cultural influences. Narrative research explores what narratives are used to make meaning, how they are formed within context and how they shape our identities.

Chase (2011) defines narrative as making meaning through shaping and ordering of actions and experiences, and "a way of understanding one's own or others' actions, of organising events ... or connecting and seeing the consequences of actions and events over time" (p. 421). Reissman (2008) describes narrative as a way of knowing and of articulating that knowing. Through this process of articulating, narratives give us a window through which we can view someone's meaning-making process (Schiff, 2012). Stories or storytelling and narrative are sometimes used interchangeably within literature even amongst literature concerning the narrative methodology (Reissman, 2008). In this research, I take the position that narrative goes beyond the ordering of events involved in a story, to a larger meaning-making construction which influences experience and identity and perceptions of reality (Riessman, 2008).

Narratives are informed by and constructed with the influences of culture, history, and audience. The life experiences which are described through narrative occur within the context of specific social norms and other cultural influences and are, in turn, understood and then told about through the lenses of these influences. An audience may be a listener, a reader or some other intended recipient of narrative, and may indeed greatly influence the narrative itself (Murray, 2000). Considering the audience's effect, narrative can be understood as a performance that has its own motives and influences and is designed to fall within or resist certain dominant narratives that it coincides with and speaks to. Such an understanding of narrative as performance aligns with feminist-discursive theory around performativity as the process through which identity categories such as gender are maintained and created, and enacted through the body (Morison & Macleod, 2013).

Social Action and Dominant/Counter Narratives

An influential concept within narrative inquiry is that of dominant and counter narratives. Narrative has been called a form of social action in that it can both perpetuate and resist dominant or

oppressive discourses which order the social world (Chase, 2011). It is through the concept of dominant and counter narratives that we may insert a politicised contextualisation to narrative and explore its actions within the social world. Importantly, dominant narratives are not always negative. However, the dominant narratives available to marginalised people, or those with less social power, often limit the positions and identities available to them (Andrews, 2004). Dominant narratives are defined by people whose interests may be in part linked with limiting the power of narratives which oppose them, or in the ability to create oppositional narratives (Rappaport, 1995).

Narrative is an identity-forming process and, likewise, an identity-maintaining and contesting process (Riessman, 2008). Ways of being in the world and stories about what is ok and normal and what is abnormal are formed and resisted by people in society and negotiated via dominant and alternative discourses. Accordingly, our identities themselves are narratives, constantly being renegotiated and evolving through narrative telling and re-telling, changing with context, audience and through the integration of new narratives (Andrews & Bamberg, 2004). In this sense, our identity itself can be a dominant or counter narrative, or complex combinations of both, as we negotiate the ways our identity opposes dominant societal stories. Dominant narratives are those which it is almost impossible to not internalise in some sense as we navigate the social world, and thereby negotiate ways in which our own identities and experiences oppose or align with them. This is not to say that counter narratives only exist in opposition to dominant narratives, but that they come to exist in relation to them and may shift and change in their resistance to erasure by dominant narratives (Andrews & Bamberg, 2004).

Narrative, Trauma and Therapy

Narrative inquiry is aligned with social constructionism in that it aims not to settle upon the 'truth' of a narrator's account, but rather to explore the narratives and storying processes of participants in the construction of their lives and identities (Reissman, 2008). It allows for participants' complex range of positions to be explored. This is well suited to this study's focus on trauma and how it is understood, and how sociopolitical factors are (or are not) included within narratives around it.

The importance of narrative sense-making following a crisis or trauma has been well documented within mental health research. Trauma researchers have highlighted the ways in which trauma, including IPV, can disrupt a person's ability to make meaning through narrative (Wigren, 1994). Trauma may cause people to have such a profound break in their own life story and meaning that they lose the ability to perceive themselves and their lives (van de Ven, 2020). In fact, one might argue that this is one way of defining trauma, as experiences which tear apart our sense-making and ability to narrate our lives. Trauma can change the very foundations of the narratives we hold and the identities which are shaped by them, making a re-storying process important after trauma. Because of this, narrative making processes are included in many trauma-based therapies, such as narrative therapy (Denborough, 2006), emotion-focused therapy (Paivio & Angus, 2017) and trauma-focused CBT (Cohen et al., 2011). Researchers also suggest that a person's ability to make meaning from negative life events is linked to levels of well-being and ability to adjust to changes (McAdams et al., 2001, 2006; McAdams & McLean, 2013). This meaning-making, within a narrative lens, involves the construction of narratives.

As well as this link between a traumatic experience and narrative meaning-making, trauma itself is the subject of contested narratives. As has been explored, narratives based in neurobiology, feminism or social justice to name a few, all provide alternative narratives around trauma.

Why Thematic Narrative Inquiry For This Project?

My research aims to explore the stories of therapists who hold conversations about sociopolitical context such as experiences of discrimination and oppression with clients, and importantly, the context of these stories. In focusing on therapists' stories, contextualising their experience becomes possible. In exploring the temporality of the story, the other characters and the plot, I can also attend to how they came to do this work, how those conversations came about, how they played out, and their sense-making of them both during and afterward.

This study focuses on therapists' stories of conversations, rather than the client's experience of trauma. However, the importance of narrative within these conversations, and therapists' stories about them, is evident. These conversations may be considered part of the narrative construction process,

whereby sense-making about the trauma occurs. The therapist's role in these conversations may be as co-constructor of narrative alongside the client, and the therapist can hold significant power within the storying process and have control over when and how politicised factors of trauma feature within the therapeutic, narrative construction process.

The focus in narrative inquiry is on treating entire narratives as data segments (Chase, 2011). This is appropriate to my focus and was a key reason for my decision to use this methodology. The history/background and identity of the therapist were tied in throughout the stories of how, why, and when they engage in these conversations with clients, and inextricably linked to the stories of the conversations themselves. It made sense to view their whole interviews as an individual dataset and try to keep narratives within them as intact as possible (while allowing for themes that emerge across participants). Further, I wanted to allow for the complexity of the therapist's positionality to be included in interpretation and understood. As therapists who are concerned with social justice, I expected participants not to have binary narratives that either reinforce or counter dominant medicalised trauma discourses, but, like other research has revealed (Peters, 2019; Tseris, 2019), a complex positioning which involves the use and negotiation of varied narratives.

This study employed what Riessman (2008) describes as a thematic narrative approach, where the content of what is said is the focus, as opposed to the structural form of the narrative. This is not to suggest that the social, political, historical and cultural context of the narrative is ignored in this approach. Rather, as opposed to structural approaches to narrative where the *organisation of the narrative* is a key focus, thematic narrative analysis focuses on *what the narrative says*.

A central element of narrative inquiry which separates it from other methodologies, including other thematic analyses, is the importance of keeping narratives intact as segments of data (Riessman, 2008). Whereas other types of analysis may break a narrative into small sections, sentences and codes, narrative analysts treat narratives as a whole unit for analysis. Maintaining narrative features within analysis is a hallmark of narrative analysis. It is done to preserve the narrator's voice as much as possible, and to keep as much narrative contextualising information as possible. Due to this, larger segments of

participants' speech have been used at times as examples when describing narrative themes than may be traditionally seen in thematic analysis. While Reissman's approach was influential in analysis, influences from other narrative approaches were also pragmatically applied. In particular, what Murray (2001) described as the four levels of narrative processes were of interest to this study: personal, interpersonal, positional and societal.

Personal levels of narrative are concerned with the narratives as constructed by the narrator within their own lived experience, whereas the interpersonal level takes into account the performative and co-constructed nature of narrative (Murray, 2021). It includes consideration of who the 'other' of the narrative is and its audience, either real or imagined. Interpersonal narrative features function at the level of a discursive exchange which may affirm aspects of the narrator's identity. Questions asked at this level include how the audience impacts the telling of the story.

Issues of power and social position are of particular importance at the positional level. A narrative may be heavily influenced by the power differential between narrator and interviewer in the research process, and by power differentials between the narrator and others in their narratives. The same co-constructed narrative may have very different implications in relation to dominant and counter narratives depending on the power differences of those involved in creating it. Finally, the societal level of analysis considers sociopolitical context in relation to the narrative. It is at this level that the narrator engages with dominant and counternarratives. As previously explained, identity is constructed within the context of these cultural narratives, or in opposition to them.

Methods

The following section details my method of research and analysis, which was informed by the methodology described above. Trustworthiness is important in any research study and involves a researcher making the steps and decision making involved clear to any reader (Williams & Morrow, 2009). In this section, my aim is to give a transparent account of my research design and process so that readers can scrutinise trustworthiness and quality. Given the influences of liberation psychology,

intersectionality and social constructionism, my research process has been one with intentional reflexivity about my own role throughout. Given this, I begin with explaining my position in regards to reflexivity, while including my own reflections on the process throughout the chapter.

Reflexivity

Researchers who use qualitative methodologies acknowledge the subjective nature of the research process and therefore see researcher influence as inevitable (Braun & Clarke, 2013). Within a social constructionist standpoint, acknowledging the influence of the researcher on the research process and the interpretation and production of findings allows for a reflective stance on this influence and an examination of the role of the researcher in knowledge production. Researcher reflexivity is the process by which this influence is examined and critiqued.

Within social constructionist qualitative research, the reflexivity process demands not merely a reflection upon researcher methodological and process decisions, but a continual critical reflexive process which examines my subjectivity in relation to my research and my interpretations. Within narrative inquiry, reflexivity is also crucial in that it can examine my role as audience to participant narratives and how this may contribute to co-constructing the narrative (Elliot, 2005). Further, researchers have argued that beyond reflecting on my own identity in relation the research and findings, maintaining a critical approach to research and reflexivity requires ongoing examination of the power dynamics occurring within the process and the multiple perspectives which are present and missing (Ackerly & True, 2019; Fook, 1999). Consistent with this approach, I have not limited my reflections on my own responses to and influences on the research process to this section but have instead attempted to include these throughout my description of my methods, including the analysis process.

It was important to me to include reflexivity on my own background and identity at the beginning of this thesis to visibilise my own role in the creation of this work and the knowledge making process. Throughout the research process, I kept reflexive notes where I recorded ideas, links between aspects of research, developing themes across literature and thoughts on how my own background and context may be influencing the research. I found Fraser's (2004) questions for reflexive narrative inquiry research to

be particularly helpful and returned to these throughout the process. Questions I reflected on during the interview and analysis phase include 'How are emotions experienced during and after the interview?' and 'How curious do you feel when you listen to the narrators?' and 'Have you clearly distinguished participants' accounts from your own? Or are their accounts becoming too subsumed by your analyses?' (Fraser, 2004).

Participant Criteria

Criteria for recruitment was first of all that participants were therapists who are registered with the appropriate professional body and work with clients who have experienced interpersonal violence trauma. For the purposes of this study, 'registered therapists' included those registered as psychologists, counsellors, or psychotherapists. While it is acknowledged that other professions work in therapeutic ways and that this criteria is somewhat limiting, it was important to me to limit the scope of participants to those who work within certain similar professional structures and processes and to have clear boundaries around participant criteria. While these three professions cover a broad range of theoretical backgrounds and trainings both between and within each profession, all are broadly recognised professions which offer therapeutic mental health support to people who have experienced trauma. They also have professional bodies with ethical and training requirements that must be adhered to. While I considered limiting participants to only psychologists, I decided in consultation with my supervisors and therapists in other fields, that broadening my criteria to other therapists would enable me to have a broader diversity of participants and possibilities for recruitment.

A further criterion was that participants had held conversations with clients who have experienced interpersonal violence in therapy about the sociopolitical factors involved with their trauma, including but not limited to gender, cultural, historical and other factors relating to marginalisation and oppression. In making this another criterion for recruitment, I ensured that participants do, in fact, hold these conversations as part of their practice. In describing the background of the study to participants as part of the recruitment process, I expected that participants would be therapists who find this element of their work particularly important, and therefore who have an interest in social justice. This was indeed the

case. In varying ways, all participants described a commitment to honouring sociopolitical context in therapy. They also described an approach which aligned, to varying extents, with elements of social justice.

Recruitment

I followed various avenues to recruit participants for my study. These included:

- Emailing therapists I know and asking them to share the study advertisement with people they think may be appropriate.
- Emailing interpersonal violence service agencies, such as (but not limited to) Rape Crisis and Women's Refuge.
- Emailing the New Zealand Psychological Society, New Zealand College of Clinical Psychologists, New Zealand Association of Psychotherapists, and New Zealand Association of Counsellors.
- Emailing Māori branches of these organisations.

I shared a short study flyer in this initial email with basic information and contact info, asking people to contact me if they would like to be involved (see Appendix A). I also shared the study flyer in various online groups, including my own social media pages and student psychology groups. To those who contacted me with interest in participating, I sent a more detailed information sheet with some background on the study (See Appendix B). I offered to answer any questions they may have and/or have a phone or zoom conversation prior to our interview to go over any questions and share any further information, and for participants to get to know me and the background of the study if they would like to, to decide if they wish to participate. While some participants had some email questions, no participants requested this initial phone call or online meeting.

If the person felt at this point that they were happy to go ahead, I sent them a consent form (see Appendix C) along with a request for some demographic information: Name, age, professional title, gender identity, ethnic identity and location. Though these are of course not an exhaustive list of identities, I hoped to at least include a diversity of respondents within these demographics, within the

limited participant scope of the study. I explained to participants that collecting this information was to monitor what diversity of participants I am including in my study to attempt to include a wide range of people from different backgrounds. I again checked in on the day of the interview that participants understood the consent form and were willing to participate.

Participants

It is common in qualitative research to include a small number of participants (Crouch & McKenzie, 2006). Researchers do not seek a sample that can be claimed to be representative of the population. Instead, a smaller number of participants allows for an in-depth exploration of specific phenomena or experiences and more nuanced and careful analysis within and across narratives (Crouch & McKenzie, 2006). Outcomes and answers to questions are acknowledged as never representing a full scope of possibilities but rather seek to provide rich analysis based on the unique life experiences included (Braun & and Clarke, 2006; Crouch & McKenzie, 2006).

A total of ten participants were interviewed for this study. This number arrived at involved discussion as a research team (student researcher and supervisors) and a decision was made that this number was appropriate for the social constructionist background and scope of the study.This decision was made after most interviews had been conducted and we could assess the richness and depth of stories and discussion. Respondents were all therapists, and most had many years of experience. Five were Clinical Psychologists, three were Counsellors and two were Psychotherapists. A majority of interest received in the study was from Clinical Psychologists, which is perhaps not surprising given my own place in these networks. Notably, only Psychologists of the clinical scope responded to the study. Participants worked in or had worked in a number of different types of organisations and workplaces, including private practice, sexual violence services, domestic violence services, organisations working with those who have used harmful sexual behaviour, ACC sensitive claims providers and the public health system. All described having worked with survivors of sexual and intimate partner violence and having held conversations often, which contextualised this trauma within sociopolitical. Due to the importance of confidentiality for both participants and those they work with, a detailed individual

description of these backgrounds is not provided; however, an overview of demographic details of participants is provided in Table 1.

Table 1

Participant demographics.

Pseudonym	Profession	Gender	Ethnicity	Age	Location
Alex	Counsellor	Man	English	61-70	Christchurch
Halima	Counsellor	Woman	Asian Pasifika/Pākehā	61-70	Christchurch
Kate	Clinical Psychologist	Woman	Scottish	51-60	Tauranga
Lisa	Clinical Psychologist	Woman	Pākehā	51-60	Wellington
Maya	Counsellor	Woman	Malay Indian	31-40	Wellington
Monika	Psychotherapist	Woman	Pākehā	41-50	Wellington
Priya	Psychotherapist	Woman	Indian	51-60	Christchurch
Rachel	Clinical Psychologist	Cis Woman	Pākehā	41-50	Wellington
Susan	Clinical Psychologist	Woman	NZ European	51-60	Auckland
Tobias	Clinical Psychologist	Man	NZ European	31-40	Wellington

I recorded both gender identity and ethnicity as described by participants, rather than asking participants to choose from a list of options. Two participants identified as male, seven female, and one identified as a cis woman. No respondents identified as holding trans or nonbinary genders. The locations of participants were primarily main centers of Aotearoa (Wellington, Auckland or Christchurch), with one participant living in Tauranga. Ages are provided here within decade ranges in order to help ensure anonymity. Of note is that age ranges were primarily older, with no participants between 21-30, two between 31-40, two between 41-50, four between 51-60 and two between 61-70.

One participant identified as of Indian ethnicity, one as Malay Indian, and another as Asian-Pasifika/Pākehā. The remaining participants were of European ancestry. Two European heritage

participants were born outside of New Zealand (English and Scottish), while the remainder identified as Pākehā or New Zealand Europeans who were born in New Zealand with European ancestry. Despite consultation with Māori therapists and activists known to me, a culturally focused Māori supervisor in my research team and some purposive recruitment through networks of known colleagues/acquaintances and Māori branches of organisations, or kaupapa Māori service provider organisations, no Māori therapists responded to the study. Given the location of the study within a colonised Aotearoa, it was important to me to reflect on why this occurred. While there are many possible reasons this occurred, I believe given the nature of the topic and my own identity as a Pākehā researcher, it is likely that potential Māori respondents may have understandably felt less safe in sharing such privileged and sensitive stories of discussing sociopolitical context of trauma with a Pākehā primary researcher. Despite efforts to reflect on my own cultural positioning, my own Pākehā experience and worldview will always play a role in hearing, interpreting and analysing these stories.

Narrative Interview Process

I initially intended to conduct interviews in person with online interviews planned as a backup or where COVID-19 restrictions or budget constraints dictated them necessary. I planned to make this possible by scheduling interviews in the same location at a similar time, so I could conduct multiple interviews in one trip to these locations. However, the majority of participants requested that their interview be online via zoom. Only two interviews, in Christchurch, were held in person. Upon reflection, I believe the timing of these interviews in early 2022 played a significant role in this. At this time, COVID was still front and centre in people's minds. Work and meetings were still taking place online much more frequently, and concerns about unnecessary contact were more prominent. There are also positive factors involved in conducting interviews online, including allowing for a broader geographical and diverse range of participants, and for some a more relaxed discussion due to being in a familiar space (Segal, 2024).

Despite the majority of interviews being online, a good rapport and natural flow of conversations were quickly developed in almost all interviews. I did feel that one online interview had a more formal

feel, with the respondent giving shorter answers and more prompts being given to encourage conversations, but whether this was due to the online nature of the interview is difficult to ascertain. I found it interesting to reflect that when remembering interviews, I remember the cadence and faces of participants whom I met online just as readily as those I met in person. Interviews took between approximately 60-90 minutes. Participants were offered a $40 supermarket voucher as a show of appreciation for their participation in an email follow-up after the interview. I posted these to six participants. Four participants either did not reply with their address or requested that the voucher be given to charity. These vouchers were given to a local Women's Refuge.

While some narrative research is biographical and features life stories, a common approach within the narrative tradition is also to focus on experiences, as is the case in this study and its focus on conversations in therapy that contextualise trauma in relation to sociopolitical factors (Murray, 2000). When doing so, the narrative method advocates an approach which encourages participants to tell stories about these experiences and their reflections on these experiences, their causes and consequences (Flick, 2018). A focus on experiences does not exclude gathering accounts of biography, within which the experiences may be situated (Murray, 2021). Context and relationships have a direct influence on the construction of narrative (Squire, 2020). Consistent with a narrative approach, interviews focused on the participants' narratives and these were given priority over being heavily directive of the flow of conversation (Riessman, 2008). Additionally, I was cognisant that for the participant to reveal and tell the narratives which are the most important to them, they must feel that their stories are deeply valued (Hydén, 2014).

To foster an environment in the interview where participants feel as relaxed as possible and able to be open and genuine, I focused on some rapport building at the beginning of the interview before recording began. I shared some information about my background and my relationship to the topic and reminded participants about the research aims. I checked in with participants about any questions and revisited the topics of informed consent and confidentiality. Interviews were still semi-structured in that I had some prepared questions which I relied on when the narratives provided seemed to come to a natural

finish. Participants were given an interview guide in advance of their interview, offering a broad overview of what I would ask about to allow time for consideration before the interview (see Appendix D). I generally opened with a broad question of '*Can you tell me a bit about what led you to start engaging in conversations about the sociopolitical context of trauma with service users, and/or what led to you considering them helpful/an important part of therapy?*'. This enabled participants to guide what narratives they feel are most important about the topic.

I attempted to interrupt as little as possible, using non-verbal encouragements to display active listening (Wengraf, 2001). I waited until what seemed to be the end of this initial narrative response before asking follow-up questions where I may direct participants back to elements of their initial response. Other initial broader narrative questions included '*Can you tell me some stories about times you have had conversations with clients which contextualise their trauma within broader systemic factors, like discrimination and oppression? Are there any conversations that stand out?'*

Where possible, I allowed the participants' narrative to indicate areas relevant to the research aims and important to participants and allowed these narratives to direct follow-up questions. If these were not already covered, I also used other questions that helped guide conversations towards reflections and narratives relevant to the research aims. This included asking about tools they use, outcomes they have seen for clients from these conversations, barriers to holding them effectively, and what learning and life experiences have influenced the conversations.

Despite prioristing the participants narratives, narrative accounts are always a co-construction between narrator and the interviewer/researcher. Considering this, there must be ongoing by the researcher about who they are and how that may be shaping narratives (Squire, 2012). An example of how I was involved in this co-construction included how I adjusted some questions as time went on based on interview responses. Some interesting issues were raised in interviews, which led me to at times prompt participants with questions about these, if they had not been covered already. For example, when discussing their background and how this impacts interviews, some participants in early interviews explored how their practice is impacted by sharing an identity with a client (or not). In some later

interviews, when discussing background, I used follow-up prompts to explore this issue. It was my own interpretation of an interview, and an issue I felt was of interest to the research aims, that led me to shape some later interview narratives towards certain areas and topics.

I checked in with participants a week after the interview via email and asked if anything else has come up which they feel they would like to add and I also asked if they had any additional reflections. Many participants shared that they enjoyed the process and found it useful to reflect on their therapeutic practice in this area. One person provided further information about her training experience which she wanted included in analysis which was added to her transcript.

Data Analysis Process

Transcription

Rissman (1993) describes five levels of representation through which analysis of narrative can take place. The third level, transcribing the experience, outlines how the transcription process involves important choices which can shape the way a narrative is represented and understood. Importantly, Riessman argues that at this stage, the power of the narrative shifts from the narrator to the listener. Because there is no one subjective representation of a narration in spoken language, transcription involves choices which should be approached with reflexivity.

Given my choice to approach analysis in a thematic narrative, I wanted to strike a balance in the transcription process between retaining important conversational and interactional features, thus acknowledging the co-constructed nature of narratives, and ensuring that the narratives were easy to understand and accessible to readers. Therefore, I used an intelligent verbatim transcription approach. This involves transcribing verbatim but omitting unnecessary features such as stutters, filler speech (Um, ah) and repeated words. While omitting these does not suggest that they carry no meaning, it allows a focus on the content of analysis as required in thematic analysis, rather than the phonological components, which are of focus in structural analysis. With consultation with the research team, I used a transcription programme for the first round of transcription (Otter.ai). This provided a rough draft,

however, I then did two rounds of detailed editing, ensuring accuracy and confidentiality, which also helped familiarise me with the interview content.

The names of participants and other people mentioned in interviews were changed or omitted during the transcription process to ensure anonymity, and pseudonyms were used to replace the names of participants. Other information which could be identifying, such as specific workplaces or training locations was removed due to the importance of confidentiality both for the participants and the survivors they work with. Brackets were used to indicate what has been removed, for example, (university) or (workplace). Asterisks were also used to describe important nonverbal behaviour such as *laughs* or *pauses*. Finally, ellipses were inserted where a small section of the interview was removed when presented in the study for brevity and succinctness in delivering the narratives.

Participants were all offered the chance to request a specific pseudonym. Three participants did this and other participants were allotted pseudonyms by me. After transcribing each interview, I sent the transcription to participants to allow them to check the transcription for anything they wanted omitted or amended. Two participants requested some minor edits, which involved removing some small sections which they felt could identify clients or themselves. One participant also added some information.

Narrative Analysis Process.

Consistent with a narrative inquiry approach, my analysis occurred throughout the interview process. To me, acknowledging this is part of a reflexive approach, where I recognise the impact my own interpretation and involvement in the interview process was shaping outcomes from the beginning. Acknowledging how my analysis of interviews began immediately also allowed for evolving findings to inform and improve future interviews and the quality of interviews and resulting data, as was described in the interview process. A non-linear and flexible approach to the analytical method is consistent with a qualitative approach, with Denzin and Lincoln (2003) arguing that because there is no one clear window into a person's life and that any perspective is contextual, "qualitative researchers deploy a wide range of interconnected interpretive methods" (p. 8). While influenced by some overview descriptions put forward in describing a thematic narrative approach (i.e., Riessman, 2008), I also allowed for responsiveness to

emerging themes and findings and participant needs. Allowing for flexibility within the analytical and data collection process is not inconsistent with a rigorous approach to research, and in fact, can improve transparency if such an approach is complemented with thorough records of a researcher's process (Stenbacka, 2001).

After interviews, the transcription process also involved initial familiarisation. I kept some reflective notes during this process. I refrained from any detailed notes, as I wanted to focus on familiarising myself with each interview and the narratives they contained, attempting to allow myself to truly listen to what was being said. As part of familiarisation, I then read each transcript several times. This approach allowed for a reading of data from multiple perspectives and an expansion of my depth of knowledge of the data. In this phase, I commented on the documents around my impressions of shared or summarised elements, levels of narrative, positionality and important features which spoke to research aims. It was at this stage that I also began identifying narrative segments, though, as was the case throughout my analysis process, this was nonlinear, and I revisited this at different stages.

Thematic narrative analysis calls for acknowledgement and attention to the way our influencing theories, positionality and research aims shape the narratives which are identified (Riessman, 2008). In identifying narratives, as a researcher it was my aim to engage in ongoing reflection on how I shaped an emergent narrative, including in ways I boundaried them from other narratives. Though I looked for thematic concepts and findings which were central to the participants' narratives and/or stood out across interviews, I tried to avoid decontextualising the narratives and narrative segments from their location within the broader conversation, acknowledging that meaning is often dependent on this location. I sometimes made notes about the context of narratives within the conversation which seemed particularly pertinent. While narratives of interest were identified based in part on the research questions and theoretical basis of the study, I remained open to alternative, unexpected or unique ideas which stood apart from dominant perspectives or offered oppositional or unique viewpoints. Though I did exclude some narratives for analysis based on them being outside the scope of the study, I did ask myself at varying points if there could be any other reason I would not include certain narratives, such as the

narratives containing differing viewpoints from my own. Often, I noticed that rather than being strictly oppositional, differing narratives across participants about an issue added depth and nuance to a theme. For example, narratives which at first seem to be sharing opposing practice positions were often, upon deeper reflection, sharing different approaches responding to different relational situations.

In identifying narratives, I used multiple strategies. I looked for narrative features of beginning, middle and end and, what Murray (2021) describes as, entrance and exit talk. I was surprised to find that a majority of narratives did follow the pattern Murray describes, with narratives often concluding with more reflective statements as part of the meaning-making involved in 'exit talk'. However, Riessman (2008) argues that not all narratives are necessarily distinguishable linguistically in such a linear fashion. Indeed, in acknowledging that stories and their construction are cultural and socially located, I wanted to remain open to other ways narratives may be organised. Riessman's (2008) description of narrative as revolving around either a setting, characters or a plotline, which may be organised by location, time, or topic, was also helpful in considering narratives within transcripts.

I then re-read the transcripts and open coded for descriptive and conceptual elements (Bazeley, 2009). I put spaces between identified narratives in these rounds of analysis of transcripts to indicate different narratives in the following stages of analysis. I didn't reduce the data at this point and returned to examining full transcripts after open coding. However, this process allowed for some initial exploration of the broad range of meanings, concepts and areas of interest in the interviews. This step involved having two columns alongside the transcript where I focused on identified narratives. One of these columns allowed for more 'content' focus reflections, for example. I summarised key words and phrases within the narratives to help identify commonalities across narratives and participant narratives. I also identified and summarised the most important aspects of the narratives as they spoke to the research aims or stood out across participants as important to them. In the second column, I made comments which involved a stepping back and a more interpretive stance, and this is where I began to explore the context, meaning making, positionality and implications of these narratives.

The next phase involved thematising narrative segments. I took narratives from transcripts and put them into different documents grouped by narrative themes that I saw emerging. These changed multiple times based on what I saw as better thematic groupings that spoke in improved ways to what the narratives contained. As I changed these thematic groups, I made new documents and re-organised these narrative segments into them. I have used several terms to describe the representativeness of participant views and narrative topics. Following Tseris (2015) I have used 'most' to describe a majority of participants (three quarters or more), 'many' or 'several' to describe half or more, 'some' to refer to less than half and 'a few' for three or less.

I used various reflective questions which could elicit different attitudes and perspectives in me through which to view data, as well as noting my own reactions to the data. These were used from the stage of open coding onwards but particularly in the stages of analysis involving thematic groupings of narratives. Riessman (2008) highlights the importance of analysing narratives asking 'Why was the story told in *that* way?' While the primary focus remains on content, such questions allowed for a deeper examination of the context and meaning-making processes involved in narratives. I was also interested in asking what subject positions are taken up by the participants within their narratives, asking what the stories accomplish (Tseris, 2015).

In conducting analysis, I also held Murray's (2000) previously described levels of analysis in mind, and at times used them as a prompt to allow for deeper analysis. I focused on the second two levels in order to examine how power operated in the narratives. Fraser (2004) poses a series of questions which were useful to analysis in examining the positional and societal levels of analysis, or what Fraser calls 'linking the personal with the political' (p.193). Examples of these questions include: What relationship do the stories have to particular discourses?', 'What do the stories say about the (multiple) lived experiences of class, gender, race, sexual orientation, age, dis/ability, religion and/or geographical locations?' and 'Are social structures – institutionalized or otherwise – present? If so, how do they appear and what is being said about them?'. Finally, I began writing out themes. Still, after this point, I changed

the theme grouping multiple times, collapsed or expanded them, and removed some aspects which I decided did not speak to the research aims.

The process of analysis was confusing at times. Narrative is a general approach without a strict framework for the stages of analysis. As someone undertaking this level of analysis for the first time, I felt a returning feeling of unease that I was not following a predetermined set of steps. However, I reminded myself that this uncertainty is natural. I believe that at times, allowing for a sense of uncertainty and not giving in to the desire to adhere to a strict framework allowed for more sitting with the data and deeper listening to narratives. I found it interesting as this process unfolded that narratives in interviews at times touched on the need for embracing uncertainty to be open to client needs and what is truly needed in the relational moment. I felt this mirrored a need to be open to data, to the narratives, to what appeared to be a next step which would allow for a good depth of analysis.

Another reason that this process was both fascinating and challenging was the interconnectedness and intersections which emerged in attempts to thematise narratives. The thematising process is one where the co-constructor role of myself as the researcher emerged very clearly. The ultimate themes represent one possible way in which the narratives could be organised, and I am very aware that there are countless others. My own interests, background, and priorities no doubt shaped the way these themes emerged and I reflected on this throughout. I was particularly struck with the intersections I saw emerging across themes. As I have discussed, it was a conscious decision to allow for reflections on discussions across the breadth of sociopolitical context of IPV trauma, rather than focus my study on only one issue. This made for a diversity of discussions but also allowed for a level of stepping-back and reflectiveness on the part of participants. I believe this enabled rich discussion about broader issues and approaches to politicised conversations in therapy. It also meant that there was interconnectedness across themes. Issues of power, non-neutrality, relationality and positioning, for example, emerge across themes. Attempting to avoid overlap and ignore or remove parts of narratives which contained connected issues to other themes would have involved de-contextualising the narratives of important information. Instead, I prioritised each theme having discreet and discernibly different emphases and focuses.

A final reflection on the analysis process and outcomes was the applicability of narratives beyond the scope of trauma-informed therapy and work with those who have experienced violence. Although this was a lens through which the study was conducted, many narratives of participants covered issues and stories which extend beyond these scopes to be applicable to therapy and mental health work generally. This is perhaps not surprising given my choices, which have already been discussed, to allow for discussions which cover a breadth of sociopolitical factors in therapy. The fact that discussions were not able to be categorised and discreetly located within only trauma or violence literature aligns with my own approach to this work, which sees these issues as interconnected and located within broader discussions of socially just therapy.

Ethical Considerations

This study was approved by the Massey University Human Ethics Committee: Southern B, application SOB 21/62.

In reflecting on ethical considerations and procedural needs involved with this study, I consulted many sources. *The Code of Ethics for Psychologists Working in Aotearoa/New Zealand* (Code of Ethics Review Group, 2012) sets out recommendations of practice, including those relevant for research, which demand that research and practice be of benefit to society and do not harm participants. Alongside this code, I also considered the ethical guidelines laid out in the Massey Ethical Code for Research with Human Participants (Massey University, 2017). While these are the cornerstone guides for ethical considerations, my critical approach to knowledge production and this study also involved considering wider social justice-related ethical considerations (Hailes et al., 2020). I considered confidentiality, informed consent, social justice and Te Tiriti o Waitangi considerations to be of the greatest importance for this study. After describing how confidentiality and informed consent were approached in this study, I will discuss my process of considering social justice ethics and Te Tiriti o Waitangi obligations.

Confidentiality and Anonymity. Confidentiality and anonymity are important in studies with human participants who share their stories (Massey University, 2017). This study also carried some areas

of particularly delicate consideration. Participants were therapists who talked about their professional practice and at times referred to employers or the practice of organisations or other professionals. Likewise, they shared stories that involved their interactions and conversations with clients who were not involved in this study and who also held less power in the dynamic of therapist/client. The stories therapists told involved clients who hold marginalised identities. Therefore, it was of utmost importance that the participant and any other people who may be discussed in the stories told are completely anonymous and not identifiable. I also ensured that clients would not be identifiable to me. This included avoiding asking any questions that could involve the participant sharing any identifying information about clients.

At the beginning of interviews, I raised the importance of client anonymity and asked, with respect and while noting that therapists likely do this regardless, that therapists consider their right to privacy and anonymity in sharing stories. I emphasised my gratitude for sharing stories from their personal and professional lives, and also asked that they try not to mention anything identifiable about others who may be in the stories they share. At the beginning of the interview, I also mentioned that they will have a chance to review the transcript and remove anything they would like to. I reminded them that they can request that parts be removed from their transcript when I send it to them. As already explained, to protect participants' anonymity and confidentiality, I asked them to choose a pseudonym for the study and explained what demographic information I would include in the study. I also explained that I would remove identifiable information from the transcript.

Interviews were recorded on a voice recorder, or video recorded when held online. I also recorded the interview on my password-protected phone as a backup if the primary technology failed. However, after reviewing the recording immediately following the interviews, this backup recording was deleted. I deleted the video of Zoom recordings and retained the audio only. Interview recordings were stored on a password-protected laptop and were only accessible to me (and research supervisors if necessary) and were destroyed once transcripts were completed and checked for accuracy.

Informed Consent. Throughout the study, I took the ethical approach that consent is an ongoing process that should be revisited. Informed consent should be practised through cultivating relational spaces where it is possible for genuine consent to be practiced (Hydén, 2014). This involves participants feeling comfortable in their decisions, fully informed and able to comfortably remove consent if desired. It is widely acknowledged that there is always a power differential between researcher and participant, which can have implications for informed consent (Fontes, 2004). In order to cultivate a relationally safe space and to ensure participants have all the information I offered to discuss the study over the phone prior to making any decisions about involvement after potential participants had read the information sheet. I answered questions openly about the critical and social justice stance of the research and provided interview overviews explaining general topics which may be covered in questions prior to the interview so that participants were able to reflect on the topics covered and give more opportunity to withdraw if they wanted to. I also involved participants in checking transcripts, reinforcing their right to withdraw at any time and encouraging an open line of communication after the interview is complete.

The power dynamic was somewhat complex within this study, where I interviewed registered therapists about their practice from the position of a doctoral student in clinical psychology. While having experience across a range of areas, including community and advocacy work, I was a student of clinical psychology and not yet registered, and therefore in this specific role arguably had less power. Upon reflection, I believe that this dynamic was helpful in helping the participants feel more comfortable sharing certain stories. At times, participants shared stories or criticisms about their training or the broader profession, and I observed participants pausing then appearing to make the decision to share criticisms despite reservations about doing so. It is possible they may have felt more trepidation about sharing such stories had I been someone well-known within the profession or with more social power and influence.

Participant Wellbeing. While it was not anticipated that the interviews would provoke significant distress for participants, the possibility that the interview might raise distressing topics for participants was still real and must be considered. Aside from discussing any upsetting stories, there also

existed the potential for participants to feel vulnerable due to discussing their work in detail or sharing stories where they feel they may not have made the best choice. There was also the possibility of being concerned that they would be assessed or judged based on their answers. To address these risks to well-being, I first told participants at the start of the interview that we could stop the interview at any point if they felt uncomfortable. As described, I also began with rapport building and gave participants a chance to become more comfortable before commencing the interview. Being comfortable with me was an essential part of ensuring that participants felt they could pause or end the interview if needed. No participants became visibly distressed or tearful during the interviews. I also checked in with participants at the end of the interview, and some days later, to check on how they found the interview and to enable them to raise any issues they experienced.

Social Justice Ethics

As social justice was paramount in the conceptualisation of my study, it was important to me to consider social justice principles in terms of ethical considerations. Despite other broader ethical codes including social justice as a key principle involved in psychological practice, these tend to be fairly non-specific. A framework of ethical guidelines for social justice in psychology which I found useful in informing my project, developed by Hailes et al. (2020), highlights three key domains, namely, interactional justice, distributive justice and procedural justice. Although not specific to research, these domains were useful in reflecting on social justice as it applies to research development and procedures. Though many elements of research have connections to each domain, below I highlight a few key considerations within each domain in relation to this study.

Interactional Justice. Interactional justice relates to power dynamics and the need to reflect critically on the power involved in psychological work and the relationships involved. It also mitigates power where these relationships may perpetuate unjust societal dynamics. This domain also echoes feminist ethical frameworks, which, while varied and diverse, involve "attentiveness to the power of epistemology, boundaries, relationships, and the situatedness of the researcher" (Ackerly & True, 2008, p. 694). In reflecting on this element of ethics, I believe reflexivity is of paramount concern. Power, and

where I have held it and where I have not, influences my decisions as a researcher, my epistemological influences, and my shaping of the boundaries and scope of research. An ongoing reflexive process, which has been described throughout the description of methods, was important to me in reflecting on how my own power as researcher shaped this research and my construction of knowledge.

While I do not consider my participants to be representing a marginalised group in this research, I still have considerable power over how their stories are chosen, analysed and expressed as outcomes. As part of my reflexive analysis process, it was important to consider my own positionality and what wider narratives were being perpetuated within my interpretations of narratives. In choosing narrative analysis, my aim was to enable interactional justice in various ways. Firstly, by holding narrative-influenced interviews, which focus on following areas of interest to the participant and prioritising open, broad questions, I hoped that the participants would be able to share stories that felt connected to their experience and feelings about the topic. In analysing narratives rather than smaller subsections of interviews, my aim was to enable the participants' own voices to be heard through the telling of this study, while acknowledging my own co-constructor role. Other reflexive considerations around power and role have been described throughout this chapter.

Hailes et al. (2020) also highlight that part of maintaining interactional justice is holding a focus on empowering and strengths-based practice. While this element may at first appear to be more applicable to practice, I believe it applies to my research choices. Primarily, it is my hope that the framing of this research within critical and social justice approaches, a critical approach to trauma which explores the harms of a individualising and pathologising approach, and the way this shaped research questions, contributes to knowledge construction which will ultimately assist in creating more empowering and strengths-based practice in practitioners as they work with those who have been marginalised and pathologised elsewhere in society.

Distributive Justice. Distributive justice relates to 'provision for all' (Halies et al., 2020, p. 5), or focusing on equitable services and outcomes. This translates to focusing time and resources on work and issues which are of importance to marginalised communities, who face multiple systemic barriers to

receiving quality and appropriate care. When applied to research, I believe this principle was foundational in my decisions around my research area. When deciding on a research topic, I wanted to focus on something which I felt would 1) bridge the gap between individual and collective healing and thereby focus on mental health practice which considers social justice, and 2) would help make me and others a better practitioner working with such an approach. These personal motivations influenced my decision to focus on trauma-informed practice with survivors of violence which discusses sociopolitical context. While only one element of a practice which is socially just, such practice is important and, as already explained, spoke to a gap in literature between theory and application to practice. This gap between theory and practice equates to less appropriate care, particularly for those who have experienced significant marginalisation. Therefore, I hope that my research contributes to distributive justice in being part of filling this literature gap.

My decision to focus on therapist stories was one which involved significant reflection. Why not just ask service users their stories about sociopolitical context in therapy? Distributive justice considers involving the marginalised in research as important in counterbalancing unequal power distribution within research and where it focuses. My decision came about for two primary reasons. One, I consider understanding practice, as understood by therapists, would allow me to use my own status as student psychologist to engage in research which translates the narratives of therapist practice into real-world outcomes. In other words, I felt my own role would enable me to communicate outcomes about practice as described by therapists into recommendations for meaningful changes, and language that could be understood across different spheres. Secondly, I believe it is our responsibility to hold each other accountable within communities with significant privilege (Reynolds & Hammoud-Beckett, 2017). This involves understanding how those who hold these positions of privilege understand their role and work, and how those who are working towards social justice came to do so. Therapists hold significant power within the therapeutic relationship, and I believe it is vital that those with social justice approaches seek to understand and translate the work of experienced social justice-informed practitioners into knowledge which may contribute to filling the gap between theory and practice regarding social justice. My hope is

that in communicating these stories, other therapists will be more inspired and upskilled to do so. It is important, however, that similar questions be asked of service users about these conversations in therapy as part of furthering knowledge in this area.

Procedural Justice. Procedural justice relates to how we, as psychologists, bring social justice work beyond the micro level and into efforts for wider systemic change (Hailes et al., 2020). It also speaks to how decisions are made at all levels of practice which may contribute to more just outcomes. One way in which procedural justice was applied to this study was in my efforts to consult with relevant knowledge holders at various stages. In the subsequent section, I explain how engaging in cultural consultation was conducted. Alongside this, in the early stages of the study, I consulted various therapists and people with lived experience of violence about the study and its scope and aims and design. These consultations were largely informal and held within my broader community of networks within service and activist organisations. These conversations helped shape what my research would become. Along the research journey, involving my participants in reviewing their transcripts and allowing them to delete sections was one way I felt a collaborative process could be achieved, along with allowing participants to define their own demographic information and have contact as an opportunity for feedback. I see such decisions as part of ongoing consultative work.

Finally, procedural justice will only be achieved in this study, as I see it, with efforts to communicate the research and its findings to wider audiences and into meaningful change. My intention is to share my research and surrounding knowledge at conferences and in articles and other educational possibilities which extend beyond the academic sphere and into mental health workplace, political, legislative and activist spheres. This is not always easy. Speaking up about, for example, the criticisms of training, which were included in some participant narratives as a student researcher, does not come without some level of trepidation. It is easy, I think, when entering a profession, to internalise desires to fit in, to align with the status quo in order to succeed. However, engaging in efforts for change and speaking truth to power is something I have engaged in in my work far pre-dating my entry into psychology. In sharing my research as widely as possible and by it informing my advocacy, my aim is to

not only honour the stories shared with me by participants, but to also be part of a long tradition of scholar activism, whereby knowledge is academic work is combined with social change efforts (Stephens & and Bagelman, 2023).

Cultural Considerations

This study is of direct relevance to Māori. As the indigenous people of Aotearoa who have faced and continue to face colonisation and dispossession alongside structural and direct discrimination and racism, Māori experience increased rates of trauma and mental health challenges and multiple barriers to accessing culturally appropriate mental health support (Government Inquiry into Mental Health and Addiction, 2018; Wirihana & Smith, 2019). This study explores conversations about oppression and marginalisation within therapy and of central importance within such discussions is the experience of Māori. While I did not direct the interviews with participants towards discussing conversations about any one particular experience of marginalisation or oppression (e.g., sexism, queerphobia, ableism, classism, racism), I expected discussion of racism and colonisation to occur, as it indeed did. Further, discussion of privilege in relation to Pākehā identity also featured in this study and contributes to the discussion about socially just practice and therapist experiences of privilege. Outcomes of this study include recommendations for having conversations with service users about sociopolitical factors of trauma, including sexual violence and interpersonal violence. This will be of relevance to mental health professionals working alongside marginalised populations, including Māori.

Along with the ethical codes already described, which include cultural considerations, Te Ara Tika (Hudson et al., 2010), which is a guideline of Māori research ethics, also informed the development of my study. It includes specific considerations based on four principles of Mana, Manākitanga, Whakapapa and Tika, which in turn relate to Te Tiriti o Waitangi principles. Early in the research development process, I sought advice and consulted various practitioners, including Māori therapists and also a Māori Clinical Psychologist, who would go on to join my research team. Multiple considerations were made around ensuring participation was possible for Māori participants which included using Te Reo, reaching out to Māori therapist networks and utilising personal networks, engaging in

whakawhanaungatanga, making efforts to meet kanohi ki te ohi (face to face) and allowing as much time as possible on building trust and rapport. Other plans were in place for interviews such as offering karakia (prayer) and beginning with pepeha.

As already noted, no Māori participants participated in the study, which has been explored above in the participants' section. However, this does not mean that considering cultural issues and my own Pākehā lens in analysis and interpretation was not critical. After analysis, I again consulted with my research team around the discussion of racism and white privilege included in results and discussion. It is also important to me that results, which include discussions around the importance of white therapists exploring privilege as part of their training for these conversations, is as widely disseminated as possible. The practices described in the discussion have a direct impact on the level of service and quality of therapy people receive, including Māori. I consider this part of my responsibilities as a Pākehā to educate and hold each other accountable when it comes to our side in the Te Tiriti relationship, rather than relying on Māori to do this work for us.

Layout of Results and Discussion

The aim of this study was to explore therapists' stories of engaging in therapeutic work which contextualises trauma within sociopolitical factors with survivors of sexual or interpersonal violence. Something which I found challenging in writing my discussion was that despite feeling that each theme was distinct, there were also commonalities across all themes, making it difficult at times to tease apart discussion points, which interconnect and overlap. It occurred to me that this echoes my research subject itself, and the emphasis on contextual practice, intersectionality and seeing all issues as connected. Although I attempted to keep narrative segments intact through analysis and to keep important context, I also acknowledge that the process of thematising itself is one of separating and fragmenting. In reviewing my analysis, I decided the five themes respectively fell into three separate, thematically linked sections, while still distinct enough to be five separate themes. Therefore, my results and discussion will be divided into three sections. Chapter five includes theme one and two, chapter six includes theme three and four

and finally, chapter seven includes theme five. This intertwining of results and discussion also aligns with the social constructionist underpinnings of this study, which asserts that an objective presentation of the data is not possible (Denzin & Lincoln, 2003). Chapter eight includes a summary, a reflective framework for discussing sociopolitical context in trauma-practice for practitioners, limitations and conclusion.

Chapter five is titled 'Contextualising Trauma and Holding All Context' and includes theme one 'Trauma is context (is resistance)', and theme two 'Becoming the big, safe container'. The first theme describes a broad position which participants described in their work, and why they considered inclusion of the sociopolitical as a vital element of their trauma-therapy practice. It also outlines how they felt this positioned them in resistance to mainstream narratives and, for clinical psychologists in particular, their own training. The second theme describes a capacity and skill that participants identified as necessary in order to engage in such an approach, and practice in a way that made exploring the sociopolitical possible. This section describes a broad lens and approach, and a key stance that is involved in this approach.

Chapter six is entitled 'Survivor Outcomes' and includes theme three, 'Working with shame and self-blame: Externalising the narratives and being with injustice', and theme four 'Building agency and resistance'. These two themes and the related discussion both focus on the outcomes clients experience from conversations about sociopolitical context. These outcomes included reducing or transforming shame and increasing agency and resistance. It explores how therapists navigate and facilitate the discussions which lead to these outcomes, and the tools of externalisation, validation and witnessing which are involved.

Chapter seven is entitled "Power Privilege and Therapist Reflexivity' and includes the final theme 'Therapist identity, power and sharing of self: Working with intersectionality, reflexivity and principled non-neutrality'. This final theme focuses on the therapist in the relational encounter of the sociopolitical discussion. It explores how therapists understand identity differences, self disclosure and power in these conversations and therapeutic relationships.

Chapter Five - Contextualising Trauma and Holding All Context

As described, this first section explores the first two themes and associated discussion. This first section outlines and unpacks how participants described their commitment to exploring all context in trauma therapy, the position of resistance involved in doing so, and the holding and safety capacity they need and have built, which enables them to do this. This section explores the broad approach taken to these conversations and a key capacity involved in that approach.

Theme One: Trauma is Context (Is Resistance)

This theme encapsulates a narrative that participants held about therapeutic work, which also informed their conversations about sociopolitical issues with clients. Participants' stories described an approach to therapy that sees the whole person in context. Being open to working with any experience (including experiences of marginalisation and oppression) was vital within this approach, which saw all layers of experience as interconnected.

Seeing the Whole Person Means Working with Any Layer

In the stories they shared, participants framed their work as an approach to trauma therapy where sociopolitical conversations are an inevitable part of the therapeutic process. These conversations sat in the broader context of trauma-based therapy, which included a willingness to see a person holistically and to go anywhere with and alongside a client. Some participants suggested that exploring sociopolitical context is especially crucial with survivors of sexual violence. This was in large part because of internalised victim blaming narratives around violence, where many clients positioned themselves as responsible for the violence inflicted on them, as well as the intergenerational aspect of many experiences of trauma. The failure of systems and organisations to respond appropriately to violence was also a part of the trauma that clients experienced. Unpacking the sociopolitical climate within which these systems sit was therefore positioned as inevitable within therapy when taking a trauma-informed approach. Given that people are always impacted by sociopolitical context, Kate suggested that “all roads lead to Rome. And so it doesn't really, really matter where you go from, you're going to end up there”.

Below, Lisa described her approach to including broader sociopolitical context in trauma therapy. She does so through sharing a story of a comment made at a trauma conference.

> Lisa: Absolutely, yeah. And I always remember, [therapist name redacted], who has been doing this work for as long as I've been doing, longer than I've been doing this work. And we were at a conference like…… And [the therapist], stood up at the end and said, something like, this is all, this is great, this is all really good. And we can't look at this sexual trauma in isolation. And for lots of my clients, and lots of your clients, there is also racism and the impact of colonization. And at some point, when people put their hands up, or notice, or want to be able to address that, too, we need to address that as well. And she was making the point that it's not just this and that, right, too… that people come to different parts of this at different times, and resolving one part of it can make it possible to then resolve another part of it…So they're all part of the person's experience. You know, they all need to be resolved. And, and they are all part of seeing that all this stuff happens, it isn't our fault.

Lisa discussed the argument made that therapists must be willing to address the complex layers of trauma that people experience because sexual violence does not occur as an isolated incident but is interwoven with other experiences of trauma or oppression and internalised narratives. Within Lisa's narrative the therapist is positioned as an active participant in this identifying, addressing, and resolving. In describing the therapist who stood up and spoke as having worked in the field longer than she has, she positioned them as an expert and their approach as one she agrees with. However, it is significant that the comment made at this conference was in response to the main conference content and therefore suggests it was not a core part of the main conference. The approach advocated in this quote was not the mainstream or dominant one at this trauma conference. Lisa was therefore positioning this approach as one which is a speaking back to, or at least an addition to the trauma narratives which were present, and which did not include the context of colonisation and racism.

Seeing the therapeutic encounter as an addressing and 'resolving' of layers or parts appeared in the narratives of multiple participants. Experiences of colonisation and racism, therefore, cannot be compartmentalised or entirely separated from an experience of sexual violence. The layers of a person's experience are interwoven and connected; picking one apart inevitably leads to others. To be unwilling to address any layer, then, may impede reaching the next important area of experience. This willingness to reach any layer was a foundational part of trauma therapy for Lisa, and many other participants.

Contextual Practice as Resistance

The contextualising approach described above was positioned by many in resistance to a medical diagnostic model, to Western dominance and to fragmenting or compartmentalising people's experiences. Lisa, a clinical psychologist, shared what was perhaps the most scathing critique of diagnosis amongst participants:

> Lisa: One of the gaps is that the clinical psychology world still insists on teaching people diagnosis, and diagnosis is just bullshit. And it's, it's completely useless. And why do we still do that? It wasn't even our game at the start. It's like, I'm going really off-piste here, but…so if we've focused on teaching people how to match up what someone is saying to this list of experiences of a human being that we know we, absolutely know, is rubbish…. We know there's nothing useful in that beyond an easy way for me to say to you, this is the general place that this person's distress shows up. It shows up in their eating, it shows up in them being stuck at home… Beyond that there is no… it's not useful whatsoever. I know then we say 'oh no we're psychologists, so we put in a formulation too', but the diagnosis is still there. And we should be formulating and conceptualizing what are the contextual experiences that have brought this person to this….We still perpetuate the myth that diagnosis are these actual categories and actually useful. And that just hides the effect of 'isms' and trauma on people, which is what all this is all about.

Lisa's tone in our conversation was one of unleashing a strongly held criticism that she may hold back in other spaces—a sense of offloading her deeply held concerns about dominant diagnostic models of practice. She illustrates the way that the profession attempts to include contextualising practice within a diagnostic model but suggests that this is not done effectively because they are inconsistent with each other. Instead, she insists that while diagnostic models are used, 'isms' (oppression, marginalisation, etc.) will continue to be hidden and silenced. She positions the diagnostic narrative as more powerful and dominant, but ultimately useless in its overall capacity to create positive change. Meanwhile, she positions contextualising trauma practice as being practically more useful for clients. Lisa also positions herself as part of this problem by using the term 'we' when discussing clinical psychology and its focus on diagnosis, while suggesting alternatives. Lisa went on to share why she feels the medical model is a barrier to implementing contextualising practice:

> So actually, yeah, okay, I will put a case to you that the other reason [that there are barriers to therapists implementing contextualising, socially just practice] is that we still rely on a medical model, we still buy into that ultimately being explanatory, and diagnosis being explanatory, and the medical model. And that results in people being medicalized, being medicined, and getting the message that there's something wrong with *you*, which that person already has, because of the experiences that they were alone with. Now, we give you a label that confirms there's something wrong with you.

Lisa framed her contextualising practice as opposing the location of deficit within the client. Diagnosis and the medical model can compound a sense of deficit that survivors may already feel as a result of experiencing abuse and/or violence (Burstow, 2003: Sutherland et al., 2016). Lisa goes on to suggest that diagnosis leaves 'no space' to effectively contextualise and remove blame and deficit from the individual.

> And there's no space to be like, fuck, look what happened to you. That was not your fault. There's nothing wrong with you. You've just done the best that you can to cope with the situation that you've been in.

Multiple participants shared the view that a diagnostic approach is a barrier to strengths-based practice, and to effectively exploring sociopolitical context.

Kate provides an example of how contextualising practice can enable a sense of brokenness and deficit to be located outside of the client.

> Kate: I just think, and I think that that's really useful to look at a person from their whole context. Because I think as Westerners, we have a tendency to think of diagnoses and the person is to blame, and they're, they're dysfunctional in some way. And my own view is actually no, people have really adapted to really extreme circumstances…People are not necessarily broken. There's broken systems, and there's broken things around them.

Kate positioned diagnosis as a Western dominant narrative and like Lisa, she located herself within this problematic narrative by using the term 'we'. Kate went on to explain how she emphasises a contextualising practice which normalises instead of pathologising distress.

Many saw contextualising practice and a diagnostic model as inconsistent with each other and incompatible. In this sense, trauma practice was inherently political. This sharing of criticisms of diagnosis and medicalisation was especially clear within the narratives of psychologists interviewed. This is not surprising, perhaps, given the emphasis on diagnosis within this field, and that it is within the scope of this profession that diagnoses are made. Those who do not orient towards such narratives may therefore choose or be forced to position themselves more strongly in resistance to them. In their commitment to contextualising practice and narratives, the therapists came into conflict with dominant individualised, diagnostic practices. This suggests that a commitment to exploring trauma contextually which includes wider systemic context may be a politicising stance, particularly within this field.

Training Lacking Sociopolitical Context and a Trauma Focus

For the psychologists interviewed, a trauma-informed and contextualised approach, which includes the sociopolitical, sat uncomfortably in contrast to their formal training. Most participants spoke of the focus on assessment, which came at the expense of gaining more therapeutic or trauma-informed skills.

> Susan: My training was incredibly poor, in terms of sociopolitical stuff. We did a lot around understanding assessments and almost nothing, almost nothing on therapy. And I remember just going, I have no idea- the only thing that we were encouraged to do was CBT. Which doesn't, you know, it's kind of a doesn't do, certainly not what I've been trained to do, that wasn't very, none of sort of, in the room stuff, you know, looking at, you know, at all of that stuff.

Susan's narrative highlighted the lack of therapeutic focus and lack of 'in the room', interpersonal, relational and interactional skills that were covered in her training. She went on to highlight these skills as foundational when working therapeutically in any setting, including when working with trauma. She also went on to discuss that her training had discounted psychodynamic approaches but this is what she now draws on heavily in her work.

The participants also discussed the lack of bringing the therapist's self into view within training, which meant that these interactional and reflective skills needed for trauma and contextualising approaches were not highlighted. Lisa, who also has a background as a trainer within a clinical psychology programme, said:

> Lisa: We don't make lots of space for the psychologists being human beings as well, who are sitting there with their own trauma histories, trying to listen to someone else's trauma history, or having their son be trans, while the lecturer is being dismissive about people being trans, all that stuff happening all the time, we don't do a good job about making space for that, I don't think. And helping psychologists be okay with their own worries, their own thoughts, their own feelings, their own experiences, and how can they hold them lightly while they go in and try to connect beautifully with somebody else?

Lisa discussed the lack of contextualising approach within training where the therapist's positionality was missing in this relational context. Some of the participants highlighted that their training was many years ago and voiced hope the training had changed in regard to focus on therapeutic skills, trauma and sociopolitical context. However Tobias, who was the most recent graduate interviewed, highlighted many of the same thoughts.

> Tobias: So it didn't equip me terribly well for the broader cultural stuff. But also there wasn't really a conversation about how this would be talked about with clients or how to make it relevant. The conversation was more: right, you know, you're gonna set an agenda and that's practically how you do it. And I think that is a little bit of a failing to be honest. Because what I'm talking about to you would have been what I wanted someone to say to me when I was a student. And it's not a hard conversation to have, but it is a hard conversation if you are someone who isn't comfortable having it.

Tobias' narrative highlighted the need to include practical discussions in training about holding conversations about political events, violence and experiences of marginalisation and discrimination. He highlighted that without practising the conversations in training, students do not get a chance to work through discomfort they may hold about certain topics of conversation. In actually practising the conversations, clinicians become more comfortable working with the sociopolitical context of clients' lives. These narratives raise the issue of how a trauma-informed and contextualising approach includes visibilising the therapist themselves within the therapeutic space and what they bring to it, to develop the awareness and capacity for these conversations.

Rachel's narrative included a strong rebuke of clinical psychology training institutions at the time she was training. She spoke of abuses of power within training programmes that rendered trainers ill-equipped and incompetent in delivering training concerning trauma, abuse and power dynamics, given they were perpetuating problematic behaviour in these areas themselves. Rachel said she was aware, at her time of training, of several instances where faculty were romantically or sexually involved with

former or current students. She emailed the following after our interview as she wished to provide further context to her comments.

> Rachel: In all of the situations bar one, the individual with higher power in the situation was male. As such, I believe that during the time that I was training, clinical psychology programmes were profoundly ill-equipped to teach students how to treat interpersonal traumas, because of the broader systemic blindness to situations in which sexual consent could not be freely given owing to the differences in power between the individuals. I see this as an example of institutional betrayal, which has been identified as a key controlling variable in the severity of PTSD symptoms.

Rachel illustrates that her training was a space in which abuses of power were perpetuated and normalised. Within such an environment, she described faculty as unable to teach students how to approach violence or power dynamics and systems surrounding it, because they could not identify it themselves. Rachel highlights this as an example of institutional betrayal, where powerful institutions enforce harm on those who are dependent on them for safety and/or well-being (Smith & Freyd, 2014). In this case, the betrayal discussed affected arguably not only the students who were subjected to abuses of power, but also the eventual clients of those trained in these institutions, who may not be equipped to appropriately handle abuses of power and violence due to this being perpetuated within their training institutions.

Multiple Trauma Narratives - Trauma Is Context (But Not All Context?)

In many participants' narratives, trauma-informed therapy and contextual practice, where sociopolitical context was openly discussed, were positioned as essentially the same. Participants held a view that a trauma-informed approach was inherently politicised due to their approach, which saw exploring any relevant context as essential to trauma therapy. Some participants suggested that therapists who avoid trauma work often avoid sociopolitical context. Kate shared such a view:

> Kate: Yeah, I think it really depends on how comfortable people are with looking at a bigger picture. I think if you are, you know, I mean, it's, it's exactly the same, like why

> do people… can handle the trauma? You know, why work with trauma? And how, you know, we've got some physicians who really avoid it. Yeah, do anything but, you know. So, um, yeah, I wouldn't like to hazard a guess about who does and who doesn't just, I just have a feeling the more you work in the field, the more that you kind of realize that, okay, you can't think of things in a sort of systematic way, without it being that you don't take the whole person into consideration or don't have more of a holistic approach.

Kate shared a narrative that positions working with trauma as being inherently open to all layers of context. She also suggests that if you can see 'the bigger picture' and systemic issues, then you will inevitably, with time, see the value in working in a contextualising way that invites discussions about sociopolitical context.

Some participants storied inherently politicised conversations where oppressions are named as in contrast to dominant trauma narratives. For instance, Halima argued that the language of marginalisation is othered within Western frameworks, including in the trauma and attachment model used in assessment at her workplace.

> Halima: I mean, the languaging of it, the naming of it, is probably... I guess, like, our programme has a trauma and attachment lens that allows us to identify trauma in family history and oppression in that way, but it's never named as social political issues and the realities of the patriarchy. And when I came here, I was really shocked that there was nothing specific on gender in the whole assessment, or toxic masculinity. Yeah, because it's like, we've got 98% male clients here [A service that works with harmful sexual behaviour].*laughs*. You know? … So, so the naming of, the languaging of it and the power of that…

Halima identified the trauma and attachment lens used at her workplace as enabling an exploration of context because of the acceptability of this theory and the associated language. Halima, however, also highlighted how such a lens prioritises some experiences while not including certain

sociopolitical experiences, such as colonisation and patriarchy. She described how the language of patriarchy and gender is still not used within the frameworks and assessment models used in her workplace, despite what for her are obvious important links between these issues and harmful sexual behaviour (which is the focus of work in her organisation).

> Halima: So yeah, um, you know, you get away with poor attachment because it's an established lens to look from. If you had an established lens around disenfranchisement due to colonisation... I imagine people would get pretty uncomfortable *laughs*, and, yeah, um, you know, diving into that space. And like, you know, it would be othered. Yeah. You know, so it's like, I guess it's an internal and external barrier, is what's seen to be acceptable in therapeutic conversations. Yeah. Versus imposing an ideology or.... whereas I just see it as essentially giving visibility to other realities…

The example Halima shared illustrates how using a trauma and attachment lens can give the illusion of being inclusive of sociopolitical context, while also rendering more marginalised experiences invisible. She resists this position and argues instead for the explicit discussion of these invisibilised experiences of colonisation and patriarchy. In naming these experiences, the realities of marginalised bodies are visibilised. Halima demonstrates how institutions embracing a trauma lens does not necessarily mean that all context is prioritised equally, or that experiences of oppression or marginalisation are accepted as necessary trauma context to explore. This echoes Lisa's narrative, shared above, in which connecting the discussion of colonisation to trauma was positioned as a marginalised position within the trauma field.

Seeing the Whole and Resisting Fragmentation

Participants often struggled to separate conversations about sociopolitical factors from other aspects of therapy and even expressed resistance to doing so. Just as the client's experience was layered and interwoven, the therapeutic practice and response were too. Below, Kate reflects on how she emphasises an approach of seeing the client holistically and, therefore, exploring context.

> Kate: I'm just thinking of which clients I haven't had those conversations with…I can't imagine that you wouldn't. I can't imagine even having a conversation that you wouldn't, that wouldn't be part of it. Yes. …
>
> Because it's just, I mean, and it's even surprising to me to call it like separate because it's just, you know, and it's their, their spiritual background. It's their, you know, all sorts of things that impact human beings. …
>
> And, and to not talk about those things would be disrespectful to everyone concerned. Yes, this has made me realize how much, how much I emphasise this…

Kate argued that all aspects of someone's experience are equally valid, but she went on to express surprise at the idea of teasing out conversations about political factors. Kate illustrates a possible clash between the framing of this research and the approach to therapy, which she and other participants describe. Teasing out these conversations for analysis may in fact be an example of the compartmentalisation of clients, rather than seeing them holistically. It is for this reason, perhaps, that many stories shared by participants often covered various topics that sometimes were clearly sociopolitical in nature and sometimes appeared to be ostensibly more about another topic. For these therapists, it was difficult and at times impossible to disentangle the sociopolitical context from the personal, spiritual, and relational. Indeed, this is the very approach being advocated by many participants: that you go where the client goes, you address whatever layer of experience is arrived at within therapy and seems most important for the client, and that these layers are seen as inextricably linked.

Tobias shared a commitment to contextualising practice as a resistance to compartmentalising clients. This resistance to fragmentation the clients experience was evident in Tobias' story, wherein he critiqued Clinical Psychologist practices of specialisation, or of avoiding working with certain areas of distress.

> Tobias: I mean if you came to see me and said, oh, what I want to talk about, is what happened with my Dad. And I said, oh actually, I don't do that kind of work. I mean, what is that? You know, it's this kinda stuff. And I have a bit of a, I'm probably quite

> zealous about this, but I have a bit of an issue with this idea. I remember when I was studying there were a lot of psychs who were ' I only want to work with this', 'I only work with anxiety', And I think, great, but, what happens when someone brings anything else? How does that feel for them to make this effort, muster up the courage to say, and for you to say, look that's outside of my thing, or I can't handle that. I just don't know how that really works for the patient. And the same with the sociopolitical stuff. If I can't handle talking about Ukraine or say it's not relevant. What does that say to the person, when this is what they've mustered up the courage to bring to you, you know?

Tobias described his approach to discussing sociopolitical issues as the same as any issue a client brings: he commits to meeting the client with what they bring. This practice opposes the compartmentalisation Tobias describes, where psychologists turn away clients if they bring specific issues for discussion due to it being out of their scope or specialisation. In positioning himself as a zealot, Tobias emphasises the degree of resistance necessary to push back against what he framed as the dominant, powerful (compartmentalising) approach to therapeutic practice. A contextualising approach being inherently a position of resistance is again evident in this narrative, where seeing the whole and working with trauma and context is contrasted with a specialised approach. The multiple rhetorical questions illustrate a demand for answers and change that Tobias is calling for from the wider profession. Tobias positions the client as courageous in bringing a new layer of experience to discuss, and the psychologist who decides an issue is not relevant as unresponsive and potentially unsafe.

In summary, theme one describes an approach to sociopolitical conversations which sits within a broader way of understanding trauma therapy with survivors of interpersonal violence and therapy generally. Participants saw trauma-informed work as synonymous with being open to working with all context, including the sociopolitical. Trauma work was contextualising work. However, they also positioned themselves in resistance to more dominant ways of understanding both trauma and mental health generally, which were more individualising and pathologising. Clinical Psychologist participants

were all highly critical of their training for not including a sociopolitical or trauma focus or involving spaces to practice these conversations.

Theme Two: Becoming the Big, Safe Container

The first theme described participants' broad contextualising approach to trauma and therapy and why they considered it essential to include sociopolitical context in therapeutic discussions. Theme two explores the capacity and skill to hold a containing, safe space, which was storied as essential within such an approach. Participants described providing a 'container' which included safety, openness, and curiosity, and reflected on developing their ability to discuss any topic. An ability to hold such a space was essential in alleviating core client fears and building trust for difficult conversations (including about sociopolitical issues). This container was described as both an internal capacity grown through diverse, politicised and/or marginalised life experiences, and a skill which is practised and learnt.

An Inner Capacity and a Cultivated Skill

The containing experience needed to hold and have conversations about all context was described both as an inner felt sense and capacity, as well as a developed and practiced skill. These descriptions were not in conflict but instead were different and complementary paths to becoming this container; both were important. The experience of being a holding container for clients was constructed differently in different participants' stories.

Many participant stories described curiosity and openness as key elements to providing this safe, container experience for clients, in which any discussion can be held. Below, Kate discusses curiosity and openness to learn as the foundational tool in holding what the client brings: in this case, a discussion about toxic masculinity.

> Kate: One of the foundations I think, with any client is curiosity. I am not the expert on toxic male New Zealand, I'm like furthest away from it *laughs*. I don't understand that culture. Right. You know, yeah. So absolutely an openness to, openness to learn . And an openness for people to bring their own perspectives and what that means for

them. His view of it is his view of it. It's not necessarily the truth, it's just holding the view that he has on it, and having a look at how does that impact him? Because I can't change that environment, right? I can't do that. But I can help them hold the hurt that they have. And so I see that as, as kind of, you know, that's the link in- is to actually, or how do you hold the hurt? Or how do you not, you know, drink the poison, that resentment will actually create within me Yeah, yeah. So it's more in that sort of line.

Referring to toxic masculine culture, Kate suggests she uses curiosity to unpack what this culture means for the client and provides a holding experience for what is revealed through this curiosity. In this sense, the container she constructs is an empty one, a container of curiosity where the client's knowledge is held rather than one in which she uses her own knowledge. However, she also explains how her own life experiences have built this capacity to hold the position of non-knowing and curiosity. When this description of how she has developed this stance of curiosity is added, the container is not empty or a blank slate, but one which has been constructed, in part, through Kate's own experience. Her experiences of being the outsider and living in different countries and cultures, in which she does not hold insider knowledge, have helped build her skills in curiosity and a sense of comfort with not being the expert.

Monika narrated her capacity to be a container for clients as one built through personal experiences of similar, diverse and/or marginalised experiences; a capacity built through knowing.

Monika: Yeah. And I guess, plus, I've been a solo mum. And I was on the DPB[Domestic Purposes Benefit] and, and I, you know, I had a good chunk of time, where I was really financially struggling and I, I did a stint of time where I worked as a sex worker…

And I'm, yeah, and… and I'm an activist, and I thought really deeply about injustice. And I worked at Women's Refuge with people who were trying to escape gangs and people who were right at the bottom of the scrapheap where people get left to rot. Where most agencies don't go. So although I am reasonably, yeah have a shit tonne of privilege and stuff, I feel like I have gone to places that a lot of ivory tower

> colleagues just haven't gone and just don't get it. And, and I kind of feel like as a result of that, not a lot can shock me. And that being quite unshockable makes… makes me a very large container . Because that's often people's fear. If I tell you this, are you going to be horrified? Are you going to be shocked? and you're going to be disgusted? Or just, are you going to get it? Yeah, like and, and I don't tell any of those stories to my clients, obviously. But I feel like I am a big container. And, I am quite unflappable, that I feel that on the inside of me. Yes. Sorry. It took me a very long time to get very straightforward point. *laughs*

Monika highlighted that the key ability she brings to these conversations is a cultivated ability to be a big container, to be unflappable and not easily shocked. She described how having diverse life experiences, which included experiencing firsthand experiences of marginalisation and experiences working in marginalised spaces, has helped build her capacity to be the container clients need. She positioned this capacity as sitting in contrast to colleagues who have not experienced or reflected on systemic injustice or marginalisation and may be shocked by experiences which are outside of their comfort zone. This container is, therefore, one in which Monika is the knower. She knows through personal experience and working with the impacts of structural and systemic influences on personal lives. Because of this personal knowing, she can provide a knowing container which alleviates client fears; that the therapist will be disgusted or won't 'get it'. This sits in contrast to the non-knowing container, which Kate describes above. In both cases, comfort and ease build trust and provide a holding space for the client, who experiences non-judgment. In Kate's case, this is created through being the non-knower and holding a place of curiosity, which honours the knowledge of the client. In Monika's narrative, her ability to facilitate the experience of the big container has been built through her knowing. This does not necessarily include a knowing through lived experience, though she does describe this as well, but also a knowing through witnessing and working with those 'who are left to rot', in other words, those who are the most marginalised in society. However, Monika went on to echo the importance of bringing openness and curiosity to discussion.

> Monika: Yeah, so I don't really get rugby, can you? So how does that work? And then they explain the move to me. And then I get in there so that I can work with the metaphor. And I guess, the same needs to go for politics, or the intricacies of pegging. I guess I feel like that's the thing, that's the superpower that I'm always trying to grow is my capacity to get into different things and different...
>
> And yeah, so I think um yeah, I think people who aren't comfortable talking about politics, even if they're not having an opinion.... I kind of always say that, you know, like, you shouldn't be a therapist, if you're not comfortable talking about sex, like that's just ridiculous.

Monika illustrated how the capacity to hold is still being used by the therapist when approaching a conversation as a non-knower. In comparing discussing sex or discussing politics, Monika insists that a similar capacity is involved regardless of the content: an ability to hold, contain and bring curiosity and non-judgment, regardless of whether you are a 'knower' in the subject matter or not. A similarity can be seen then between the holding and containing that Kate and Monika describe. A capacity to be the containing and holding non-knower which has been developed, which is brought into these conversations using curiosity. They both express comfort with not being the expert and a capacity to contain what is revealed through curiosity.

Monika also described this capacity to hold and contain as something she feels 'on the inside of herself' and a sense of unflappableness. She suggested that it is a felt capacity which she has grown through her own personal development, rather than simply a therapeutic tool or a learnt way of communicating. This sense of containing as an internal capacity was echoed in Alex's narrative, where he describes 'okayness' and congruence as a foundational core to therapy.

> Alex: I'm not sure that we as professions understand or express enough the power of sitting in a room with someone who can be congruent. …. So if I can be okay. And I can look, okay, that's the best way I can describe it, the client will pick that up. So often, I genuinely believe that being okay is an incredibly powerful start.

Later in our discussion, he also described developing the tools of curiosity and nonjudgment in training situations.

> Alex: one of the things I was really lucky in lots of the training I had, in specialist agencies, if we think around sexual abuse and gender. We did all sorts of crazy things in our qualifications and experiential groups. And some of us were quite provocative in the subjects we wanted to talk about because we want you to understand how we're going to be if we're going to talk about this. So even some of my colleagues here, mostly male colleagues, but sometimes female colleagues, you know, what do you, what do you do if you've got a client, you know, who's, who's really struggling with, say, menstruation. Say, well we will talk about it. Well how the hell do you? We spent two hours in the experiential group with eight women talking about menstruation, why the hell did you do that? Because somebody said, it's the wrong time of the month. I'm not saying it's all about me, and I went, it's really interesting to hear that, tell me what that actually means for you? Which wasn't me, me trying to be a counsellor. It was saying, Well, okay, I know what I think it is. But I don't menstruate. So I can't know if you don't tell me. And you can see the two other guys in the group, la la la *fingers in ears*. They're going, oh shit. But. but I learnt that it's not the subject that's difficult. It's how I might respond to it. And I'm in control of that. So if it's a discussion a client wants to have, I can go, aah, it's not about me. And that's really empowering for me and them.

Alex's first quote illustrates how the containing experience can be one which is a nonverbal experience resulting from the therapist's own inner groundedness and congruence. This 'okayness' may be a similar internal sense to the unflappableness which Monika describes. It may provide a similar feeling of holding and safety for a client. However, the therapeutic skills used in holding conversations about unfamiliar topics, or those which may often be considered uncomfortable, were also described as skills Alex developed through practice and training. Alex learnt through this training that no topic is

complex if you can respond with openness, nonjudgment and curiosity. The inner capacity, then, was the skills of curiosity and responsiveness, which he has grown through practice. This inner capacity to contain and hold may be a felt sense for therapists and was also storied as resulting from different experiences. Personal experience with marginalisation, diverse life experiences, working in marginalised spaces, as well as practising difficult conversations and tools of curiosity about unfamiliar topics, were all positioned as important personal avenues in growing this containing capacity.

Across participant narratives, the experience and skill needed to hold this containing space, as well as developing knowledge of the sociopolitical context of trauma, was largely one described as being developed outside of formal learning institutions. Many participants spoke about their own experiences of marginalisation, informing their approach. Others spoke of politicised family cultures or spending time engaged in activism as key spaces in which an understanding of systemic power, and the language needed to discuss it comfortably, was developed. For others, it was working with those who were marginalised, including in spaces such as Women's Refuge, where they developed a political analysis of power and violence. This learning was narrated as experiential and personal, though not necessarily containing experiences of personal marginalisation. There were some exceptions where formal training did equip participants to hold a space for the client's whole context, which included the sociopolitical. Notably, in Alex's narrative above, he describes ways in which his counselling training enabled space for participants to engage in practical exercises which enabled them to overcome fears of topics they found uncomfortable and practice curiosity when discussing topics with which they are less familiar. Elsewhere, specific training was highlighted as useful in gaining experience discussing sociopolitical context and understanding its importance in clients' trauma experiences; namely, narrative-based therapy training (Maya) and social work training (Priya and Monika). In both of these cases, a political analysis of people's lives, distress and experiences was a foundational element to the training and threaded throughout. This gave participants a foundational framework of politicised analysis through which they could understand and work with client distress. Notably, however, all three of these participants described other experiences, including activism, working with marginalised, and personal experiences of

marginalisation, as fundamental in their developing the ability to hold political conversations and become the ‘big container’.

The Container as Safety: Alleviating Fears and Building Trust

The containing experience was described as one in which clients’ fears of being shamed, judged, or not understood were alleviated, and trust and relationship were built. Building trust and relationship then scaffolded other therapeutic interventions. Multiple participants referred to the core fears clients bring to therapy. In Monika’s quote, shared earlier in this theme, she referred to the container as one which can hold and calm the client's fears of the therapist being horrified, shocked, or disgusted. These fears were sometimes described as the result of the narratives and responses survivors have received elsewhere in society. The container, therefore, is one which can provide an experience which counters harmful narratives. Likewise, Alex described how people who have experienced trauma are attuned to whether the therapist has this internal capacity, this ‘okayness’. Clients were also described as testing out this capacity and safety before sharing themselves and their stories. Below, Priya describes a client who did not raise their gender or gender expression, but who slowly started wearing more traditionally feminine things to sessions, beginning with nail polish, then a handbag, and then finally wearing a dress to the session.

> Priya: And then I felt like they brought it into the room in a way that they wanted to engage me, like, you know, I thought the nail polish and the handbag was sort of picking it out like they saw, I saw, they saw. In talking with them explicitly about it, you know, their experience was, they didn't want to 'yuck me out'. That was what I remember them saying. I think, was it them, I may be conflating two people, one person said, 'I've had to rescue doctors and counsellors from themselves'. I can't remember if it was them or somebody else. What I took from that is that they didn't want a shaming experience. And they wanted to make sure that that wasn't going to happen, or as far as they could ensure. And I guess all of us have a way of protecting ourselves from potentially shaming experience.

Priya's story describes how a client may test out the safety of the therapy space and see if they receive the response they may receive in broader society: in this case, an oppressive and marginalising response to their gender expression. The client is left managing the therapist's own discomfort, and the trust for the client to be their authentic selves and bring any issue is diminished. In describing these fears, participants storied the essential experience of the container as one of safety. Priya's story also illustrates how clients co-construct the container's safety through testing the therapists' abilities to safely respond and hold. The suggestion from a client that they have had to rescue counsellors from themselves illustrates how the therapeutic relationship is affected when therapists cannot effectively contain and hold.

In summary, the safe container was a necessary space constructed and held by therapists to build the trust and relationship needed to hold discussions about all layers of experience, including experiences of marginalisation and oppression. This safe container was constructed using the therapist's internal capacity and sense of inner 'unflappableness' as well as a space in which tools of curiosity and openness and 'non-knowing' are used. This capacity and these skills were described as primarily developed outside of formal learning situations, including working in politicised and marginalised spaces and being an outsider or personal experiences of marginalisation. Exceptions to this were training spaces which allowed for experiential practice of conversations about uncomfortable topics or that were grounded in political analysis. The safe container was one in which oppressive and marginalising narratives which shame and judge are examined, and the therapist provides an experience which counters these narratives. The container, then, may be seen as one which provides a counter-narrative to those that shame, internalise and silence marginalised experiences.

Discussion: Contextualising Trauma and Holding All Context

Trauma is Context (is Resistance)

The first theme describes a broad position which participants described in their work, and why they considered the inclusion of the sociopolitical as a vital element of their trauma-therapy practice. It also outlines how they felt this positioned them in resistance to mainstream narratives and, for Clinical Psychologists in particular, their training. The second theme describes a capacity and skill (becoming the 'big container') that participants described as necessary to hold such an approach, and practice in such a way that made exploring the sociopolitical possible. This contextualising practice was positioned in resistance to medical and diagnostic narratives, the dominance of Western frameworks for therapy, and the compartmentalisation of distress. A contextualising practice was seen as synonymous with how they viewed a trauma-based approach, but was also positioned as resisting or speaking back to some conceptualisations and frameworks of trauma. Clinical Psychologist participants also spoke of this approach as being in opposition to the training they received.

Trauma-informed therapy was seen as inherently political. Participants shared narratives about why they saw conversations with clients about sociopolitical factors of trauma as an essential and indeed inevitable part of the therapeutic conversations and process. Sociopolitical context was described as one of many layers of human experience that a therapist must be willing to unpack and explore. In other words, given the interwoven nature of these experiences, their approach was described as being willing to go anywhere the client needed and wanted to, which often inevitably included the politicised context of people's lives and trauma. This approach was described as both unavoidable but also one which positioned them in resistance to more dominant diagnostic-focused, specialised and medicalised narratives of mental health and trauma therapy. Clinical psychologists, in particular, criticised the diagnostic model and their training programmes for prioritising diagnosis and assessment at the expense of sociopolitical context and trauma. They positioned trauma-informed practice as seeing the whole person in their full context, which includes the socio-political.

Most participants shared a politicised and socially contextualised view of trauma, highlighting how violent trauma and its effects often involve the failure of systems and social networks to respond to people's experience of violence. The sociopolitical context is an essential facet of trauma therapy with survivors of violence, including what has been coined 'institutional betrayal' (Smith & Freyd, 2014). Institutional betrayal describes the failure of institutions to prevent or respond to interpersonal violence appropriately. Likewise, participants spoke explicitly of the inevitable link between survivors' experience of violence and that of colonisation and transgenerational trauma (Pihama et al., 2016; Wirihana & Smith, 2014), highlighting that many had a view of trauma therapy that was inextricably linked to intersectional and social justice-oriented understandings of trauma (Goodman et al., 2016). Many participants also spoke specifically of rape myths and victim blaming as part of this crucial sociopolitical context which needs unpacking in trauma-therapy. This is not a new idea as scholars have highlighted the rape myths involved in most survivors' experiences of processing the aftermath of their trauma (Winn, 2018). The participants work in trauma-therapy with survivors speaks to feminist models of violence which see the trauma of gendered-violence as inextricably linked to social position, power and patriarchy (Cockburn, 2004, Hearn, 2012).

Participants shared a sense that this politicised understanding of trauma is common sense and a non-issue in their practice. Some described being drawn to do trauma work specifically due to their social justice focus, something which Boylan (2021) suggests may be a common motivation for those in trauma fields. Such a common positioning amongst participants sits in contrast to views in literature which argue that trauma discourses has been co-opted by psychiatric and pathologised understandings of trauma which erase sociopolitical context (Burstow, 2003).

It is worth noting that self-selection due to study description and recruitment process likely played a part in this. I explicitly sought trauma-informed therapists who *do* have conversations about the sociopolitical context of trauma. It then follows that those who were involved in the study consider this aspect of their work essential and advocate approaches to trauma-therapy which is contextualised sociopolitically.

Resistance to Medicalised, De-contextualised Practice

Many participants positioned themselves within contextualised and power-focused understandings of trauma therapy as being in resistance to another, often more dominant, approach within their work and broader mental health narratives. This more dominant approach to trauma-work was one of medicalisation, pathology, individualisation and specialisation. Their commitment to an understanding of trauma that included considering power and a politicised context was one which they identified as a form of understanding marginalisation in many cases. This finding mirrors earlier research with providers of services in the trauma space, which found that trauma was understood in multiple different ways and was contested between politicised and psychiatric understandings (Peters, 2019; Tseris, 2019).

The medical model within mental health is difficult to avoid and has become so hegemonic that practitioners struggle to avoid using its language to help clients understand their problems (Sutherland et al., 2016). In participant narratives, particularly those of clinical psychologists, the dominance of the model was something the participants positioned themselves as working to reject. However, they did so alongside positioning themselves as part of the profession which enacts this narrative dominance. This aligns with research highlighting the tension that is often at work in the discourse and practice of mental health professionals who work in medicalised settings but hold politicised views of trauma (Omur, 2023; Peters et al., 2019; Tseris, 2019). Some research with therapists and clinicians has found that therapists often have a focus on diagnosis as well as more political analysis side by side in trauma work (Peters, 2019). Some have argued that the dominance of medicalised narratives makes it difficult to include it alongside other approaches, as it tends to swallow and render less critical other perspectives (Conrad, 2007; Sutherland et al., 2016)

Diagnosis and the psychiatric medical model for mental health broadly is alluring in that it may offer explanation and validation, while being accepted as legitimate, value-free, scientific knowledge (Lafrance & McKenzie-Mohr, 2013). However, diagnosis locates deficits individually and places priority on the individual to change rather than addressing the social conditions which led to someone's distress (Burstow, 2003; Reynolds, 2020). Diagnoses may reinforce a sense of brokenness ,which those who have

experienced trauma likely already feel (Egan, 2020; Gómez et al., 2016). These points were echoed by participants who positioned diagnosis as a barrier to contextual practice and as a barrier to effectively deconstructing narratives of self-blame and deficit which have been instilled by the violent trauma itself. This is an interesting finding in that it suggests that therapists may need to undertake a significant amount of reflection and work to build practice which either does not include, or critically includes, medicalised narratives within their practice, to be able to adequately emphasise sociopolitical factors. It may not simply be enough to 'include' sociopolitical factors alongside medicalised ones. Instead, practice which effectively includes broader context and sociopolitical discussions may need to speak back to and be in active resistance to medicalised understandings in order to work against the individualisation and deficit focus which results from them.

Some participants also highlighted how some sociopolitical context is deemed legitimate (such as broader familial attachment dynamics), while others are invisible within trauma models of assessment within their work (such as colonisation), which makes raising these issues harder for therapists. These findings also suggest that explicitly using more socio-politically contextualised models of assessment, such as culturally situated models such as the Meihana model, or the PTMF, is important in countering dominant narratives which do not include sociopolitical context, visibilising these issues of power and oppression and legitimising them, and in developing the therapists confidence in discussing them. This finding aligns with that of Stevenson (2023) whose work around service user views of Clinical Psychologist competence also resulted in recommending that using such models is needed to address service user needs for cultural safety, non-pathologising practice and confidence traversing issues of power.

Training Critiques and Learning Mostly Outside the Classroom

Many participants, but particularly psychologists, who all shared similar training narratives, described feeling ill-equipped to work with trauma and violence upon leaving their training, despite this affecting a large proportion of their clients. The lack of focus on trauma in training corroborates international research which suggests that trauma specific training within psychology postgraduate

programmes is still limited and may not adequately prepare graduates for working with those impacted by trauma (Cook et al., 2017; Sadusky et al., 2021). Knowledge about sociopolitical issues in clients' lives, or the skills to navigate discussions about these, was also described as lacking in training. All Clinical Psychologists described an overall lack of context and emphasis in training programmes about sociopolitical context and issues. Very few participants (and none of the psychologists) described having received training which included practising and active reflection or therapeutic discussions about sociopolitical context. Those who did, and who had been trained in humanistic or narrative-based modalities, positioned themselves as lucky to have had this or highlighted how useful it was in becoming comfortable with easily discussing sociopolitical context in therapy. Where the sociopolitical context was included in training in general discussion, the practical skills for discussing this context of client's lives was absent for all Clinical Psychologist participants, and some other participants. It should be noted that there was a wide range of times across which participants were trained. Therefore, not all narratives may reflect current training. However, such criticisms were in line with recent international research which suggests that despite the need outlined in Psychologist competencies, social justice related context is still not widely or well-integrated into training (Abraham et al., 2022; Treichler et al., 2020), and that Psychologists who wish to incorporate this into practice are left feeling ill-equipped and in a minority (Abraham et al., 2022; Kozan & Blustein, 2018).

Anderson (1991) suggested four ways of knowing: rational, technical, relational and bodily. In the context of therapeutic skills, relational knowing, or the skills associated with being with a particular person in a specific place and context, are often more marginalised and less prioritised (Smith, 2004). Indeed, this was echoed in the criticisms of psychologists that their training focused on assessment and diagnosis at the expense of therapeutic and relational skills in training. These were the type of in-the-room, person-centred skills that have been described as necessary for sociopolitical conversations in the 'Big Container' theme. Relational information, such as those needed to follow a client to any topic including the sociopolitical, can become obscured by the attempts of a clinician to focus on the rational

and technical knowledge involved in diagnosis or specific interventions which stem from these. As Smith (2004) has said:

> I wonder how my graduate experience might have been different if the "rational and technical" modalities were presented as offering provisional, general background information. How might things have been different if I had been encouraged to hold this information lightly so that my relational and bodily know-ing could come forth more confidently and allow me to stay in the fullness and complexity of each particular moment in my evolving dialogue with clients? (Smith, 2004, p. 89).

Participant narratives regarding training are notable in that it was a practical training focus that was often raised as lacking in training programmes. Some psychologists highlighted a need in training for more practice of conversations about topics which may be unfamiliar to therapists or may challenge them that are explicitly about the sociopolitical context of people's trauma. This was seen as necessary in order to become more comfortable with uncertainty and adopting a non-expert stance, while highlighting the importance and relevance of sociopolitical context in therapy through practical discussion. Such suggestions are in line with research around incorporating social justice curricula into therapist training, which highlight group discussions and practice of sociopolitical conversations as an important component of social justice curricula (Arczynski, 2017; Chung et al., 2018; Treichler et al., 2020). A pilot study of social justice curricula in psychology training completed by Treichler et al. (2020) found that participants viewed lecture content as the least useful when increasing their knowledge and competencies, while group discussion and other more practical components were the most helpful in meaningfully engaging in social justice-related training. Chung and colleagues (2018) suggested that 'safe brave' spaces, where students were involved in setting guidelines for discussion and faculty facilitate reflection on discomfort or resistance to topics, was beneficial to psychology trainees' deeper engagement in social justice topics. Some narratives in the current study argued that roleplay or practising therapeutic discussions which incorporate sociopolitical topics would have been useful in developing capacity for discussing

sociopolitical context. This suggests that such a 'safe brave' approach could also be useful in applying to such practice conversations in training, as well as general class discussion.

Cultivating capacity and ease to hold nuanced sociopolitical discussions is a particularly important consideration, given that practitioner discomfort was described as a barrier to practising more contextualising conversations in therapy that value sociopolitical context. It follows then that the desire to practice in socially just ways may not equate to this being carried out in practice if a clinician is not comfortable with the language and topics involved in exploring power and sociopolitical context with clients. They also align with Allen's (2011) study results, which highlighted that a focus on areas of discomfort is a useful tool in integrating social justice into training, and that training programmes should have an ongoing process of individually or collectively reflecting on areas of discomfort as they arise in discussions about sociopolitical context.

Rachel shared a powerful narrative about her training programme, which raised abuses of power which occurred in the psychology department while she studied. She indicated how this rendered staff inept at teaching about trauma or sociopolitical context given an apparent lack of understanding about power relations or practice aligning with social justice. While this was just one narrative, it is a powerful example of how universities are often sites of personal or institutional trauma and betrayal enacting abuses of power (Pinciotti & Orcutt, 2021). Research has suggested that in developing social justice competencies, it is discussions with trusted others or mentors, often including staff, about social justice and power issues, which is amongst the most useful for students (Caldwell & Vera, 2010; Treichler et al., 2020). Rachel's narrative also highlights how simply inputting social justice-related content into training is not enough. Instead, there is a need for programme staff who hold a deep understanding of power and oppression, and a commitment to social justice-informed practice, in order to convey and teach these issues effectively. Students need to witness and learn from this power awareness in practice, such as in the everyday interaction between students and staff and between staff themselves.

While the issues raised by Rachel's narrative extend beyond the scope of this study, they highlight that further research into students' experiences of and perceptions of faculty social justice

knowledge and competencies may also be useful. This narrative around staff involvement in abuses of power also echoes the results of the report around racism and oppression in psychology (Waitoki et al., 2024), which highlighted significant experiences of racism and bullying in training programmes. Although Rachel's narrative was about a different issue (inappropriate staff/student relationships), what they share in common is the highlighting of a perpetuation of unequal and unjust power relationships and oppressive power relations.

The abilities to stay in the relational moment, keep curiosity, be comfortable discussing any topic including the sociopolitical, were storied by participants mostly as skills developed outside of the formal classroom. These skills were developed through the personal experience of being an outsider, or of being marginalised, or through working in marginalised spaces. This suggests that such politicised experiences are important in developing the capacity to hold political conversations. The ability to discuss sociopolitical context specifically and have appropriate knowledge and language to do so was also described as being developed through working in activism and in politicised workplaces like women's refuge which held politicised analysis of people's lives. This finding aligns with that of Winter (2021), whose findings suggested that prior careers and training were relied upon for political understanding and applying sociopolitical context to therapy. While no research has explored specifically how therapists describe developing the ability to address sociopolitical context in therapy, the finding that this knowledge was developed outside of formal training also echoes suggestions that social justice is not yet well integrated into therapist training (Arczynski, 2017; Pearrow & Fallon, 2020).

Only one out of the ten participants highlighted that the training programme for their current profession was instrumental in developing their abilities to discuss sociopolitical context specifically. In this instance, the training was based in narrative therapy. As previously described, narrative training includes social justice and a politicised understanding of power as a fundamental part of its framework (Combs & Freedman, 2012). This is in line with suggestions in research, which have found that social justice being integrated into all training, rather than as additional components, was important in developing social justice competencies (Kozan & Blustein, 2018; Morrison et al., 2022). The other

positive description of how training helped in gaining tools for conversations was the description of practising therapeutic discussions about issues which made them uncomfortable. This was attributed to growing their capacity to be a 'big container' and remain curious in areas where they held little knowledge. This also reflected other participants' critiques of training, which did not provide such opportunities. As outlined earlier, this finding aligns with research around social justice in training programmes which have highlighted that group discussions which allow reflection and exploration may be particularly valuable (Chung et al., 2018; Morrison et al., 2022; Treichler et al., 2020).

These findings are notable in that they highlight that there are multiple avenues to developing the skills to be the 'big container'. The fact that formal training was only rarely part of this development begs the question of whether personal and politicised experience outside the classroom is a necessary part of developing abilities for these conversations, or whether this was the case for participants due to the lack of this in their formal training programmes. While politicised experiences were part of most people's development in some way, so too were experiences which developed their ability to hold, contain and stay in the relational moment with curiosity and non-judgment regardless of the topic. This is important in that practitioners seeking to develop their skills in discussing sociopolitical context should not only seek 'content' about the impacts of marginalisation and oppression in people's lives and their intersections with interpersonal violence trauma but also develop their person-centred and relational skills in order to hold these conversations effectively. They also suggest that developing such skills, and experiential learning which explores areas of therapist discomfort, is important in training programmes which seek to centre social justice. This corroborates previously described research, which has highlighted the lack of these more 'process' focused elements of social justice training (Esmiol et al., 2012; Morrison et al., 2022; Zimmerman & Castronova, 2021).

Specialisation as a Barrier to Contextualised Practice

A few participants highlighted specialisation, or working only with certain areas of mental health or not working with trauma, as a barrier to working contextually and to highlighting the sociopolitical. The increase in specialisation and fragmentation in mental health, and resulting increase in discrete

‘expert’ areas, has been linked to important benefits, such as increased expertise in specific areas and therefore better client care in such areas (Laugharne et al., 2018). However, specialisation within mental health has been the target of criticisms, particularly due to its links to increased medicalisation. One consequence of specialisation is that care has become more fragmented, often resulting in people seeing different therapists or clinicians for different issues. Likewise, specialist clinicians often focus on particular diagnoses, making diagnosis more necessary for treatment, and clinicians less likely or able to work with clients either without diagnoses or with more uncertain or ‘complex’ co-existing diagnoses (Laugharne et al., 2018). This increased specialisation and corresponding emphasis on symptomatology and diagnosis can replace contextual understanding and more holistic care.

Little research has focused on the social justice implications of specialisation within trauma therapy with survivors of violence, or on the outcomes for contextual practice which includes sociopolitical context of clients' lives. However, within the trauma field, some have highlighted how an increased focus on symptomatology and manualised specialised ‘treatments’ has resulted in deficit-based pathologising practice (Tseris, 2019). Such arguments are relevant to narratives shared in the current study, which described compartmentalising aspects of clients’ experiences as compounding victim blaming narratives, which locate deficit and blame for distress and trauma within individuals (Gavey, 2018). If survivors’ experiences are fragmented into discrete areas to be focused on solely in therapy, then the systemic context within which their distress has emerged is deemed less relevant. An important implication in the findings was the reflection and view that within a compartmentalised view and specialised areas, the sociopolitical context is likely to be considered out of scope.

Participants positioned those as reluctant to work with trauma or who identified as only working with some specialisations as often doing so due to their own discomfort with certain areas. This raises important questions about the more personal therapist's reasons for specialisation or avoiding certain areas of work. Laugharne et al. (2018) highlight that feeling ‘special’ and being seen as an expert can be an alluring aspect of specialisation, and that being at the top of a field can be seen to be the domain of ‘specialists’. Conversely, within socially just and contextual practice, which sees the sociopolitical as

important, there is a need to relinquish expert status in order to prioritise the lived experience and knowledge of the client, and to engage collaboratively (Bava et al., 2017).

Relational and Person-Centred Approach Needed to Explore the Sociopolitical Context

The contextualised practice and approach to these discussions described in themes one and two aligned with some principles of person-centred approaches to therapy. Person-centred therapy was first advocated by Rogers (1951) and has gained prominence and has influenced many subsequent modalities of practice (Murphy & Joseph, 2016). It argues for the client to be centred as the expert in their own life, and for the therapist to take a non-directive stance. Central in such an approach is unconditional positive regard and empathy, and the therapist bringing their authentic, congruent self to the therapeutic process and genuinely engaging with the client's emotions (Murphy & Joseph, 2016). It has been described as the curation of a space for uncensored self-exploration (Yao & Kabir, 2023). The participants also described an approach aligned with core feminist-informed trauma principles, which prioritise the empowerment and choices of the survivor, and seek to share power within the therapeutic process (Herman, 1992). Indeed, Herman highlighted that:

> The first principle of recovery is empowerment of the survivor. She must be the author and arbiter of her own recovery. Others may offer advice, support, assistance, affection, and care, but not cure. Many benevolent and well-intentioned attempts to assist the survivor founder because this basic principle of empowerment is not observed (Herman, 1992, p. 133).

Additionally, the findings also highlight an approach which explores any layer of experience. The capacity and skills needed to effectively include these conversations were described by the participants as becoming the 'big container' for clients, where therapists and clients co-constructed a space of safety and openness to explore any topic. Person-centred practices were evident in describing the core components of this 'big container'. Curiosity and holding a stance of the 'non-knower' was defined as essential in effectively being the 'big container' and allowing space for all topics. Within such a stance, therapists are grounded and open to explore any topic and do so with curiosity that may allow the meaning and

importance of the issue to emerge relationally, rather than the therapist applying their own meanings (Bird, 2004). Findings showed that it was not necessarily knowledge about the topic which enabled therapists to discuss sociopolitical issues in a way they felt was effective (though this was also discussed as important), but often it was a comfort with holding the role of non-knower rather than expert.

Collaborative approaches which centre the client as an expert of their own lives have been highlighted as central to social justice-informed practice (Winter, 2019). The storying of becoming the 'big container' in therapy describes a collaborative dialogic practice, which centres co-creation of meaning and involves the therapist sitting with uncertainty. This necessitates prioritising the therapeutic relationship in its context in the moment rather than applying any method of practice or trying to follow a template or manualised approach (Anderson, 1991; Bava et al., 2017). Such an approach aligns with social justice practice in that it is entirely contextual, it situates the relationship in the moment, considering the context of power, history and language which are involved (Bava et al., 2017). These findings which highlight the importance of a relational approach to conversations of sociopolitical context also aligns with Stevenson's (2023) research around service-user views of Clinical Psychologist competencies, which concluded that despite not being included in NZPB's competencies, relational skills and presence was of crucial importance to people who used the services of Clinical Psychologists, alongside an understanding of issues of stigma, culture, power and discrimination.

Participants described bringing their congruent selves to the moment in order to provide a sense of safety and trust upon which sociopolitical context could be explored. A relational approach centres around the notion that what is right, or just, emerges out of relational context rather than a predetermined set of rules (Anderson, 2012). Working relationally involves bringing the therapist's human self to the relational moment in order to attune to a client's needs (DeYoung, 2015). Within a relational approach, uncertainty and relational processes are valued over the confines of adhering to any modality (Bird, 2004). Participants had to prioritise relationship in the moment in order to be attuned to what context was important for the client to explore and for the therapist to be open to doing so. Findings show how,

through being open and curious about all relevant contexts, including the sociopolitical, a relational approach must also be a power-aware and sociopolitically contextualised one.

The big container, and the capacity and skills which contributed to it, constitutes a relational practice, but also involved an awareness of power operating in clients' lives and a commitment to explore this. Not feeling judged was identified as a foundational experience for clients through which the sociopolitical context of trauma could be explored. Winslade (2013) has highlighted how the person-centred concept of therapist non-judgment, while important, does not go far enough in its attention to the context of power. He argues that it should be extended to deconstructing the 'normalising judgment' clients experience outside of the therapy room. 'Normalising judgment' was a notion developed by Foucault (2004) who describes the more subtle yet equally repressive forms of power in society which shape individuals' thoughts, behaviours and lives through societal narratives, norms and expectations which set out what is 'normal' and 'abnormal'. Winslade (2013) challenges therapists to question how the experience of non-judgment can also enable an exploration of how this power impacts everyday life:

> Rogers' research demonstrated that being non-judgemental and empathic had a positive effect on the therapeutic relationship. So far so good. But did it have an effect on the client's internalisation of social norms? Did it allow persons to re-evaluate themselves in ways that reduced the authority of the normalising judgements that were affecting many aspects of their lives? (Winslade, 2013, p. 524).

Participant narratives appeared to be answering this challenge, and went further than offering non-judgment, to a commitment to unpack sociopolitical context. In describing non-judgment and openness as keys to establishing the safety and trust required to go to any topic, participant narratives showed how these person-centred skills are used as foundational tools within a relational approach within which exploring the sociopolitical becomes possible. The 'big container' involved safety and non-judgment and was foundational, and was employed alongside a commitment to exploring sociopolitical context. This is again an important finding in that it suggests that while person-centred and relational

skills are vital in effectively holding sociopolitical conversations, so to is a commitment to prioritising the sociopolitical context and awareness of structural power in clients' lives.

In summary, participants saw all contexts as linked and important. They positioned themselves in resistance to mainstream, more medicalised and compartmentalised models of trauma and mental health, suggesting that a commitment to social justice and exploring sociopolitical context positions therapists as having to reject these dominant narratives. They were critical of the specialisation of therapy and of trauma models, which did not contextualise survivors' distress within the sociopolitical. Their approach and criticisms of the mainstream approach aligned with feminist, indigenous and social justice models of trauma and therapy. Clinical Psychologists all shared similar criticisms of their training, saying it prioritised assessment over therapeutic skills and trauma and social justice knowledge and skills. Participants used person-centred and relational skills of non-judgment, acceptance and curiosity to build a space of containment, safety and trust in which raising and exploring any issue, including the sociopolitical, was possible. Skills for holding such conversations and the knowledge and commitment to explore sociopolitical context were described, with some exceptions, as being acquired outside of formal training. This suggests that there are multiple avenues to developing competence for holding sociopolitical conversations, and that the skills required are still not well integrated into formal training. These narratives suggest that commitment to a sociopolitical contextualised stance, alongside relational and person-centred skills involved in creating the necessary conditions to explore all contexts, were both important in approaching sociopolitical conversations in therapy.

Chapter Six - Survivor Outcomes

This second section of results and discussion includes themes three and four, and associated discussion. It describes and unpacks participant stories of the outcomes their clients have experienced from conversations which explore the sociopolitical context of trauma, and the tools used in aid of these outcomes.

Theme Three: Working with Shame and Self-Blame: Externalising the Narratives and Being with Injustice

This theme explores the key positive outcomes for survivors associated with holding conversations in therapy about the sociopolitical context of their trauma and other experiences. It includes narratives that highlighted working with shame, self-blame, and associated dominant societal narratives that clients may have internalised. The approaches they used to shift, reframe, or transform this shame and internalisation will be described. Participants emphasised externalisation, non-neutral validation and witnessing, and affirmation of rights as key tools used in this process.

Client's Experiences and the Sociopolitical Context of Shame and Blame

To describe client narratives within context, it is useful first to explore how the participants talked generally of shame and blame within trauma therapy with survivors, and also what sociopolitical issues and narratives related to this work. Participants largely described self-blame in terms of clients holding beliefs around being at fault or deserving of their violence or abuse. Shame was defined in terms of people's sense of who they were: being a bad person, or a weak person, or somehow being broken or undeserving of good things. This shame was shaped by the trauma they experienced, the invalidation or silencing around it, and the narratives they had internalised around it, often reinforced by those around them or by institutions. The shame people experienced was not solely attributed to narratives surrounding the violent trauma itself. Wider dominant narratives around the person's identity and lived experiences (such as transphobic or racist narratives), as well as intergenerational trauma, contributed to a sense of shame which was sometimes then described as being compounded by the violent trauma (or vice versa).

Some participants, therefore, told stories of targeting shame and blame that were not directly related to the sexual and interpersonal violence clients experienced.

Below, Kate described the background of a transgender client and how the impacts of their sexual abuse was amplified through living within a transphobic environment.

> Kate: Their environment in which they grew up and was a very staunch farming background. They were expected to work on the farm as a youngster. Was ... a lot of expectations within the family. … And he just didn't fit into any of those norms whatsoever. Like none, none. *laughs* I guess....too effeminate, too shy, too timid. And so the atmosphere of the family was one of shame. They were ashamed, it seems to me, as if they were really ashamed of this person, and ashamed of who he was. And that has had an incredibly devastating effect on this young person, when they were younger. They were victimised in their home, they were victimised on the farm,they were victimised at school. They were thrown into areas where they were meant to cope and couldn't cope at all. So what, what he was born into, this kind of sociopolitical climate, that he was born into, this, he *so* didn't fit the mold. And that made him stand out for those views. So, he now has a belief that he will attract it. that it will come to him. And it has, it certainly has. And so when he was victimised, in his family, sexually abused, it was, he couldn't go to anyone, there was no one he could share that with….
>
> Interviewer: So as part of your work there, have you discussed those, those issues of what those societal…
>
> Kate: Yeah, well, actually I didn't, I didn't even need to bring it up. He brought it up. He said, I didn't fit in, you know, this was the, this was the context. This is the sort of thing this is, this is the thing, but what it got utilised as was de-shaming. This was not his fault. You know, that his genes ended up this way. This is not, you know, it's the societal burden that was put on him. It's not his fault. it's really not.

Kate described here how existing discrimination and oppression related trauma, in this person's case related to transphobia and homophobia, contributed to shame, isolation, and invalidation following an experience of sexual abuse. Kate also described the beliefs that have resulted for this person which link to shame, particularly around 'attracting' or being deserving of abuse or violence. This illustrates the way that exploring oppressive and discriminatory trauma clients have experienced, such as that of transphobia, is part of the work of targeting shame, which has been compounded by sexual abuse. Kate described the functions of her discussions around the transphobic environment her client grew up in as that of de-shaming and removing of self-blame. Other examples of client stories involved in narratives included shame and self-blame related to victim blaming rape myths, shame related to racist experiences, and shame related to intergenerational violence which was linked to colonisation.

Externalising Beliefs and Narratives to Counter Shame

The importance of conversations which explored damaging societal beliefs, whether it be around rape, gender, racism, or another issue, was exemplified in how participants constructed the experience of trauma. In their stories of their work with survivors, participants identified victim blaming (and internalising victim-blaming beliefs, in other words, self-blame) as a key part of the process of trauma, rather than simply a symptom of it. Therapeutic work then involved exploring and transforming these internalised narratives. Rachel, for example, described how the 'controlling variable' associated with trauma is generally shame. She listed the PTSD criteria themselves, and specifically changes of perception about yourself, as indicative of the importance of exploring societal beliefs which contribute to those changes of perception. In describing what beliefs contribute to self-blame, Tobias highlighted how these narratives are intertwined with the 'personal trauma' itself. The trauma includes the meanings clients made about it. Therefore, societal narratives and trauma were two sides of the same coin.

> Tobias: I'm not sure how I fell into this niche, but the majority of my clients are the ACC sensitive claims ones, so who have experienced sexual assault. And there's just so many layers of complications to any personal trauma. From the toxic masculinity, which should be, right, what is rape, what isn't rape, religious pressure, just you name

it. There's always something else surrounding that incident to some degree. And that's usually internalised by the person. Well, if I hadn't have been drinking, if I hadn't made him mad - whatever it might be. That actually makes it a relevant, in my opinion, target for therapy, just because it really perpetuates this belief of 'I am at fault' and in my opinion, the sociopolitical stuff is a way of externalising that. Letting it more out into the world of, actually, men shouldn't be abusive, or , maybe ah, we shouldn't blame people for what they wear. That kind of conversation can kind of take it away from 'I am solely at fault' to 'maybe there's something in the world that's bigger than me, maybe I didn't do anything wrong, or maybe I am not only to blame' or whatever it might be.

Tobias' narrative highlights a process of externalising what is internalised: an introduction of counter narratives through a process of externalisation which is part of the therapeutic goal to shift shame and self-blame. Tobias described his role as active within these conversations in that he is choosing these beliefs as a target for therapy. He is part of exploring or introducing new beliefs or narratives that may oppose those contributing to self-blame and shame. All participants' narratives included elements of this visibilising and externalising of internalised societal beliefs and narratives to target shame and self-blame.

The participants also described the co-constructed therapeutic discussion as a site of resistance. Halima described exploring narratives about class, gender, and race with a client as helpful when working with internalised narratives about worth, blame and self-pathologisation. Halima acknowledged that she often works with narratives she is 'warmed up to' or familiar with, which she named those around gender, class, and race. Halima highlights the process of exploring and making dominant narratives visible which occurs within therapy, and her own role in this.

Halima: So, I guess, I think it's therapeutically useful, because it locates the trauma, the responsibility for particular circumstances, outside of the client. So often they are self pathologizing. You know, about their worth or why something bad happened to

them and them not deserving or, you know, the myriad of internalizing stuff that young people particularly do. So it's part of what sits in my thinking about therapy, I guess. I suppose for me, to be really helpful. It's not only about internal processes, but about how people interact with the world and how they see themselves and their different narratives around who they are. And yeah, often that's really influenced by gender and race. Yeah, particularly. Those things I'm pretty warmed up to I guess. And class, obviously, property and housing, all of those sort of, discourses. And often, it's what people are bringing too. So often with disclosures of what's happened to them. You know, a narrative kind of falls out of it, that invites a different kind of questioning or reflecting or reframing or inviting in to different narratives I guess. Those alternative stories about what, what this might mean. …

So I guess in some ways, it feels like there's some subversion in what we're doing in the sense that, people bring a normalized picture of the world, where often they're disempowered or the victim of or feeling that they're at fault. So it does feel like part of the subversive nature of therapy I guess *laughs*, is to… to turn it on its head to have a look at it really. And quite a different picture. But not subversive in the sense of not being transparent to the client. But, so in terms of the bigger picture, yeah.

Halima's narrative again highlights how when exploring shame associated with trauma, sociopolitical narratives around race, gender and class are often involved in creating or compounding this shame. Like Tobias' narrative above, Halima's position in these conversations is an active one. She describes herself as facilitating and exploring, questioning or reframing these internalised narratives, such as those about race, class or gender. This highlights the collaborator and resistor role which is taken up by therapists in externalising sociopolitical narratives alongside survivors. While suggesting she follows the client in what they bring with their narratives, she also acknowledged that she co-constructs the experience, given that she may be more likely to pick up on narratives she is familiar with. In describing this particular element of therapy as subversive and a radical activity, Halima claimed a role of activist

within the therapeutic space, where she engages in resistance to those dominant narratives through externalising them and exploring alternative, counter-narratives. The tension inherent in this active role is clear as Halima went on to clarify that this subversion must be 'transparent' to the client. Like other participants, Halima expressed an awareness of the power that she holds when exploring these narratives and introducing other possible narratives. She expressed this awareness in her collaborative language, saying she 'invites' the client to explore different narratives or meanings.

De-Centering Deficit and Blame from Self to Systems

Multiple participants also described normalising experience and de-centering deficit away from the client as an essential process that targets or has the potential to transform shame and self-blame. This normalisation was one in which distress and experiences which resulted from trauma were normalised as opposed to the trauma itself or the unjust sociopolitical context surrounding it. In describing work exploring gendered expectations of young woman who have experienced sexual violence, Susan said that exploring these factors was *'creating the opportunity to walk around and perhaps take a different view, and to normalise as well. I think that's probably a really important part of it is to normalise that.'* Susan did not use the explicit language of externalisation of narratives. Still, she described a similar process by which she invites clients to a conversation in which clients are *'able to look at it from a different perspective, to be able to walk outside your trauma and look back at it and look at the factors that contribute to it, rather than being stuck in the middle of it'.* Normalisation of the struggles clients face, and the symptoms or distress they now experience, was often described as responding to a feeling of brokenness or badness which many survivors experience. In the following quote, Maya explained how exploring these stories can normalise survivors' experiences and thereby help shift from a shame filled identity of 'bad'. This quote illustrates how externalising and exploring these narratives can help shift from a stuck position associated with shame, to a place of more possibilities.

> Maya: Yeah. I think like, shame is often related to feeling like a bad person, right? And that's really a stuck position. Because if we're a bad person, then nothing we do matters. Like, we can't change anything. What's the point? Bad. But if we can look at

> why that has been constructed, and it's not like a fixed state, but like a story that's been fed from all of these different kinds of norms and angles, and people and support it in lots of different ways. Then yeah, it changes that… that identity, I guess, yeah, yeah.

In Maya's narrative, she also illustrates a process of de-centering which can occur when narratives about shame are explored. By exploring the sociopolitical context, and specifically the dominant narratives they may have internalised, survivors could understand events in their life differently. Rather than traumatic events being a reflection of themselves, they could re-imagine them as a result of the broader context and structures which helped enable them. Invalidation or silencing from loved ones following abuse, for example, could be understood as about those loved ones' own context and beliefs, rather than about the survivor and any perceived deficit within them.

In describing a trans client who experienced an invalidating response to abuse in their home environment as a child (which was also influenced by homophobic and patriarchal narratives), Kate describes this de-centring as removing some of the 'sting'.

> Kate: I would say we talk about it at least every second session. Yeah. And, you know, and kind of going, No, it's not okay. It was not ok to go through that. I'm… not to say that the people are wrong. They were culturalised like that, you know, so it's kind of trying to take out the sting of it. Yeah.

Kate balanced validating that an experience was unjust at the inter-relational level while also exploring the systemic factors that contribute to a person's behaviour in order to de-centre that unjust behaviour. In doing so, the person's abusive behaviour could be seen in the context of systems that enable and perpetuate conditions for it rather than simply one person targeting the survivor due to any deficit within the survivor.

This normalisation was often done through highlighting the strengths and resilience that survivors had displayed in the face of trauma or injustice. Tobias discussed a survivor he worked with who

experienced shame after a sexual assault. He discussed her internalising beliefs that it was her fault due to not fighting back more:

> Tobias: And what a courageous choice it was, was how we ended up framing it. And she was able to see herself less as a 'I was a passive person' and more of a courageous person who chose to protect her kids in the face of mortal danger.

Like in earlier narratives, Tobias shows his active collaborator role in this process of reframing through his use of 'we'. Not only did they normalise the survivor's response to violence but also explored the ways in which the response that the survivor had previously felt shame about was, in fact, one of courage, survival and protection. This echoed other narratives which described exploring survivor strengths and resilience in the face of, not only their interpersonal violent trauma, but also in the face of marginalisation and oppression.

Validation and Witnessing of Experience

Many participants described validation as a key tool used with clients in conversations about sociopolitical context. Participants described the ways in which many survivors had experienced ongoing and pervasive invalidation in relation to sexual or interpersonal violence, but also in relation to identity based discrimination and marginalisation.

Participants described different ways they provide validation. For multiple participants, providing an affirming and validating response to experiences of discrimination, marginalisation, and injustice was particularly powerful because of the power they hold as a therapist as a representative of society. Lisa reflected on this when answering a question about what key therapeutic benefits she has seen as part of exploring sociopolitical context and narratives with clients.

> Lisa: Well, on a really basic level, it's validation. Because you, you are vulnerable to a certain degree in a session, and you're exposing yourself to somebody who's representing society and who is a human being. And every time you make yourself vulnerable, you might get hurt. Somebody might say: 'Oh, there's no homophobia anymore. Why would you be bothered about that?' And, you know, I, I don't think that

> wellness means that all of a sudden, after a life of mistrust, you can trust everybody, because you shouldn't trust everybody, like you need to be discerning and to test out what's a good and wise way to trust people. But at its best, somebody is vulnerable and explaining how painful something was. And so it's really validating and settling as a human being to have somebody say, that's really awful. I'm really sorry that that happened to you. It's kind of a connecting opposite of isolation. Like, we are seeing this together, you and I, we are noticing the pain and the impact of this on you together. And if when you bring in the systemic part of it, it's a bigger version of that because all of a sudden, you and your experience of homophobia is now connected to everybody else's experience of homophobia too. You're part of this whole group of people who have had this experience and it hasn't been okay. And it's been a struggle for them. So I think trauma and secrets and abuse, lead to silence and having conversations that are noticing your experience and the systemic parts of that is the opposite of that. It's opening it up, and it's connecting you to a broader experience. And other people.

Lisa described how survivors make themselves vulnerable when sharing an experience of discrimination or marginalisation, which makes the validation all the more powerful. She also emphasised here that sharing this may be difficult due to other experiences of invalidation leading to mistrust or hesitancy to trust. Lisa and other participants described a process of validation here that counters the experiences survivors have had elsewhere. She goes on to express something that multiple participants described: that the act of sharing their story and it being witnessed and validated was an act of resistance to the abuse itself, in that it resists the silence and isolation which abuse and violence often enforce. Lisa reflected on how this sharing and noticing (and the experience being validated) also connects to a broader group of people who have had a similar experience (the sociopolitical). The language Lisa uses here of 'noticing' is similar to that of witnessing. This witnessing was also expressed by multiple participants in standing alongside, noticing and acknowledging the experience, injustice and pain together.

Validation was mostly discussed in the context of the therapist providing this directly to the survivor when a story or experience was shared. However, other tools were also used to support survivors in experiencing validation. Halima described the power of sharing in therapeutic groups, sharing that *'what I've also seen, that's really therapeutic, is when people get to hear each other's stories, because it challenges that dominant narrative even more…'.*

Some participants emphasised a need for non-neutrality, or what Alex described as *'getting off the fence'*, to provide this validation and witnessing. This was sometimes described as affirming the experience and returning to a validation of the injustice over and over again, reminding the client that it was unjust and unfair. Lisa described taking a non-neutral stance to counter victim-blaming narratives and returning to this consistently throughout therapy.

> Lisa: Like, at the very, at a very basic level, part of what you're talking about is my role taking a non-neutral stance with people's experiences. And so I do that all the time. …..And there's kind of all these layers to hearing that and shifting into actually believing it and believing it in different ways. Like it's not just a one off, 'oh my goodness, that wasn't my fault, how about that?' It's kind of like, bits of them kind of know that and bits of them don't and so I think partly why it feels like for me, what you're asking about is like a thread which is just kind of all the time in there because we come back to it and come back to it.

When Lisa says *'what you're talking about'* she is referring to conversations about sociopolitical factors involved with trauma. She emphasises that while some people can get a 'sense' of the therapist believing them and believing that they were not at fault for the abuse or violence they experienced, for some survivors it is important and influential to affirm this directly repeatedly. Lisa gives validation by providing a counter-narrative to the victim-blaming narrative that survivors may have internalised and heard in wider society or from the perpetrator. The concept of layers rises here as it did in Theme One. Survivors may hold beliefs at different levels of experience and these victim-blaming beliefs or narratives may be held at different layers of a person's understanding. The therapist must therefore come back to this

non-neutral validation repeatedly as these various layers of believing or resisting dominant victim blaming narratives are reached.

Affirming Rights to Just and Fair Treatment

Priya described a kind of validation of fundamental rights and entitlements that is sometimes necessary, especially with more marginalised clients. She described working with survivors of the Christchurch Mosque terror attacks, and that she would validate their experience of racism and religiously targeted violence, as well as the invalidation and minimising they had experienced for years before this attack, when raising this Islamophobia with institutions or in broader society. In doing so, she described a response of gratitude from the survivors which she found uncomfortable.

> Priya: So the results, which I found quite grating, and that's kind of broader than just the focus in the mosques. Weekly, I might experience is that when I validate that, or they tell me about it, and I respond in the way that I realize they were expecting invalidation, is gratefulness, as if I'm doing them some incredible service. I find that quite repugnant because I feel like this is basic human decency and I'm not doing anything above and beyond and the fact that you're experiencing it as such, I find it painful. Just veering away to another client, a much more recent client who was sexually assaulted in the course of her work by somebody that she had been working with, like her client for many years. And this client behaved in an obnoxious way with her suddenly out of the blue, and she was very shocked and humiliated. And the fact that I just did what, you know, what I do with every client. And she found this, you know, she's just written me emails about how grateful she is, and she doesn't want to take up the space, that other people “who are New Zealanders” who have suffered more serious harm, she's really appreciative and..and so, you know, I wrote to her to kind of just say, you know, this is your entitlement. This is what happened to you. This is what ACC makes available to anybody in your situation. You don't have to thank me over and over, you know, I'm pleased that it's working for you. But please

> take it as a right, something like that. And so coming back to the mosque focus, there was a similar sense that somehow, they were incredibly grateful. And given what had happened in the mosque if it felt quite, yeah, sickening or disproportionate, their appreciation that was my overwhelming thing about how appreciative people were that, and this is all kind of speculation on my part, because this wasn't in the content of the therapy, but that somehow they didn't expect that. That somehow they were expecting invalidation or redirection or reframe, or to say, well, it's happened now let's move on.

The gratitude places Priya in the role of providing something above and beyond or that they may be undeserving of, a role she is not comfortable with given her desire to affirm the survivors' experience and rights. Like other participant narratives, this illustrates the power that the therapist can hold to provide a validating experience (in this case, validating of Islamophobia) which counters that which survivors may have experienced elsewhere. The excessive gratitude shown by survivors reinforces the power therapists hold. Priya suggests this must also be met with a clear affirmation that this validation is both what they deserve and are entitled to. Affirming this right was framed by Priya as one way she resists perpetuating a narrative where she, as a representative of New Zealand society, is somehow framed as superior or as a saviour.

In summary, throughout narratives in Theme Three, tools of externalising, normalising, validation and witnessing were used to target shame and self-blame. This shame and self-blame were centered around oppressive internalised narratives related to the violent trauma directly, but also related to other experiences of marginalisation and oppression, which then compounded trauma experiences. Participants illustrate the potential of the strategic use of therapist power. Participants acknowledged the co-constructing role they hold in their position, which is employed in externalising and exploring societal narratives. They highlighted the active and non-neutral stance which was involved in countering unjust and traumatic experiences. This illustrates how therapist power can be used in the practice of justice-doing within therapy, and in countering the experiences of power-over which may have been experienced

by survivors elsewhere. Theme Five will explore how therapists spoke reflectively on the use of this power in their role. Reflexivity, curiosity and a client-affirming stance were all also involved in the tools described, highlighting the interconnectedness of the themes. As described in Themes One and Two, a relational approach where curiosity and a reflexive openness to what the client brings is also evident in the participants' descriptions of being with, witnessing and collaboratively externalising narratives.

Theme Four: Building Agency and Resistance

This theme includes the various stories and reflections shared by participants that centered around the building of agency and resistance. This was described as part of the process and/or outcomes of conversations about sociopolitical context and dominant narratives. This agency and resistance building often occurred within the same conversations that both externalise narratives and begin to shift shame and blame, which were discussed as key outcomes in the last theme. Some participants acknowledged how survivors may lose agency in certain circumstances when they 'become' the story of this trauma and/or oppression and shared the ways they navigate this to both validate oppression and work towards a greater sense of agency. Participants also explored where discussions about politicised context or events were a gateway to exploring individual emotion and experience. The stories offer counter-narratives to dominant discourses which individualise therapy and trauma. Instead, they speak of how bringing in the broader political context of survivors' lives can lead to an exploration of and invitation to various forms of agency and action.

Visibilising Alternative Actions and Spaces to Occupy

Participants described how acknowledging the structural and contextual reality within which clients live can provide an opportunity to explore possible actions within that reality. Sometimes the possibility of new forms of agency was through the exploration of context and narratives shared by clients. Other times, this included some sharing of knowledge or ideas, such as about rights as migrant women, or a suggestion of what narratives may exist about trans people in society, which may be relevant to a survivor's situation.

In the following passage, Tobias reflects on different reasons he thinks discussing toxic masculinity and rape culture can be therapeutically useful. He suggests that identifying and exploring dominant and harmful narratives enables more possibilities for survivors to act within that reality and more choices of where and with whom the survivor wants to spend time.

> Tobias: And lastly I guess it would tie into exactly what the nature of their thoughts about themselves and the world are. If you think to the PTSD criteria it talked about, usually the world is dangerous etc. If we relabel it as a cultural thing, it doesn't change that the world is dangerous, but it means it's AN aspect of the world, rather than the whole world. And it means that, if I know there's a toxic culture at the rugby clubs, actually you know what? I don't care about rugby that much, I'm gonna take up water polo instead. That kind of stuff lets people make some choices given the reality of what I can't change for them, which is making the world safe... would be the other time I would bring it up.

An exploration of rape culture and toxic masculinity, as Tobias described, resulted in survivors being better able to assess social contexts and identify if such narratives and attitudes were present. Tobias explains how the very act of exploring the 'cultural' elements of what makes the world unsafe (in this case, rape culture), brings into existence counter narratives. If this dominant narrative can be named, then other, safer spaces and narratives can also exist, creating different choices they may act on. Tobias' narrative also offers a counter narrative to a pathological model of trauma where the survivor's beliefs about safety are deemed illogical or part of a pathology; he advocates instead for acknowledging and validating the reality of the risks and realities of rape culture and explores agentic possibilities that emerge from such acknowledgement. This narrative echoed that of many others, where exploring damaging societal narratives led to new possibilities and actions for survivors.

Fostering Resistance

The participants' stories also reflected on the fostering of resistance and more collective action as one possible outcome for clients of contextualising practices. Halima reflects below on the therapeutic

impacts of exploring narratives about gender, race, and class. Her story shows how dominant narratives about ability and sexuality had the effect of 'constraining' or disempowering this young person or limiting agency. Making these narratives visible enabled the young person to see possibilities for themselves beyond those narratives; consequently, agentic counter-narratives were adopted.

> Halima: I think it is hugely impactful. Often because it just gives people other possibilities of, of seeing their own potential, you know, seeing what the constraining narratives might have been on their head. Like, I've worked with this young man with autism, the last school I worked at, a highly functioning young man, and also identified as non binary. And he was really excluded from his peer group and in the school. The narrative around his leadership capacity was quite marginalised. So I did quite a lot of work with him, ended up in the senior management group. He ended up just running this whole several, like a wellbeing focus for the year. One was around rainbow youth. So we had a rainbow assembly, we had a wellbeing mental health assembly, and we were going to give one about cultural differences and racism, but then we got locked down. *laughs* Yeah, that was just mind blowing. It's kind of like, his sense of himself just took off. Yeah. And I think it was unpacking his experience of autism and how he was treated, because he was from the UK, and bullying. Yeah, kind of, I suppose the narrative around ability or disability was really oppressive to him. Yeah. But yeah, when he was able to unpack it, and I suppose, just in that way of trying to be totally equitable about his capacity. And him being heard, I suppose, and understood. Unpacking that powerlessness, he felt. He really flew. just a really powerful thing.

Halima described how unpacking narratives around his ability enabled this young person to re-frame their capacity and to see other possibilities for the impact and agency they could have in the world that resist the stories they had internalised. The client goes on to create and run well-being-focused

assemblies, and in doing so, they turned their new critical consciousness of the issues into resistance and provided a space for others to explore the same issues.

Maya also reported exploring actions of resistance as a key therapeutic benefit of conversations about sociopolitical context. As a consequence of this exploration, clients connected to movements of change and others who have similar experiences.

> Maya: Yeah. I think identifying them helps with that. I think, also what helps is like identifying points of resistance. So like, by changing how I feel about myself, I am no longer being complicit in this narrative about, you know, women or trans people or brown people or whatever. And then if I'm no longer going to be complicit in that for myself, how can I help other people not be complicit in that? And then like, yeah, especially for people with trauma, I have found that that's super, like just having that power, feels really healing to know that there are things you can do, even though like structural oppression feels really massive and huge. But to put that energy somewhere, other than hating yourself, I guess is. Yeah.

Maya narrated a desire in clients to engage in wider movements for change. She describes this as a common outcome of externalising internalised oppressive narratives and shifting the shame associated with them. Maya describes this ability to not be complicit in harmful dominant narratives as power; here, power and agency are linked in important ways for the client or for both. Identifying the narratives increases the potential for power in the survivor through the opening up of a possibility of resistance. Giving visibility to the invisible creates power to act. This process of action is also healing in that it is an action that is directly resistant to internalisation and resists frustration, anger, and hate inwards. Later, Maya also described that this identifying of points of resistance, and of exploring how to share these possibilities of change for others, is often a part of the closing phase of therapy; an exploration of how to bring the powerful change they have experienced: '*And like, this has been really powerful for me. How do I bring that to other people? Like, Yeah. How do I fuck shit it up? *laughs* Yeah. (Maya)'.* Here she

describes how people often want to be part of changing the status quo, of collective action towards challenging the systems which harmed them.

Navigating Powerlessness

In participant stories, not all discussions around sociopolitical issues were described as seamlessly fostering agency and resistance. Monika and Lisa both explained how they balance acknowledging and validating experiences of marginalisation and oppression with the need to build agency. They described how sometimes clients may be involved in a process where identifying with the sociopolitical factors of their trauma and marginalisation is part of an ongoing sense of lost agency and experience an overwhelming sense of powerlessness. Participants were aware that a therapist has the potential to perpetuate a sense of powerlessness if conversations were not approached in a considered way. Both Lisa and Monika seemed keenly aware of the potentially problematic or victim-blaming language that can be involved in raising this issue. They expressed a desire not to perpetuate victim-blaming narratives. They wanted to emphasise the importance of acknowledging the injustice experienced by survivors. However, they balanced this with the importance of the therapist not feeding into a sense of powerlessness, which may be part of the very issues or dynamics which led the survivor to seek therapy. Monika suggests below that 'colluding' with this narrative is an easy trap for therapists to fall into, while also struggling to find language to describe this, which does not perpetuate victim blaming narratives.

> Monika: Yeah, not just joining people in victimhood. Which isn't something I would say out loud to many people because it's really problematic language. But it's really easy to just collude with, yeah, being persecuted.

Monika displays the use of dominant and counter-narratives simultaneously: a strategic use of narratives that individualise trauma when it becomes therapeutically relevant and useful and fosters agency, while observing and visibilising this individualisation's harmful potential. By suggesting she 'wouldn't often say what she said out loud', she suggests using language here that she would not use with her clients. Monika describes a practice of attending to the dynamic of 'victimhood' and loss of agency

through exploring a survivor's coping mechanisms and visibilising a person's role in their circumstances.

Lisa also storied how a loss of agency could be involved with a focus on the sociopolitical context of people's lives. She described how people can sometimes swing from resisting or not identifying with ISMs in their lives (Lisa uses the term ISM to describe marginalisation and oppression), to not being able to distinguish a self beyond them.

> Lisa: Yeah, that's when, when you become the story. So yes, I worry about it and Yes, I have seen it. I mean, it happens to everybody. I think it's a broader principle that we are all at risk of doing to greater and lesser degrees. That we have stories about ourselves. And sometimes we hold them lightly, and they're flexible, and we can just sort of use them helpfully, and other times they become us. And I've watched a swing sometimes happen for people from trauma is not part of my experience at all. It was nothing, or I literally can't remember, I've packed it off somewhere, and I don't really even know what happened. So it's like, you can go from trauma is nothing, and has no explanatory power, for how I am and how my life is at the moment. And then it can swing through to 'I am trauma', and I am a trauma victim. And every part of my being is about that. And I don't think that's ever true. I don't think that's actually ever true. It can feel like that. But there's a risk that, that we still get lost in the story….So, or that about the tension between seeing the effect that the world has on you, but also seeing the effect that you have on the world, like, they both need to be there. And for some people, everything becomes about the ISM for a while, you know, everything in my life is because of this ism, or this disability or this experience that I had. And I believe that, and I think there's evidence to support this belief, that a person's always more than any single kind of thing. I'm not saying the experience isn't important at that time. But getting caught up in thinking that it's all of you and explains everything, and there's no space for anything else in your life. I don't think that's helpful.

Lisa normalises this process of moving between feeling more and less agentic by highlighting how we all have stories about ourselves, which we can sometimes hold lightly or which may 'become' us. Lisa uses the phrase 'for a while' when describing this process, suggesting that this can be a common phase in people's trauma healing. In explaining how seeing both individual impact as well as the effect of our sociopolitical context, Lisa says 'they both need to be there'. Lisa's narrative flows between the importance of validating context and exploring agency and self within and beyond it. She appears to be highlighting the nuance involved in these therapeutic processes, a dialectical approach between individual and collective/systemic foci which centres on what might be most beneficial for the client within the relational space of the therapeutic encounter.

Lisa goes on to describe how she approaches this 'becoming the story'. Where this powerlessness and enmeshment of self with an experience of trauma and marginalisation existed, the therapist's role was described as facilitating a gentle exploration of processes at play within this dynamic, and of agency and self beyond or in resistance to the systemic or violent trauma they have endured.

> Lisa: Um, I would try and use language that's focused on behaviour and experience and stay away from labels. So bringing it back to them as a human being and helping them notice any variability in their experience, or variability in impact. So any other kind of stories or ideas they've got about other things that might have an impact on them or on what might be possible for them. So that you're kind of broadening the picture of who they are. In ACT, there's a concept called self-as-context, which kind of describes a little bit about what we're talking about now. And so I would be thinking about it as a self-as -context issue. And therefore using self-as-context ways- trying to help people see a distinction between them as a person and the experiences that they have. Trying to help them see themselves as a container for the experiences that happen in their lives. Um, but also still, it's still true that the experience, that the system, that the ISMs does have an impact on you. I'm not at all saying that that's not important, but looking at the difference between it being important and being the

> whole story. The answer to everything is, well, I was sexually abused. Well, no, there's more to you than that.

Lisa described 'staying away from labels,' linking to a critique she also raises elsewhere about diagnostic labels. Here, she suggests such labels may contribute to this sense of powerlessness, of 'being' your diagnosis. Again, externalising is described as needed to explore agency and self beyond the 'ISM' while still acknowledging its impact. Lisa describes using the ACT concept of self-as-context to explain how she helps survivors differentiate between an experience of trauma and oppression and themselves.

Politicised Events and Experiences as a Gateway Back to Individual Experience

At times discussions about sociopolitical context or events were positioned as useful within therapy more for the gateway they provided to link back to individual experience. For example, someone's emotional response to a political event may indicate a wider relational pattern and provide an opportunity to explore how politicised opinions may also have links to individual patterns and dynamics. In these narratives, the contextual discussion allowed for survivors to reach a place of action through enabling a discussion of their own emotions and experience.

Tobias discussed how using a current political event about which most people experience some strong emotion was a way to explore feelings which may otherwise be difficult to access or discuss. Tobias described talking about the war in Ukraine as a way to explore anger, which a survivor may have trouble accessing about their own trauma. Likewise, Tobias reflected on how he worked with a survivor to explore their anti-feminist views in order to access underlying emotions and beliefs about themselves and the world resulting from their trauma. Alex described how a client's exploration of narratives about gender and gaining comfort with not fitting any dominant narratives around gender, built a groundedness and resilience that enabled them to then unpack and explore their violent traumatic experience(/s).

Monika described how she has come to understand that sometimes clients raising political views or events can also be a diversion from exploring painful emotions or feelings. She explains her process of gentle exploration and witnessing of that dynamic with clients. Throughout our discussion, Monika returned to expressing how she tries to bring people back to their own experience and emotions when

clients raise political events or opinions. This illustrates a way Monika harnesses these conversations to facilitate the building of understanding of self, power, and agency in the world. In the below passage, Monika gives an example of this, where a client comes to a session wanting to discuss the Supreme Court decision in the United States which overturned the Roe v Wade, thus threatening abortion rights. After outlining how she joined her client in sharing outrage about the injustice involved in the situation, Monika went on to explain how she brought this situation back to her client's own experience.

> Monika: And she's just, she's very, very passive. She can't ever…it's been very hard for her to access any anger about the horrific mistreatment that she's experienced in her life.… And anyway, so she, so having her all full of rage and anger. So it was lovely. And I did, like I pointed out, it's much easier to be angry about other people isn't it. And there were several times she said, you know, if this happens, there's just so many bad things that are gonna happen. A couple of times, I said, lots of bad things have already happened. Kind of just trying to link it in... At another point in it, she said, you know, just imagine if I was to… if I was to get raped and, and be pregnant and not be able to have a termination. I can't quite remember the example. And I said, or imagine you were, you were sexually abused all through your childhood. She just laughed. Like, that sort of like, well, you know, we've already got stuff to be angry about; what really happened. We don't even need the hypothetical! 'Yeah, yeah, I get what you're saying.' (mimicking client)

In Monika's story, she was happy when her client expressed anger and rage about injustice others are experiencing; an emotion she has trouble accessing about her own experience. She described a playful interaction where she brings attention to the injustice of her client's own experience, suggesting it is also worthy of a sense of anger and rage. This illustrates how humour can be brought to these conversations where the relationship has been built to support it. Monika later discussed this approach as being in contrast to how she used to operate as a social worker. She reflected how she would not have understood some of the deeper, individual processes which may be at play when she was working from a social work

lens (and did not have psychotherapeutic training), and that she now understands her role to be exploring the individuals' own experience and agency within their context, rather than staying only at a more structural level of analysis. Monika's understanding of facilitating change and empowerment for survivors appears to have shifted, her focus has become more on the complex individual processes which can be shifted, within a wider acknowledgment and validation of sociopolitical context. Building agency within clients' lives involves exploring and acknowledging sociopolitical context, alongside working with the individual's own response to their context and power within the world.

In summary, Theme Four outlines the ways in which conversations about sociopolitical context in trauma therapy with survivors worked to build agency and empowerment, fostered resistance and connection, and was a gateway towards further therapeutic exploration. Participant narratives also outlined the nuanced and reflexive stance involved in the balance between building agency and honouring experiences of injustice, while being aware of not further entrenching narratives of victimhood.

Discussion: Survivor Outcomes

Themes three and four focus on how participants described the key outcomes and therapeutic benefits (or occasionally, risks) involved with having discussions which explore sociopolitical context in therapy with survivors of interpersonal violence. In theme three, shame and blame are described as key targets of these discussions, and the ways in which shame can be transformed through such discussions are explored. Externalisation, validation and witnessing are discussed as key therapeutic processes involved in this. In theme four, therapists' stories which involve agency and resistance are described. Participants emphasised how conversations that make societal narratives and oppression visible empower clients and thereby develop agency and assist in connection with broader communities and resistance. They also highlighted the reflective and relational therapeutic skills involved with occasions when a focus on sociopolitical context can perpetuate self-limiting and non-agentic beliefs or dynamics.

Shame and Sociopolitical Context

Participants in this study highlighted the reduction or transformation of the shame which survivors experience as a key outcome associated with holding discussions about the sociopolitical context of their trauma. In participant stories, which often focused on therapy with sexual assault survivors, shame was inextricably linked to the sociopolitical narratives which their clients had internalised. Most participants highlighted victim blaming narratives and rape myths as central to the development of self-blame and shame which impacted clients/survivors. These findings corroborate research previously outlined which has argued that the shame which survivors experience after violence is not only perpetuated by societal rape myths and victim-blaming narratives but can even be in large part created by it (Bhuptani & Messman-Moore, 2018; Gavey, 2018; Kennedy & Prock, 2019).

The findings of this research highlight how exploring sociopolitical context of victim blaming narratives and rape culture were an essential element to targeting the very core processes of shame and self-blame involved with this trauma and its effects on survivors. In explaining the role they saw of these internalised rape myth narratives, therapists' stories demonstrated significant knowledge of rape myths

and rape-culture narratives and how these played out in client's lives. Therefore, findings also highlight the importance of the therapist having developed knowledge about this rape culture and relevant social narratives key to the post-trauma experience.

Shame and Isolation are Compounded by Marginalization and Discrimination

Rape culture intersects with other forms of oppression and violence to make marginalised groups uniquely susceptible to violence (Gavey, 2018) and less likely to receive appropriate support and help (Dworkin & Weaver, 2021). As has previously been outlined, people with multiple marginalised identities face compounding experiences of trauma, which exacerbate each other (Crenshaw, 1991; Gavey, 2018). In participant stories, the shame which was targeted through discussions about sociopolitical context was not only associated with gendered rape culture and victim-blaming narratives but also experiences of identity-based discrimination and marginalisation. Intersectional marginalisation worked to instill shame and to compound the shame experienced by survivors after violence (and vice versa). Stories included discussions with survivors which explored the racism involved in victim blaming myths, experiences of transphobia, intergenerational colonisation and Islamophobia, for example. Such stories may be seen as examples of exploring the pervasive attunement to shame which researchers have identified as a result of ongoing experiences of marginalisation and discrimination (Bartky, 1990; Dolezal, 2022)

Participants described working with the feelings of low self-worth, shame or internalised discrimination and the social narratives associated with them as crucial in the process of therapy with violent trauma. This is supported by research, which shows how experiencing discrimination is linked to higher rates of post-traumatic stress after interpersonal violence (Cabral & Pinto, 2023; Eshelman et al., 2024; Gold et al., 2007; Salim et al., 2023; Straub et al., 2018). These findings highlight the importance of a therapist's ability to explore broader oppression and discrimination with clients who have experienced interpersonal violence. They show how the ability to work with the sociopolitical context of interpersonal violence is not restricted to societal narratives around rape and violence alone. Rather, a therapist must be

familiar and comfortable exploring the intersecting and compounding experiences of oppression and identity-based trauma which may be influencing someone's sense of identity, worth and meaning making around the violent trauma and themselves. This finding builds on the previous theme which highlighted the importance of being able to explore any layer of experience with a client/survivor, and to hold a relational approach which involves going where a client needs to go.

Externalising the Narratives

When describing their discussions about sociopolitical context and the worth they saw in them for their clients, participants often used the language of externalisation. Some explicitly discussed externalising narratives which may be contributing to shame, such as victim-blaming narratives or gender or race-based narratives that have influenced how survivors view themselves, in order to explore them and make alternatives possible. Others discussed stepping back or stepping outside to look at an issue to highlight narratives or beliefs which may have been invisible. Susan, for example, discussed how we are often caught up in the 'Borg' - a term used in the show Star Trek to describe a group of people with a hive mind. She discussed the need to get outside of this 'borg' and to explore what has shaped our thinking. All participants, in some sense, described a drawing out and externalising of the narratives and sociopolitical experiences which have shaped clients' views of themselves and their sense of shame or deficit. Susan described this as developing the ability *'to be able to walk outside your trauma and look back at it and look at the factors that contribute to it, rather than being stuck in the middle of it'.*

While the concept of separating a person from a problem or belief is not exclusive to any therapist modality, externalisation as a practice within therapy is a core aspect of narrative therapy (Carr, 1998), as outlined earlier. Externalisation in narrative practice is particularly relevant to these conversations as it works upon the assumption that a persons struggles are often rooted in the sociopolitical. Within narrative practice, externalising dominant stories in people's lives should include explicitly seeking to visibilise ways that different levels of discrimination cause problems in people's lives (White, 2007). It is a technique which aims to separate people from their problems but also from their internalised views of themselves, and to make re-authoring people's narratives and understandings of

themselves possible. In this study, only two therapists explicitly mentioned having been trained in narrative therapies. However, it is significant that the language used by all participants aligned closely with this concept. Findings indicated that therapists engaged in externalising conversations in order to draw out sociopolitical context as it impacted survivors, often due to interalised harmful and oppressive societal narratives. These findings suggest that externalisation and tools involved in externalisation in narrative practice may be particularly useful for therapists in learning to discuss sociopolitical context and practice in socially just ways effectively.

In discussing externalising internalised narratives, participants talked about the power of making their trauma less personal and not tied to any brokenness or deficit within the person. Rather than a shame-based narrative and one which self-pathologises and self-blames, externalising the social structures and stories which have contributed to a person's experience and beliefs enables a more flexible view, in which dominant narratives are available for critique and re-storying. This is also explicitly the goal in externalising conversations in narrative practice, where seeing a problem or experience as separate from identity is linked to reducing feelings of shame (White, 2007). As Dupuis-Rossi and Reynolds state, in discussing the power of understanding trauma politically

> …the responsibility for it is handed back to its rightful source, the Settler government and other historical and contemporary colonial forces. […] understands her experiences as historical, political, social, and specific to a colonial agenda, as opposed to being experiences that reflect her worth-lessness, unloveableness, rejection, and abandonment. (Dupuis-Rossi & Reynolds, 2018, p. 305).

The process of drawing out and exploring clients' internalised narratives about themselves due to marginalisation was described as an active one in which the therapist is directly involved. Participant stories involved their positioning as therapists as actively resisting unjust social structures and narratives in the therapy process alongside clients. Some participants even admitted that there were areas or issues (such as racism or sexism, for example) where they may be more likely to explore narratives with clients

in depth, due to their own knowledge or lived experience. These findings emphasise the co-authoring role which is taken up by the therapist in this process of therapy, and extends it to these sociopolitical conversations (White, 2007). As has been argued by many including indigenous (Linklater, 2020), narrative (Combs & Freedman, 2012) and feminist (Burstow, 2003) scholars and practitioners, an active role in resisting oppression and exploring power is required in trauma therapy within a social justice and decolonising approach, otherwise a therapist leaves the status quo of unjust power relations unchallenged. The findings support that this active and non-neutral role is required, at times, within these conversations. This therapist's use of power and non-neutrality is explored more fully in the final discussion section. However, such findings highlight the need for ongoing reflexivity and exploring the co-authoring role and how a therapist influences the externalising process. What was made visible through this process of externalising could then be validated and witnessed, opening up new agentic possibilities, which will be described in the following sections.

Validation of Sociopolitical Experience Inextricably Tied to Traumatic Experience

Participants often described validation as a key tool in discussions about sociopolitical context and to counter blame and shame associated with the dominant narratives client/survivors may have internalised. They discussed affirming and acknowledging the reality of what had happened to survivors, but also the injustice of what they had been told or led to believe about themselves or their experience, for example, victim blaming stigmatisation, or racist or transphobic narratives. Some participants referenced this validation as something that had to be returned to repeatedly, that a validating stance was necessary throughout therapy. This focus on validation in trauma therapy aligns with research which suggests that experiencing invalidation is a key determinant involved in the development of trauma-related symptoms following abuse or violence (e.g. Hong & Lishner, 2016).

Linehan (2015) defines traumatic invalidation as “extreme or repetitive invalidation of individuals’ significant private experiences, characteristics identified as important aspects of themselves, or reactions to themselves or to the world” (p. 304). This traumatic invalidation is particularly relevant to marginalised groups whose very identities are systemically invalidated in society through

microaggressions, prejudice and discrimination compounded by societal norms and narratives, and institutions which perpetuate this or fail to protect people from it. Indeed it has been argued that chronic invalidation, for people who hold marginalised identities, may be the key causal factor in the poor mental health outcomes associated with minority stress (Cardona et al., 2022). The stories shared in this research placed an emphasis on repeated validation not only of the injustice of violence or traumatic events, but of experiences of wider stigma, oppression and marginalisation. Indeed, some participants highlighted the concept of layers here. Working through identity based invalidation and oppressive narratives based on their gender identity, for example, opened up the ability and sense of safety for someone to be able to then work with and process their experience of interpersonal violence.

The validation of someone's story, trauma and the violence they experienced, and its effects, should be expected within trauma therapy. However, the stories shared in this research highlights how experiences of marginalisation and discrimination are inextricably linked to experiences of violence and are equally vital to address when important to a client/survivor. In order to provide trauma-informed care, a therapist should have the skills to acknowledge and validate this sociopolitical context which both compounds the effects of violent trauma and is impossible to compartmentalise from it.

A Witnessing Stance to Injustice

> A witnessing approach requires that we situate personal suffering in its sociopolitical context and resist the individualisation and medicalisation of suffering. Activist practices of witnessing are enacted through an ethical stance for justice-doing, which includes the duty of the witness to work to change the social contexts of oppression, and engage a true reckoning with power (Reynolds, 2020, p. 347)**.**

While validation, or an affirming and acknowledging of someone's reality and experience, was described in participant stories as a key tool that therapists used when discussing sociopolitical context, this was often described as a broader stance or way of being with the survivor which aligned closely with the concept of witnessing. While validation is affirming someone's reality and experience, witnessing is a way of *being with* a person (Herman, 1992). Witnessing practices come in various and diverse forms

(Goodman & Meyers, 2012). However, witnessing literature has some common threads that weave together its multiple traditions. Witnessing has a long history within social justice and indigenous activism, intending to hold Governments and corporations accountable for abuses of power (Reynolds, 2020). Witnessing also has a history in therapeutic practices such as narrative and constructivist therapies (Barak & Stebbins, 2017). Constructivist therapies (including narrative therapy) suggest that witnessing, in which a therapist (or other invited party) serve as a compassionate audience to a story which may not have been told, is a central component of how change occurs for clients (Barak & Stebbins, 2017), and that it goes further than validating experience to validating existence (Felman & Laub, 1991). Reynolds describes taking on a witnessing stance in therapy as one which bridges the worlds of activism and therapy (Reynolds, 2020).

Judith Herman, in her seminal work *Trauma & Recovery* (1992), describes witnessing as key within the trauma therapy process, and ultimately one which is inherently political. Witnessing, according to Herman, involves a willingness to be with someone fully as they share their story, to fully receive the story and to be present in holding the pain or other emotions alongside the survivor. In doing so, the therapist-witness acts in opposition to the isolation and disconnection which trauma leaves with survivors. Such an act explicitly sides against a perpetrator of violence, and with a survivor, something essential in trauma-therapy with survivors (Herman, 1992). When witnessing involves hearing stories of trauma involved in chronic invalidation of identity, marginalisation and oppression, then, witnessing involves an explicit stance of being with the survivor in speaking truth against what is a culture of silence about this injustice and isolation for survivors.

Findings clearly showed how witnessing involved this connecting as an act of resistance to the isolation of violence and oppression. Participants spoke explicitly of this ‘connecting opposite of isolation’ (Lisa) that comes with standing alongside a client as they tell their story of, for example, racism or queerphobia, and how the power of this may be amplified by the fact that a therapist may act as representative for society. Witnessing, then, involves a use of the power which a therapist holds to act in resistance to the power the perpetrator (which in some cases may be society itself) has wielded to isolate

an disconnect, and instead to use power to be with, to connect. In doing so, the witness highlights how shame does not rest with the survivor for their experience.

Other literature has also spoken of the connecting and 'belonging' power of witnessing. In witnessing practice, Reynolds (2020) argues that an ethic of belonging and solidarity is practiced, in resistance to the dislocation that occurs through a pathologising and individualising approach of medicalised trauma narratives, which serve to further the narrative of the survivor being the source of deficit. In being witnessed in their story, which involves an opportunity for new narratives and realities to be voiced, White (2000) argues that a person may gain a sense of membership rights to a group. He calls this the opportunity to be re-remembered. This links the concept of validating existence, and to joining communities of resistance which occurred following these therapeutic conversations, which is explored later.

Participants repeatedly spoke of normalising a person's responses to trauma and injustice and removing them as the cite of deficit of brokenness as a key part of exploring sociopolitical context. These stories spoke to a highlighting of strengths within a person's story, of their acts of survival and resistance in the face of trauma and injustice. Morley (2015) discusses practicing a stance of being a 'hopeful witness' within therapy, where a therapist honours and witnesses what people have done to survive and cope in the face of injustice and violence. Alan Wade describes resistance as any

> mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with or oppose any form of violence or oppression (including any type of disrespect) or the conditions that make such acts possible (Wade, 1997, p. 25).

Resistance can include small acts of everyday resistance which might include behaviour which is generally pathologised under a medicalised view of trauma. This is also linked to witnessing, which involves not only being a compassionate audience of the political realities of people's lives, but also bearing witness to the resistance, courage and wisdom of survivors in their creative responses to violence and oppression. Reynolds (2020) identifies the acknowledging of a person's acts of resistance as central to

the justice-doing stance involved in witnessing. Findings of this study emphasised the importance of highlighting strength and resistance in response to trauma where this may have been previously pathologised, and show how this can only be done once the sociopolitical context of someone's life is aired, told, externalised. Within this contextualising, someone's acts of everyday resistance to these realities can be witnessed.

Building Agency and Resilience, and Navigating Powerlessness

> Agency requires critical consciousness, the ability to define the situation so as to unmask ideology, especially the ideologies of inferiority that afflict the disadvantaged…Selves who accomplish linguistic resistance may go on to engage in collective action, building equitable social worlds (Musolf, 2017, p. 12).

Enhancing agency is a key concept and element of therapeutic processes across different psychotherapy traditions (Williams & Levitt, 2007). Though agency is a contested concept with different definitions across different modalities, it includes the ability to change thoughts and behaviours, including in aid of personal or goals. The terms agency and empowerment have come to at times be used interchangeably, however important differences exist. While agency refers to a static or individual ability to act, empowerment refers to someone's capacity to make choices and act on agency within the context of structural power. While agency is a state, empowerment is a process of change (Drydyk, 2013), and one which expands power where it was previously more limited (Kabeer, 1999). Richardson (1994) argues that empowerment is also a more relational and collective term in that while agency describes an individual ability, empowerment refers to the power that is gained relationally and through connection.

Social oppression acts to limit agency in people's lives and therefore is important to address in therapy (Prilleltensky, 2003). Many therapeutic modalities highlight the importance within therapy of exploring factors limiting internal and external agency, which should include the sociopolitical context of people's lives (Williams & Levitt, 2007). However, Winter (2019) suggests that therapists may neglect sociopolitical factors in developing formulations with clients due to the well-intentioned desire to focus on things they feel they can influence in therapy. It follows that therapists may be hesitant to focus on

factors which they feel their clients may have less control over, especially considering the powerlessness which many survivors of trauma may already feel (Herman, 1992). This study's findings show how sociopolitical conversations, in which politicised aspects of clients' lives are discussed and social narratives explored, contribute to clients creating new agentic possibilities and narratives.

In exploring the social narratives which had been unquestioned in a client's life and that contributed to their trauma, clients came to see these narratives as only one of many possibilities. Dominant narratives that victim blame could be seen for what they are, a social narrative, rather than a truth that suggests some internal deficiency. Exploring and externalising dominant narratives around ability and sexuality, for example, allowed space for narratives to be developed about the self which were more empowering and less limiting. Stories described clients being able to make new choices for themselves based on these new understandings about themselves and the world, such as choosing different relationships, engaging in activism, or making positive choices due to no longer internalising harmful narratives Instead of these conversations being a barrier to increasing agency for clients due to having a focus on external factors, findings suggest they can be a contribution to this therapeutic process of empowerment and development of personal agency. This, in turn, may result in engagement in collective action, which then supports transformation at broader levels of society. This supports and adds to the suggestion that sociopolitical context is crucial to include across all modalities, which include agency building as a core target (Williams & Levitt, 2007).

These findings showcase liberation psychology praxis in action through the process of externalising narratives and creating new ones, which create new agentic possibilities. Conscientization to the political forces that limit agency is seen as crucial in the development of agency and collective action within liberation psychology (Moane, 2003). Political empowerment through conscientization is argued to be an act of resistance and agency in and of itself, and one which occurs collectively. Externalising sociopolitical narratives and witnessing the client's experience were the tools which were used in this relational empowerment and agency building process.

The findings highlighted how the connection to communities affected by the same sociopolitical conditions or experiences was one common outcome of the exploration of sociopolitical context and narratives. Clients often went on to develop a desire to make change at a more collective level through activism. These findings support suggestions that fostering and highlighting possibilities for engagement in collective resistance is one aspect of socially just and liberatory trauma therapy and psychological practice (Goodman, 2015; Prilleltensky, 2008). Research suggests that engaging in collective action and activism may carry psychological benefits such as feelings of connection, increased coping and self confidence (Strauss-Swanson & Szymanski, 2020), and bring particular healing and coping benefits for those marginalised by social oppressions (Hagen et al., 2018; Velez & Moradi, 2016). Findings indicate that therapists played a role in connecting survivors to collective action and, by doing so, were a part of collective efforts for social justice through individual-level conversations. The therapeutic space is linked to collective spaces of resistance through raising awareness and understanding about the role of structures of oppression in trauma. Power is everywhere and dispersed (Foucault, 1977), and these stories are exercised through a collaborative challenging of internalised oppression, which then links people to communities of resistance. Although therapy is an individual pursuit, it links to liberatory practices of collective action and developing further agency through collective action. In this way, these stories blur the binary lines between individual-level therapeutic change and societal social justice change efforts.

The findings provoke a reflection on why discussing and connecting clients to communities of resistance is not prioritised as just another tool in therapy, which therapists should have the knowledge to use, just as they do other tools such as distress coping tools, psychoeducation, or cognitive change exercises. As therapists interested in social justice, these stories suggest we should be ready to connect clients with others with similar experiences or who are helping make change for others, where this arises and is appropriate.

Conversations about shared political context were not storied as an exclusively and necessarily empowering or agency building process in therapy. A few participants described a risk that these conversations may contribute to perpetuating a felt sense of powerlessness. They described the potential

for survivors to develop a sense of not having any impact or control over their lives, and that a therapist who focuses on sociopolitical context without awareness in this dynamic could perpetuate this dynamic; one which may also be part of why a person faces the issues which led them to therapy. This is especially relevant when considering working with survivors of violence, as research suggests that having a sense that only external factors control outcomes in life can be a common outcome of trauma and is linked to ongoing areas of distress (Roazzi et al., 2016).

The findings call attention to the nuances of including discussions about sociopolitical context and providing care with liberatory aspirations. An approach that sees all conversations about sociopolitical context as helpful or useful, regardless of the client's context, would succumb to the essentialism which a contextualised approach resists. Such a pitfall, where a therapist could impose their views of liberation devoid of relational complexities in therapy, has been raised as one possible pitfall of these conversations (Afuape, 2012). Reflexivity is required which includes the client's unique context, how they may experience discussing sociopolitical context and how it interacts with their inner world.

Given that research has suggested that therapists may avoid discussing sociopolitical context because it is out of their control (Winter, 2019), clients focusing on sociopolitical context in a way that perpetuates feelings of powerlessness could easily contribute to this avoidance of sociopolitical context. However, findings showed that, instead of a felt sense of powerlessness being a reason not to include sociopolitical context in therapeutic conversations, it was instead a reason to be reflexive on how this is done and the therapist's role in these conversations. A balancing and reflexivity was described, which aimed to validate sociopolitical impacts, as well as the agency a person holds within their lives. Therapists described using skills and knowledge to assess when a sense of powerlessness is part of a dynamic. They described an approach which saw them explore where the person still holds agency in their lives, while validating the impact of social structures.

In summary, findings in themes three and four indicated that transforming shame and self-blame was a central outcome of sociopolitical conversations in trauma therapy, which aligned with research around the compounding role of marginalisation and oppression in trauma and associated shame. The

descriptions of externalising narratives involved in these conversations suggest that this is a key tool involved in these conversations, and that this element of narrative therapy may be a valuable tool in developing skills in these conversations. Validating injustice and a witnessing stance were also at work in these conversations, aligning with theories around the importance of a 'being with' witnessing stance to injustice and trauma. Building feelings of agency and choices in action was described as another key outcome of these conversations. This is an important finding given that therapists may de-emphasise sociopolitical context due to a sense that clients have less control in this area. Building connections with those with similar experiences and fostering involvement in active resistance to injustice were also common outcomes, highlighting how these conversations have collective and liberatory outcomes. Participants acknowledged the need for a reflexive awareness of survivors' unique context to avoid perpetuating any unhelpful beliefs around powerlessness and victimhood.

Chapter Seven - Power, Privilege and Therapist Reflexivity

In this final section of results and discussion, theme five is presented along with associated discussion. This final theme turns to exploring the therapist's own positionality and power, how they negotiate these relationally and key personal learning and development involved.

Theme Five: Therapist Identity, Power and Sharing of Self: Working with Intersectionality, Reflexivity and Principled Non-Neutrality

This theme describes participants' narratives about reflecting on and negotiating their own privilege, power and identity within the therapy process, specifically within conversations about sociopolitical factors of trauma. Participant narratives explored how their own identity and experiences of marginalisation impacts conversations and how shared experience and identity can create a shortcut to connection. They balanced this alongside the need to listen and explore the unique world and identity of the client. Narratives also included reflections on the sharing of self in the therapy process. While highlighting a need for reflexivity around therapist power, many narratives highlighted the importance of careful self-disclosure and non-neutrality in socially just practice and conversations about sociopolitical context. The narratives emphasised the need for intersectionality, self-awareness and consistent self-reflection around power and identity and how to balance the considered use of power to resist oppression alongside being client-led.

Shared Connection Through Shared Identity

Within participant stories, a major positive of shared identity or experience was discussed in terms of how this can create a shortcut to relationship and connection and help build rapport. While not all participants shared marginalized identities with their clients, some did, and Maya's example below highlights the value she saw in this shared identity. Maya reflected on how sharing identity, such as being a person of colour, may mean that conversations about experiences of marginalisation come up earlier in the therapeutic relationship.

> Maya: Yeah, I think my position in the world as a migrant woman of colour, like sort of touches everything that I do. And so I guess it makes it more important to me to have that kind of context and analysis when I'm working with other migrant women of colour in particular….and maybe that might be situations because we have already, not always, but a kind of shortcut to ally ship with each other, both in the therapeutic way and the like living our lives kind of way. Where we might get to that kind of stuff faster. Yeah.

Maya highlights how central her identity as an immigrant woman is in her work, and how the lived experience of this identity enables her to see the importance of a politicised analysis when working with others who hold this identity. Her narrative suggests that it is easier or more readily accessible to her as a therapist to raise this sociopolitical context because of her personal understanding of its importance. She does not fear mistaking the importance of the sociopolitical context of this experience because of her own experience living in the world with this identity. Maya acknowledges that it is particularly important for her to hold this analysis when working with migrant women of colour, which suggests that self-reflection is needed when working with clients about how therapists may see the importance of sociopolitical factors more easily, or rate the importance of these factors higher, when there is shared experience.

Participants also reflected on how their own positions of difference or privilege can be a barrier to having enough understanding about a client's world or that they feel less skilled when working with clients whose experience is vastly different to their own, which will be explored in greater depth below.

Intersectionality, Unchecked Assumptions and Reflection on Privilege

Many participants shared a pro and con narrative around the usefulness of shared identity and experience, highlighting the positives explored above, as well as negatives. Within the same narratives as the positives of shared experience were discussed, participants highlighted the risk of making assumptions about clients with whom there is a shared identity or experience. Multiple therapists highlighted the need to engage with curiosity to understand the client's unique experience, and that the importance of

consciously doing so is heightened when you share identities and/or experience. Halima, for example, reflected that a shared Pasifika identity can raise difficulties for her as a Pasifika therapist, given the vast differences within this community, and the importance of applying an intersectional lens to conversations. A narrative of self-reflection and critical self-inquiry was again shared by Lisa when reflecting on the therapeutic benefits of a shared knowing that comes through sharing an experience or identity with a client. She balances this alongside the risk of losing an open and curious stance or losing one's intersectional lens.

> Lisa: Um, I was kind of wondering about this today. There's, like, there's the question about.... there's a balance between the connection you get from sharing an ISM [an experience of oppression or marginalisation] with somebody, so, there can be usefulness in sharing in ism. There can be an ease when you have a shared experience that you are both aware of. So being female and working with a female, being trans working with a trans, being Māori and working with a Māori, any of those shared experiences that you're both aware of, can provide a sort of a, I think, a different quality to *pauses* a knowing and an understanding about what that's like. But I also think sometimes, that sometimes a difference- being female working with a male client- can invite you to listen more carefully. To really understand what- so what actually might that experience be like, rather than, a bit like I'm saying before, just the automatic kind of quality of you know, I know what experience is of being a woman….Yeah, assumptions is the thing. Yeah. And, to miss things that are important, and to not really see, to just kind of be flopping on your own experience onto someone else. So I think both of those things are true, though. Yeah.

Lisa concludes that both the potential positive impacts on the therapeutic relationship and process of sharing an identity, as well as the risks of losing a sense of curiosity or making assumptions about client experience, are important. Lisa went on to position her own experiences of marginalisation as central to understanding the importance of such experiences in people's lives. She suggests, as did other

participants, that having an experience of oppression, even if not the same, has been a gateway to understanding the impacts of sociopolitical context in others' lives. Despite these personal politicised experiences being important in developing the knowledge for conversations and in developing connection, Lisa also raised the risk of 'flopping your own experience' onto others. She and others describe a dialectic of knowing and holding that these potential positive impacts and possible risks can be true simultaneously.

This risk of making assumptions was elsewhere positioned as particularly likely or common amongst therapists who have not examined their positions of privilege. Maya and Halima (who identified as Malay Indian and Asian-Pasifika & Pākehā respectively) both reflected on the unchecked and unexamined privilege of their predominantly white women colleagues as a barrier to many of those therapists holding these conversations effectively.

> Maya: And so if you can't see outside your own, like lived experience, it makes it really hard to be able to do that kind of work well. Yeah. And I think also because, like, my experience of other practitioners is largely older white women who mean very well but like, generalise and extrapolate their experience as white women onto all other women or, you know? And yeah, so it's that over-identification kind of thing of, you know, I've experienced one kind of oppression that means I'm able to understand all others, which is kind of the flip side of what I was talking about before, if you're not careful about it, like if there isn't nuance and care.
>
> Researcher: The flip side of what sorry?
>
> Maya: Oh when I was talking about how, like, life experience as a marginalised person is helpful in working with other marginalised people who don't directly have the same kind of experience as you. Yeah. Yeah. But that's the danger of that. Right? Yeah … So they can see their own marginalisation, but not their own privilege, and how those things relate to each other and why that makes their experience different from someone else's. Yeah.

Maya's narrative concludes that the most important skill involved in these conversations is deep reflection and learning about a therapist's own areas of privilege rather than simply understanding one's own areas of marginalisation. She reflects that many white women therapists who do not do this may project their own experiences of sexism onto other forms of oppression and marginalisation, thus lacking an intersectional lens. She includes positioning these therapists as holding good intentions but still doing harm due to not engaging in this learning and reflection.

As well as unpacking privilege, other participants highlighted the ethical need to learn and work beyond tokenism when working with different identities. This was echoed by a few other participants who highlighted their feelings of being less equipped to work with clients who hold vastly different identities or life experiences to themselves. When reflecting on working with people with various identities, Priya highlighted the ethical responsibility to work with clients not similar to us because of the reality of there simply not being enough therapists with lived experience and shared identities, for example, trans therapists.

> Priya: Yeah, like, you know, 'I'm not going to see a trans person because I'm a boomer'. Well, you know, there are not a lot of millennials who are trained therapists just yet so i'm sorry, Boomer, but it's on us. until there's a better option, or, you know. I wish it was a world where only trans people saw trans people, but it's a bit like saying, you know, like, I've done my waiata now. And that's it. That's what I can offer Māori people. If you are seeing Māori people, then are they getting the same service from you as anybody else is? And if they're not, then well, either charge them half price, or do the work that's needed.

Priya highlighted that therapists have a responsibility to make sure marginalised clients who may have different identities to our own get equally good service as any other client. This involves a commitment to learning about that client's world, culture and community. This narrative argues that intentions and holding an understanding of social justice is not enough to equitably and appropriately work with marginalised people and hold conversations about politicised experience. Instead, a process of

self-reflection and learning about the intersections of power, trauma and identity, and a client's unique experience is needed.

Self-Disclosure and Non-Neutrality

The subsequent sections explore narratives that focus on self-disclosure and non-neutrality. In sharing stories of conversations in therapy about sociopolitical experience, many participants turned to discussing their own response to the client when hearing their stories. These reflections centered on the nature of the sharing of the self, which happens in these conversations. The nature of this sharing was varied; some discussed joining with the client in sharing an emotional reaction to injustice experienced by a client, while others addressed a direct sharing of political analysis about a client's situation. Some reflected on occasions where they openly shared their aspects of personal identity or experience similar to a client. Within these stories, participants negotiated therapist power and role and when and how this sharing of self was useful.

Sharing Emotions and Joining the Client. As introduced in theme two, many participants emphasised the need for 'getting off the fence' or non-neutrality in witnessing clients' stories of trauma and systemic injustice and reducing shame and self-blame. Sometimes, this non-neutrality also involved a further level of self-disclosure, a sharing of emotion, and a standing alongside, which included an expression of rage or anger about the injustice.

Monika reflected on this sharing of emotion both in terms of its benefits to clients and the risks of doing so. Monika described how she navigated bringing her whole self into the therapeutic space to provide a shared experience of witnessing injustice with the survivor. Below, she describes working with a Māori client who has experienced ongoing abuse compounded by poverty and addiction. She describes how she joins with the client in witnessing the injustice of poverty; in this case, the client feeling angry about how those who lost their jobs due to COVID-19 were provided with more financial support than those who were on Government benefits. She describes being together in the world where this injustice happens. In saying this, she suggested that sharing anger or witnessing injustice alongside a client can

provide a counter to isolation, and to the ‘gaslighting’ she describes as being linked with the experience of poverty.

> Monika: And I guess, in that place, we were, we were both there in that world where this decision had been made. And that decision was impacting on both of us. And we kind of were sharing that experience and that... Yeah, and I guess I'm, I'm agreeing with her in that. Like, yeah, that is fucked, isn't it? You're not crazy for experiencing this as fucked. I do too. Yeah, I think there's so much... living in poverty is so gaslighting.

Later, Monika describes a reflective and nuanced approach to this disclosure and sharing of emotions when joining the client in witnessing injustice. She is describing the same client but a different experience of being tackled by police amid a mental health crisis. Instead of a useful therapeutic tool, in this case, the emotions Monika is experiencing are described as her own reactive response, which may not serve the client if shared. She reflects on the need to manage her reactions in order to serve the client, and to sometimes hold a grounded emotional stance instead of joining the client in their emotions. She describes how a sharing of anger or sense of injustice can sometimes be a barrier to holding the space needed to explore the client’s emotions and the underlying processes the client may be experiencing. Monika’s reflections show how nuance and self-awareness are necessary when considering sharing or disclosing emotions and in balancing therapeutic use versus the potential pitfalls.

> Monika: And yeah, and she, you know, she tells me this story. And I, you know, I can't not be horrified. You know, they did what?!? You were having a mental health crisis and they did what?! Yeah. Just it kind of, I feel it, sometimes it just never ends. That kind of being horrified. But that's, that's kind of my bit that I had to manage, I think quite often, is just how horrified I get and, and my own... Like, I think there is quite a lot in the witnessing thing and of like, that's unbelievable that they did that. But also, there's also the getting below it. That doesn't happen if I, if I'm up here and ' oh my god', you know, of kind of, what is going on for her, you know, because this

> woman's, this woman's story was that anytime there was a little bit of safety, she would ....she had no safety on the inside for herself. She couldn't, she couldn't connect with any kind of feeling of safety.

Monika described the work that she and this client were doing together, working to create a sense of internal security. She emphasises here that joining the client in a sense of rage and injustice, when done inappropriately, results in the therapist abandoning their role of 'getting below it'; of facilitating the exploration of that emotion, of exploring how it relates to other ongoing patterns, and of processing these emotions. She describes her role in this situation as managing her feelings to provide the space in which this 'getting below it' can be done. The first theme described the capacity of holding a containing space, or becoming a 'big container', in these conversations. Monika describes how the sharing or expressing of emotional reactions, in some instances, has the potential to break down this containing space and thereby reduce the ability to contain and explore survivors' emotional experiences. In describing that her role was managing her own emotions in this moment, Monika describes a moment-to-moment relational reflexivity where she considers what is useful and containing for the client and their relational therapeutic process. In some instances, this includes joining in the witnessing of injustice involving the sharing of emotional reaction, which provides connection and a counter to the isolation of injustice; at other times, she holds enough of her own reaction back to ensure the client's emotional reaction holds priority in the therapeutic exploration.

Sharing of Political Analysis, Opinions and Personal Experience. Many participants reflected a narrative around sharing political opinions or personal experiences in sessions. The participants emphasised considering power, self-reflection and both the benefits and potential pitfalls of engaging in conversations about politics and disclosure of individual experience. Almost all therapists described hesitancy and careful consideration as essential in using self-disclosure of personal opinions, political analysis and personal experience, considering the power they hold within the relationship and the impact self-disclosure can have on the relationship.

Similar to Monika's narrative around sharing emotions, some participants reflected on the potential or even likelihood that the space for a client's exploration shrinks when a therapist shares political opinions. Rachel highlighted the risk in raising a political analysis of someone's situation, given the power the therapist holds to guide conversation, and the risk of doing this due to our political opinions rather than what is central to the client. Below, she is discussing working with Māori clients as a Pākehā women. She first shared that she does offer information about colonisation and intergenerational trauma from others with direct experience, such as giving clients work written by Māori authors. In doing so, she takes a position of non-expert in this area, acknowledging she may be more likely to not understand correctly how such sociopolitical experiences map onto a person's own trauma experience. She then goes on to share about the risks of raising her own analysis of the client's experience concerning colonisation.

> Rachel: One [risk] is that I sort of get on my soapbox in a way that is not, you know, that I find intrinsically important and interesting. And talk about it at length whereas for my clients, it's like they're not there yet. 'Yet' is not actually right, that's just not their thing. It's like, yeah yeah, shut up about your politics. And meanwhile, back to me, can we just talk about how I felt about myself and how my family responded to me. Do you know what I mean? And people can be enormously polite when they are a minority group. They're not necessarily going to tell you when you're barking, you know, up the wrong tree. So I try and throw out lines or like do things that communicate.... Like, I'll ask questions like, I wonder if it's hard to talk about that, you know, given, given this, or given my identity, or, like... I'll try and set the scene for that conversation.

Rachel positions her role in raising the topic of colonisation or sociopolitical issues here as one of issuing a subtle invitation, which doesn't pressure a client to follow her inquiry. Instead, she has a relational focus, one which follows what is important to the client. She raises how she brings her own identity and self into the conversation as a way to open the space to sociopolitical discussions, and build trust to do so. Rachel corrects herself when saying a client may not be there 'yet' (regarding exploring

colonisation). She appears to recognise her own bias in thinking everyone may want or need to explore this issue at some point on their journey. She then asserts that instead, this exploration may not be for everyone. She also acknowledges that her role in a position of power and privilege may mean that people follow her topics of conversation, emphasising the importance of a relational and client-centred approach. In doing so, Rachel raises the salience of therapists reflecting on how their own political opinions can potentially create bias in a therapist as to what areas of experience to focus on.

Resisting Western Narrative about Sharing of Self. Many participants also shared stories which highlighted the power of sharing political frameworks which give clients a new language to understand their own experience. Multiple participants shared stories of sharing political frameworks of, for example, rape culture, feminism, or historical trauma, through which clients could explore their own experience of IPV. They discussed how this sharing of political ideas has helped survivors of violence explore politicised narratives which they hold or have been surrounded by. Some further explained how sharing more personal details related to this political analysis can be useful. Halima described the potential therapeutic power of disclosing more about her own identity and personal experience when discussing intimate partner violence.

> Halima: Often using power violence wheels, um, yeah, and I think I think in terms of techniques, though, when I'm working with people who have been othered, often that personal connection or story of me locating myself in the story, in terms of my background, and where I've been, not to the point of burdening your client, that's kind of, I've really noticed that, sort of, facilitated self-disclosure. Like sometimes you can do that with someone who is a minority, where it's really allowing them a voice to a certain experience. I don't know how to put them in terms of the social political thing, but it's kind of like, makes it more visible, I think. Yeah, so it's almost like allowing, allowing certain narratives to be visible can invite people into a different place.

Halima describes an approach she feels is particularly useful with others who hold minority identities, such as the immigrant women of colour she worked with who had experienced family violence.

Halima describes a sharing of self and a locating of herself in the narratives she is sharing. This includes a sharing of her own background, such as being a woman from a migrant family and a mother, when discussing frameworks like the power and control wheel (a commonly used framework within IPV settings which uses a feminist analysis to explain the different types of abuse suffered by survivors of intimate partner violence). In doing so, Halima describes making more narratives and possibilities available to the women she works with. She positions herself as offering a personal narrative through which those she works with might be able to see a possibility for themselves. This contrasts with sharing theoretical frameworks as an educator or professional expert. She describes this as a carefully considered approach of 'facilitated self-disclosure' and highlights that such disclosure should not come at the client's expense. Below, she shares a specific example of sharing her personal experience.

> Halima: So I had an experience of a bit of an aggressive partner at one point in my life. And I was doing some couples counselling, and I would never usually share that. But I did share that. That I'd survived that and had moved through it. And it just opened the floodgates for this woman because I could tell she was really shamed. And holding back. So I guess sometimes I've been very deliberate. Yeah, I guess as long as it's integrated in you, you know, and it's not burdening the client. And you're doing it with a purpose, I think it can be really powerful. And also, I think there's a difference between Western models of practice and indigenous models of practice and other ethnicities, you know, where community and connection trump analysis *laughs*...So like when I was thinking about that situation of disclosure, there's also the negative narratives around me sharing that, you know, the messages about, oh that's a bit shameful or, you know, you're a therapist, you're supposed to have it all together. Those kind of informal messages I can carry. So, yeah, even though it's empowering, because kind of affirming a reality that's not fitting into the patriarchal view. But at the same time there can be inhibitors playing in my head at the same time. yeah, so it is interesting.

Halima's narrative of self-disclosing her own experience of an aggressive partner is positioned as a rarity and an exception to standard practice. The choice to share this was a deliberate one made for a reason. In this situation, she described how sharing more of herself enabled the woman to share her own story despite experiencing shame around her experience. Self-disclosure and sharing of self are described as a relational decision, based on perceived worth to the client. Halima highlights that such self-disclosure should only be made when the experience which is being shared is 'integrated'. Halima highlights that if a therapist is sharing an experience which may be upsetting or has not been processed personally, decision-making around how and if to share this and the ability to do so in a way which is client-centred may be impaired.

Halima was one of the few participants who described disclosing something about their own background, though she was the only one who described disclosing experience of interpersonal violence or abuse. Halima described this self-disclosure of personal experience as sitting within her own approach, which prioritises indigenous models. She highlights how indigenous and non-Western practices prioritise 'community and connection' over analysis. Relational practice which prioritises moment-to-moment interaction and connection is positioned as sitting in contrast to Western analysis of self-disclosure. A rejection of trying to apply 'rules' or analysis about self-disclosure and instead basing such decisions in the relational space is evident in Halima's narrative. She goes on to position such practice as an act of therapist resistance to dominant Western narratives of being the neutral expert in the relationship. The power of Western models of practice is highlighted where Halima admits to struggling with a sense of shame when she uses personal self-disclosure to build connection and offer alternative narratives, due to this clashing with dominant narratives about the sharing of self within therapeutic practice. Like in the earlier theme 'Trauma is context is resistance', Halima's narrative is one of the inevitable position of resistor which is taken up by those who practice contextually and relationally, through practising in ways which confront and subvert dominant narratives around the expert practitioner and medicalised patient.

In summary, theme five outlined participant narratives which storied how their selves, identity and power were used within sociopolitical conversations with survivors in trauma therapy. They

described a pro-con narrative of sharing identities or experiences with clients. Stories of these conversations involved non-neutrality and a sharing of the self, which was discussed with nuance and involved awareness of how this affected clients and the therapeutic process.

Discussion: Power, Privilege and Therapist Reflexivity

Theme five describes participants' narratives about reflecting on and negotiating their privilege, power and identity within the therapy process, specifically within conversations about sociopolitical factors of trauma. Participant narratives explored how their own identity and experiences of marginalisation impact conversations and how shared experience and identity can create a shortcut to connection. They balanced this alongside the need to listen and explore the unique world and identity of the client. Narratives also included reflections on the sharing of self in the therapy process. While highlighting a need for reflexivity around therapist power, many narratives highlighted the importance of careful self-disclosure and non-neutrality in socially-just practice and conversations about sociopolitical context. The narratives emphasised the need for intersectionality, self-awareness and consistent self-reflection around power and identity and how to balance the considered use of power to resist oppression alongside being client-led.

Therapist and Client Identities and Intersectionality

The findings point to a pro-con narrative about how the therapist's own identity impacted conversations about sociopolitical context with clients. Managing multiple identities required a specific type of skills and practice. In terms of the positives of shared identity and experience, such as shared ethnicity, gender or sexuality, many participants highlighted the connection that shared identity and experience can create with clients. Their stories suggested increased knowledge and confidence in talking about the issues related to this shared identity. Conversely, there lies a suggestion that there is less comfort in discussing issues not personally experienced. This may also mean that experiences which are not shared are not prioritised or discussed as readily. As will be discussed, this necessitates reflexivity in clinical practice about how one prioritises different issues for discussion based on experience or knowledge.

Some participants then also described the possible downsides of sharing an identity or experience, such as the potential to lose curiosity about the client's unique experience or to make

assumptions about it. They highlighted that there can be incredible heterogeneity within communities where they may share connections, which can lead to difficulty in relationship building. These ideas are unpacked below.

The narratives described highlight the importance of intersectionality in trauma-informed therapeutic practice, including in approaching conversations about the sociopolitical context of the client's trauma. Multiple studies have explored the impacts of identity-matching between client and therapist, and their effect on client outcomes. However, most of this research has focused on 'race-matching' (Ertl et al., 2019). These studies indicate that clients have a more positive attitude towards therapists with whom they share an ethnicity (Cabral & Smith, 2011; Ilagan & Heatherington, 2022), or that they may have slightly higher retention rates with a 'match' (Kim & Kang, 2018). However, overall, research has been mixed, with many showing mixed results or no statistically significant difference in therapeutic outcomes regardless of 'matching' (Cabral & Smith, 2011; Hung et al., 2023; Smith & Trimble, 2016). Researchers have also highlighted that studies have been flawed in design due to issues such as 'ethnic gloss', where broad categorisations, such as an ethnic grouping, are used and commonality is assumed within such broad groupings, which actually contain huge differences (Ertl et al., 2019).

Due to intersecting identities, true 'matching' may indeed be all but impossible (Ertl et al., 2019). The research about therapist/client 'match' and therapy generally calls for a more intersectional approach to considering therapist and client identities when it comes to sociopolitical conversations and social justice practice, and to a reflexive approach when identities are shared (Ertl et al., 2019; Hung et al., 2023; Smith & Trimble, 2016; Watts-Jones, 2010). Therapist/client 'match' research has also highlighted, as did narratives in this study, the dangers of making assumptions and losing curiosity about a client's unique experience when identities are shared, complicating a straightforward previous narrative which assumed positive outcomes of such 'matches' (Cabral & Smith, 2011). Additionally, when considering the impacts of therapist/client 'matching' in any area, it is important to consider the risk of assuming any individual may find any particular area of their identity or life experience more important

than another or under-estimating within-group differences and intersecting privileges and oppressions (Ertl et al., 2019; Smith & Trimble, 2016). Instead, researchers call for an increased focus on developing intersectional practice and competence, and improved training in these areas (Hays, 2024; PettyJohn et al., 2020; Watts-Jones, 2010).

An intersectional approach to practice considers the various identities and positions a client holds in the world, acknowledges structural inequities in the mental health system, and forgoes stereotypes of marginalised peoples and instead recognises diversity within all communities (Hays, 2024). Various frameworks have been proposed to foster intersectional therapeutic practice (Hays, 2024; PettyJohn et al., 2020; Schindler Zimmerman & Castronova, 2021). One such framework is the ADDRESSING model, (Hays, 2001, 2024). The ADDRESSING model for intersectional practice in therapy argues for exploration of the complexities and individual differences in a person through exploring where a client may be positioned in regard to **A**ge, **D**evelopmental **d**isabilities, acquired **D**isabilities, **R**eligion, **E**thnicity, **S**exual orientation, **S**ocioeconomic status, **I**ndigenous group membership, **N**ationality, and **G**ender (Hays, 2024). Models of intersectional practice highlight the need to develop understandings of structural oppressions faced by people with intersecting identities and of the resilience and strengths associated with intersecting identities or experiences of oppression.

Using models of intersectionality in practice is not without complexity. Such models may simply become a checklist or not necessarily encourage reflection on where these intersect, rather than just reflecting on these identities separately (Bilge, 2013). Merely looking at where someone sits regarding each of these identities could lead to furthering of monocultural assumptions. Instead, when reflecting on where someone sits in regard to any area of identity, such a model should be used to help reflect on how other areas of oppression and privilege may interact, change or compound their experiences.

Intersectionality models may also arguably lead to a focus on identity at the expense of exploring larger structural inequities and barriers (Adames et al., 2018). Indeed, Hays (2024) responds to this directly in highlighting that using the model should provoke thought about the larger structural issues influencing a person's experience. It is also important to note that identity is fluid and evolving, as has

been highlighted by black feminists such as Hooks (1989) and Crenshaw (1991). Exploring where a client holds diverse and intersecting identities should include a recognition that these are not necessarily all equally salient to a person, nor are they necessarily fixed or static.

Critics have argued that the language around intersectionality has become so complex, that clinicians, such as therapists, can barely keep up with evolving terms and may become intimidated by them, resulting in avoiding their use (Lago, 2023). In light of the various complexities and possible downsides described, using any model to initiate more intersectional practice should be an introduction to discussion and reflection, rather than being a checklist for practice. This call was echoed somewhat by participant narratives in Theme Three, which emphasised that clients with marginalised identities often are met with being tokenised through therapists doing the bare minimum effort.

Importantly, it has been highlighted that for intersectional practice which attends to these various social locations and is relationally led, and to avoid the pitfalls of such nuanced discussions, a therapist must be deeply reflective and aware of *their own* intersections of identity, power, privilege and oppression (Gazzola et al., 2018; Hays, 2001; Reynolds & Hammoud-Beckett, 2017; Rigby, 2018; Watts-Jones, 2010; Zimmerman & Castronova, 2021). This was echoed by participants in this study who highlighted that while experiences of marginalisation can be useful in gaining experience, language and comfort to discuss sociopolitical experiences, a reflection on where privilege and power are held is equally essential, and as raised by participants of colour, often lacking amongst their white women colleagues.

Researchers highlight the need for therapists to use models of intersectionality to explore their own privileges in developing an ability to apply social justice theory in practice, and that it is the very discomfort which these reflections and discussions often involve which evokes important learning (Abraham et al., 2022; Gazzola et al., 2018; Watts-Jones, 2010). Areas of discussion in such reflections that raise discomfort may be those where the therapist holds the least knowledge or where they hold privilege. Then, noticing and reflecting on emotional reactions is a crucial reflective exercise when developing reflexive practice and the ability to hold conversations with an intersectional lens (Monteiro,

2021). This focus on discomfort echoes the findings of Allen (2011), whose study about therapists' integration of sociopolitical context concluded that discomfort was a key barrier to effectively integrating sociopolitical context into therapy, and this discomfort should be a key focus in training. In their study exploring how marriage and family therapists developed their abilities to apply sociopolitical consciousness to therapy, Esmiol and colleagues (2012) concluded that self-reflection and discussion about personal marginalisation as well as privilege led to a greater commitment to address sociopolitical context in therapy.

Key reflexive considerations should include how to embrace the discomfort involved with exploring privilege, how to go further than acknowledging privilege and towards mitigating it (Heron, 2005), and who are allies in this work of exploring privilege (Reynolds & Hammoud-Beckett, 2017). When privileges are invisibilised or not explored by therapists, as some narratives within this study described, a dominant, Eurocentric human experience and perspective is perpetuated (Gazzola et al., 2018). As has been argued elsewhere, while therapist trainees are often in learning situations where knowledge and factual context is shared about marginalised groups, it is less common that their own spaces of belonging and how these will impact work with different groups is deeply explored (Gazzola et al., 2018; PettyJohn et al., 2020). Focusing only on learning about others' experiences without self reflection may lead to misunderstanding or stereotyping others (Marecek & Hare-Mustin, 2009).

Findings highlight the need for a focus on our position regarding colonisation in Aotearoa. Many acknowledged their own position as Pākehā to highlight where they hold significant privilege in relation to their Māori clients, which necessitates significant reflection on assumptions and conversations. For participants of colour, all raised the unaddressed issues of privilege related to Pākehā as a significant barrier to holding these conversations. In Aotearoa, intersectional practice must be place-based and contextual. Intersectional practice should begin with considering a person’s place in regards to the colonisation of the land we live and work on, and include reflection on what it means to have a Pākehā identity where this is the case, which is often left unexplored due to cultural dominance (Huygens & Black, 2007; Rigby, 2018). For Pākehā, this includes explorations of the ancestral history of privilege

from colonial and white supremacist oppression and dispossession, and how Pākehā have and continue to benefit from this. Huygens (2003) has highlighted important questions for Pākehā practitioners, such as *"What bits of Pākehā identity do we choose to accept and take on board"* (p. 14) and which do we not? Within frameworks of social justice in therapy, an argument is also made that reflection must also include how the suffering and marginalisation of client groups maps onto the power and privilege embedded within the helping professions such as psychology (Reynold & Hammond, 2017), and in Aotearoa how this includes the role that mental health professions such as psychiatry has had in the project of colonisation (Cohen, 2014).

Self-Disclosure and Non-Neutrality: Sharing of Self in Sociopolitical Therapy Conversations

In their discussions about conversations about sociopolitical context with clients, stories of most participants involved some level of reflection about different ways which they shared aspects of themselves in these conversations; a sharing or reflecting of emotions about injustice experienced by survivors, a sharing of political opinions or analysis, or of their own lived experience and identity. As was the case regarding when identities were shared with clients, these stories involved nuance, reflections of their power in the therapy process and a reflexive use of sharing of self which was contextualised in the relational moment.

Non-Neutrality and Central to Liberatory Practice. The empirical research concerning self-disclosure has been mixed, and there is a longstanding debate within psychotherapy literature regarding its use (Audet & Everall, 2010). A qualitative review of literature regarding the effects of self-disclosure found that while there was no conclusive evidence regarding positive outcomes and impacts for clients, it was clear that self-disclosure, overall and in general, did not have a negative effect on therapy for clients (Henretty & Levitt, 2010). However, literature regarding self-disclosure is plagued with limitations due to the vastly different definitions of self-disclosure, with everything from a superficial rapport building comments (Henretty & Levitt, 2010), to disclosure of political opinion (Solomonov & Barber, 2018) or an experience of sexual violence (Bennett et al., 2022) included within different studies using the term. There is also the impossibility of considering the minutiae of relational and contextual

elements involved with situations of self-disclosure and their effects on a client (Mahalik et al., 2000). What is liberatory and empowering for one client may damage the relationship for another. A majority of self-disclosure research involves Western or white participants, and there is often a Western and non-indigenous lens taken within self-disclosure research, which may not consider cultural relational processes.

In the current study, findings suggested that self-disclosure of emotions or political values and, at times, lived experience, was used in many sociopolitical conversations. This sharing of self was often described as an active choice against neutrality, which was also mentioned in Theme Three as part of a validating and witnessing stance. The therapists actively worked to side with their clients against injustice, exploring and raising oppressive narratives and discussing the systems that may be at work in their lives. Such a finding is perhaps unsurprising given the many social justice, trauma (Goodman, 2015; Herman, 1997; Reynolds, 2020; Tseris, 2019), feminist (Brown & Walker, 1990), and indigenous (Linklater, 2020) practitioners and scholars who argue for an actively non-neutral stance in therapy. In siding with the traditional aims of being a 'neutral' therapist, dominant and status quo ideologies are often left unexamined or perpetuated. Instead, for a stance rooted in liberatory and social justice values, a therapist actively works against the deeply rooted and ideologically driven claims to neutrality and side with those who have been marginalised. Many people, particularly those who have experienced oppression or colonisation, such as Māori, as Rigby (2018) argues, do not experience the therapy space as neutral. Instead, it is a space inherently filled with the narratives, ideas, beliefs and norms of Westernised white therapy. Therefore, findings emphasise that for therapists seeking an actively liberatory stance, an anti-neutrality stance is necessary to counter the pathologising and individualistic ways of thinking which have formed many therapeutic modalities (Reynolds, 2020).

Feminist scholars argue that given all behaviours are influenced by our own values and biases including those of a therapist, disclosing feminist values and certain political beliefs is the most ethical stance in that it gives clients a choice about who to undertake therapy with (Brown & Walker, 1990; Morrison et al., 2022). The findings of this study, which involved therapists taking on a more active,

collaborative role which actively resisted oppressive narratives, highlight the way therapists actively influence discussion. This supports such calls for transparency in what values and beliefs may shape this active resistor role.

Another key reason that self-disclosures and more sharing of self within the therapeutic relationship has been argued for is in aid of equalising the power imbalance inherent in the therapist/client relationship (PettyJohn et al., 2020). The traditional therapeutic relationship, where the therapist is considered the expert, has a troubling power dynamic at its base which must be problematised if working within liberatory aims (Mahalik et al., 2000). Reynolds (2020) argues that in trauma therapy, this must involve more than simply highlighting societal oppressions, but extend to how we collaborate and share power in the therapeutic relationship as part of justice-doing within therapeutic practice. In sharing more of themselves and actively taking a non-neutral stance, the participants showed how they actively used the power involved their role strategically and in aid of liberatory aims. This shows how it is not only relinquishing or sharing power which is part of these conversations, but also a strategic use of the power of their role, reflexively and with purpose, to counter injustice and harmful narratives.

Some of this sharing of self described by participants in this study aligned with the witnessing stance described in section two of the results and discussion. A witnessing stance involves bringing the whole self into the experience alongside the survivor, as an antidote to the isolation experienced by survivors of violence and oppression (Herman, 1997; Reynolds, 2020). The stories shared involved sharing a sense of injustice and outrage at survivor experiences of abuse or systemic injustices. While few studies have explored this type of emotional (and non-directly political) self-disclosure, some studies have explored how white therapists use of self disclosure with non-white clients and found that sharing a sense of outrage about racism experienced by clients helped to deepen rapport and trust, and bridge power imbalances (Burkard et al., 2006; Danzer, 2017). Such relational mutuality and standing alongside in an experience of injustice within the therapist/client relationship may support clients to reclaim their own voices and narratives (Caldwell & Leighton, 2018).

In Aotearoa, the importance of engaging in processes of whakawhanaungatanga, or a building of relationship and connection that involves sharing about the self to find connections and differences, is crucial in culturally appropriate work with Māori (Pitama et al., 2007; Wilson et al., 2021). In this study, while describing the various ways they do take non-neutral stances, most participants expressed a hesitancy around self-disclosure for various reasons, mostly noting the risks to the client, therapy process or the relationship. One participant did reflect, however, that her hesitancies can sometimes be due to her own internalised narratives around self-disclosure within mainstream therapies, and a sense she should 'have it all together' (when discussing self-disclosing a previous experience of an abusive relationship). This sense of hesitancy due to a breaking of rules is echoed within research, which suggests that despite self-disclosure being used to some degree by most therapists, there is a prevailing anxiety around its use, and a sense that it might be 'taboo' within the field (Bottrill et al., 2010). One study found a reluctance to discuss self-disclosures in supervision, which may result in less reflexivity and learning around this practice (Bottrill et al., 2010). Anecdotally, I (the author) have witnessed classmates and colleagues struggle and express discomfort with how much they share of themselves when attempting to practice Māori models of whakawhanaungatanga in therapy assessment, and sharing a feeling that such sharing may too easily be inappropriate. In seeking a liberatory stance, however, it has been argued that therapists must sit with and explore the discomfort of going against the norms of the Western and medicalised therapeutic relationship, and question where this may be due to the releasing of the more comfortable and powerful role of 'expert' (Audet & Everall, 2010).

In the present study, Halima suggested that some careful self-disclosure of lived experience of an abusive relationship helped open the door for deeper conversations around issues which may contain feelings of shame for the survivor and invited an exploration of sociopolitical narratives. While emphasising the careful consideration and reflexivity required for self-disclosure, Bennet et al. (2022) have asked '*Who stands to benefit when experience of SV deemed off limits as topic for mutual connection?*' and '*What systems of oppression benefit when we decide we are necessarily more effective or 'evidence based' when keeping lived experience of being a survivor off limits to self disclosure?*' (p.

118). In the context of sharing lived experience of sexual violence (with careful consideration and without details), Bainbridge (2022) argues that a sense of 'sisterhood' (when therapist and client are both women identifying) and a sense of shared solidarity infused therapy with her clients when she had self-disclosed her 'survivor-therapist' status. Indeed, this solidarity can open the door to more trust which can facilitate explorations of the systems of oppression which benefit from silence about these issues. It has been noted that there exists a sense that disclosing therapist status as a survivor is 'off-limits' within the field of psychology, and that there is little research in this area (Bennett et al., 2022). Findings support these assertions that there are situations where, at least from the therapist's point of view, careful disclosure of 'survivor-therapist' status can have positive therapeutic outcomes for clients.

Sharing of Self as a Gateway to Trust and Discussing Context. Findings showed how at times, sociopolitical context is introduced in therapy through the therapist sharing details about themselves and their identity as part of a reciprocal sharing and connection-building. Participants discussed raising commonalities, or differences, and a gentle questioning about these differences. Rachel described raising her ethnicity and how it differed from her Māori clients as one way to issue a subtle invitation to discussing issues of colonisation or racism without forcing her own agenda. Halima discussed that sharing about herself and her background more than may be encouraged within many Western therapies allowed different narratives to be present and opened a space for various types of discussion. Such suggestions for reciprocal sharing of self as a gateway to sociopolitical conversations align with some research. Sharing about oneself, which includes intersecting identities, is one way that sociopolitical conversations can be invited and that connection and trust can be built across different therapist/client identities (Hung et al., 2023; PettyJohn et al., 2020; Watts-Jones, 2010). Indigenous Māori models of assessment and therapy, such as the Hui process (Pitama et al., 2017), or culturally adapted CBT (Bennett et al., 2016), also prioritise commencing therapy/assessment with a process of sharing about oneself, including background, ethnicity and family details (whakawhanaungatanaga).

The timing of this sharing differs according to models. Māori models of care highlight that whakawhanungatanga occurs as part of the initial process of therapy/assessment (Bennett et al., 2016;

Pitama et al., 2007), while other models have suggested raising the conversation following initial assessment (Watts-Jones, 2010). The narratives in this study also differed in when such conversations occurred, with some being raised through the course of therapy when relevant and others discussing an opening conversation. Conversations about intersectionality in identities may occur at any point but may be important as part of the opening process for clients where differences of power may mean they are particularly anxious or hesitant to discuss some aspects of their identity (PettyJohn et al., 2020). Regardless of when this sharing occurs, Watts (2010) raises that the conversations demand comfort and experience on the part of the therapist with discussing issues raised within them. Tensions and differences the conversations raise must be explored with openness rather than avoided (Bennett et al., 2016). As discussed earlier, this requires the therapist to have developed an ease in discussing such issues and with their own intersecting identities. Such reciprocal sharing around background and identity and resulting conversations may also assist in avoiding the risk of assumptions and reduction of curiosity where there are connections or similarities (Hung et al., 2023; Monteiro, 2021; Watts-Jones, 2010).

Relational Skills and Power-Awareness Necessary. The importance of a deep awareness of relational processes and how power functions within the therapeutic relationship was made clear within participant narratives around self-disclosure. These relational skills were also evident in Theme Two, where they were used to build the containment and trust and curiosity in being the 'Big Container', which was foundational in exploring sociopolitical context. Here, the relationship was prioritised in decisions about how much of the self was shared or disclosed in discussions about sociopolitical context. Interestingly, while some narratives emphasised the risks of self-disclosure, their stories still involved some degree of sharing outrage or political analysis, if not lived experience. However, most narratives also shared this with the caveat that doing so must be in the client's interest, involves careful consideration and awareness of the impact on the client, and has the potential to take over the space of exploration which should centre the client. The risks raised align with literature around self-disclosure which highlights the danger that sharing about oneself, even with goals to correct a power imbalance, has the potential to further imbalance power by the therapist taking more space in the encounter and

overwhelming the client with their own story or emotion (Audet & Everall, 2010; Mahalik et al., 2000). This can amount to a role reversal where the survivor may feel a need to care for or contain the therapist's emotions or reactions (Bennett et al., 2016; Brown & Walker, 1990; Mahalik et al., 2000).

In the current study, findings show the importance of a moment-to-moment relational reflexivity where decisions about self-disclosure consider what is useful and containing for the client and their relational therapeutic process. In some instances, this includes a joining in witnessing injustice. This witnessing may involve sharing emotional reactions or sharing of political analysis, which provides connection and a counter to the isolation of injustice. At other times it involved holding back personal emotion or opinion to ensure the client's emotional reaction holds priority in the therapeutic exploration. This consists of the skill of knowing your power and effects in the room, moment-to-moment relational awareness and knowing *why* you do or do not share more of oneself. This aligns with the considerations feminist researchers have called for around self-disclosures. Mahalik et al. (2000) highlighted three areas for ethical consideration of self-disclosure: how it affects the power in the therapy room, whether the therapist is prioritising their own disclosure over fulfilling a therapeutic outcome, and whether they understand how it will benefit the client. If the therapist cannot answer the question of why the sharing is useful for the client, then the risks of the relationship or therapeutic process being damaged increase (Bennett et al., 2022; Brown & Walker, 1990; Mahalik et al., 2000).

As mentioned in the second theme ‘Big Container’, the sociopolitical conversations participants described often involved an awareness of one's own discomforts and a working through and discussing where these emerge and why (Ertl et al., 2019; Gazzola et al., 2018; PettyJohn et al., 2020; Watts-Jones, 2010). Other research has highlighted the relational skills and self-reflective power awareness needed to engage in the self-disclosure involved in these political conversations appropriately (Esmiol et al., 2012), which was again demonstrated in the narratives shared in this study. As has been mentioned elsewhere, this highlights how many trainings around social justice focus on theory or cognitive content (PettyJohn et al., 2020), instead of the process and relational skills involved in these conversations. In one study involving reviewing a programme aimed at developing social justice competencies in marriage and

family therapist trainees, researchers concluded that trainings must involve reflecting on the practice in real time, which works to develop what they called the 'skilled intuition' involved in assessing power and sociopolitical influences in the therapy room (Morrison et al., 2022). While developing a theoretical understanding of power and oppression is vitally important, researchers argue that so too is the witnessing, discussing and reflecting on power in the therapy room and reflecting on what social discourses are at play (Esmiol et al., 2012; Gazzola et al., 2018).

Reflecting on and discussing therapy sessions in detail in supportive and safe groups may be important in developing the process skills and power-awareness needed to identify how power is playing out in the therapy room and clients' lives (Esmiol et al., 2012; Morrison et al., 2022). There is again an alignment here with Theme Two, where participants highlighted that group discussions which explore discomforts helped them gain the capacity to be containing and safe to explore all context. In studies that assess trainees development of social justice practice, having groups of other practitioners committed to social justice with whom to discuss sessions and practice with and reflect on personal reactions was raised as an important step in bridging the gap between theory and practice (Esmiol et al., 2012; Morrison et al., 2022). This may be particularly important for therapists who are in positions of privilege, such as white therapists. Being a member in a dominant culture may result in being less able to see how personal power is being used and how it is experienced, or being less skilled in examining their own culture as it affects therapy due to the lifelong experience of this being the 'norm' and therefore unexamined (Rigby, 2018). Such suggestions on the importance of developing process and relational skills align with the current narratives, which describe how making decisions about self-disclosure in sociopolitical conversations involves such relational and power considerations.

In summary, narratives which reflected on therapist and client identity and sociopolitical conversations described both benefits and risks to sharing identities. Overall, these narratives highlighted the importance of developing an awareness of intersecting oppressions and privileges and how these may impact a client. They called for developing self-awareness around personal privilege and power. This aligns with research which highlights the importance of this self-awareness and development in

discussing sociopolitical context (Esmiol et al. 2012, Gazzola et al., 2018; Hays, 2024; Watts-Jones, 2010). The stories shared of these conversations all involved self-disclosure of emotion, political analysis and/or lived experience which supports literature that suggests practicing with a social justice lens involves taking a more sharing and non-neutral stance (Bennet et al., 2016; Brown & Walker, 1990; Goodman, 2015; Linklater, 2020; Reynolds, 2020). The findings also suggest that learning to practice this self-disclosure reflexively, with attunement to the relationship and an awareness of the therapist's power in the room, is important within any liberatory practice in trauma-informed therapy.

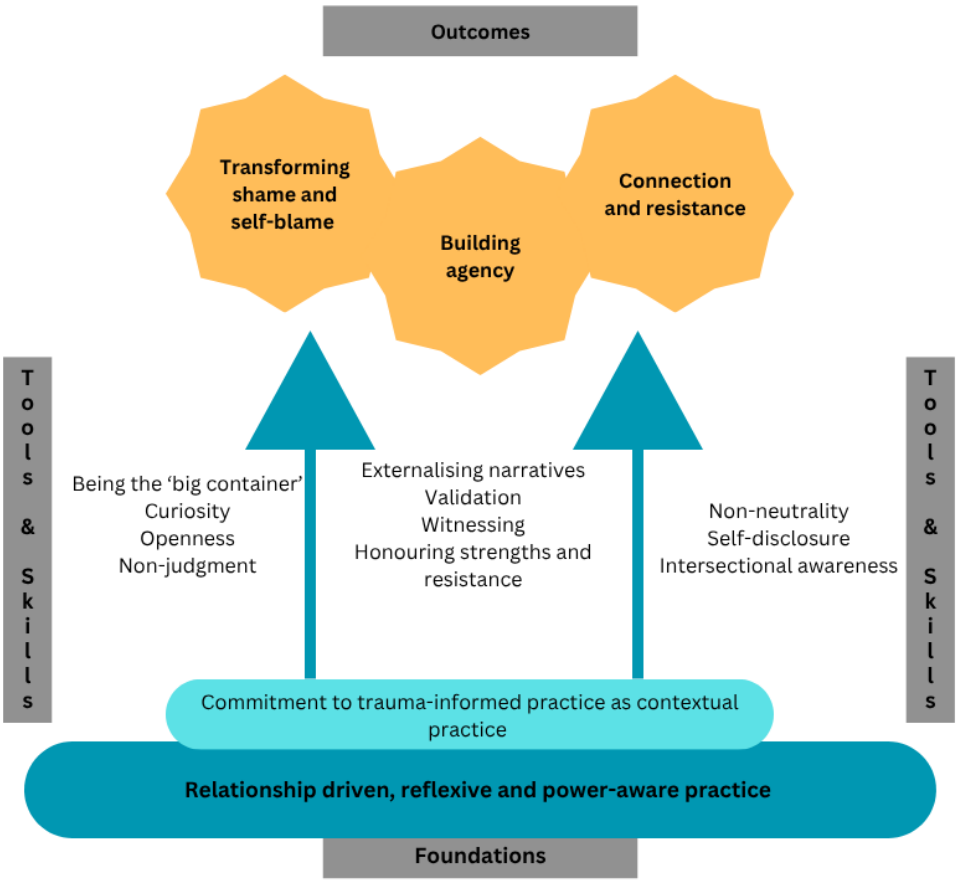
Chapter Eight - Summary and Conclusions

Summary of Findings

This study sought to explore therapists' stories of engaging in therapeutic work with survivors of interpersonal violence, which contextualises trauma within sociopolitical factors. Many of the findings of this study relate directly to implications for practice for practitioners, and thus, such implications will be included in this summary section. A diagram is presented below to help readers conceptualise the conclusions and overall narratives of these sociopolitical conversations, and how they answered research questions (see Figure 1). Following a description of this graphic by way of summary, a framework of reflective questions for practitioners is presented.

Figure 1

The practice of sociopolitically contextualised trauma therapy: Model of findings.



Foundations and Commitment

Foundations for good practice included relationship-driven, self-reflexive and power-aware practice and a social justice-driven, committed stance to exploring all contexts in trauma therapy. The foundations constituted a consistent thread identified throughout the findings. These foundations are essential for multiple reasons. Firstly, relationship-driven, self-reflexive and power-aware practice was at work when contextualising trauma within the sociopolitical, which suggests that a deep awareness of the self is vital to the practice of sociopolitical conversations. Reflection and knowledge on one's biases, privileges, identity and power in the room was referred to throughout narratives. This relational and reflective practice is active and non-neutral. It rejects claims to objectivity and, at times, embraces the role of co-collaborator. This again highlights the importance of self-awareness and reflection on how this active role is impacting clients, how to honour clients as experts of their lives, and prioritise their own goals and healing process. This reflection is foundational to a majority of the tools and strategies used in the stories of these conversations and made visible in participants' reflections.

Stories prioritised the therapeutic relationship in the here-and-now over any prescribed modality or rules. To make decisions about what was appropriate, relational and reflexive skills were at work, which held an awareness of power both within the room and outside of it. Narratives showed how reflexivity of the self and knowledge of one's own discomforts, power and privileges was necessary to carry out these conversations. Staying in the relational moment involved picking up the tools used and choosing them. This practice of relationship and power-aware practice was active: therapy became collaboration. It involved a stance of resistance on the part of the therapist, which brought their full selves into the process.

The relationship-driven nature of this work must be power aware to be effective due to a necessary focus on how each person impacts the process. This is an important finding in considering the social justice competencies of practitioners. Knowledge of social justice issues is not enough to hold these conversations effectively. Developing process skills, self-reflection skills, and power awareness in the therapeutic process is vital to carrying out conversations around the sociopolitical context of trauma.

This foundation of relationship-driven practice also suggests that in carrying out these conversations, there is a resistance to the manualised approach, which may be taken in approaches to trauma or therapy more generally. Instead, social justice-driven conversations which contextualise trauma politically involve a resistance to this alluring expert role of pre-prescribed rules or steps, in favour of the uncertainty and curiosity of the relational moment.

The findings of this study suggested that holding sociopolitical conversations in trauma therapy was conducted within the context of therapists holding a committed stance to exploring the politicised aspects of trauma and of the survivor's life. Their stance involved knowledge of, and commitment to the importance of, the sociopolitical context of sexual and other interpersonal violence trauma and to people's lives generally. This stance to their work positioned therapists in resistance to dominant, pathologising and individualising models and narratives of trauma and therapy. Therapists were critical of specialising practice which compartmentalised people's distress and thereby ignored some context, such as the sociopolitical. This finding is in line with suggestions that such contextualised practice and social justice practice may still sit in a marginalised position and not be mainstream practice (Conrad, 2007; Sutherland et al., 2016). Recommendations include that specific culturally and power-conscious models, such as the Meihana model and PTMF, may be important scaffolding to these relational practices for therapists, in that they may help legitimise and gain confidence in discussing these issues.

Tools and Skills

Findings showed how safety and trust to explore all contexts, including the sociopolitical, was developed collaboratively, with therapists using person-centered and relational skills of curiosity and openness. Necessary here was both an ability to contain and hold a grounded safe space of non-judgment, and to approach exploration with curiosity of a 'non-knower', relinquishing an expert stance. Findings suggest diverse life experiences, personal experience of marginalisation or working with those who experience it, as well as reflective spaces in which to practice uncomfortable conversations, helped to develop these skills. This finding shows how social justice practice includes working on person-centered

skills and exploring how to hold curiosity and sustain safety when discussing content one may be unfamiliar with or uncomfortable with.

In discussing tools that led to the outcomes at the top of the diagram, participants emphasised that making visible and externalising the oppressive sociopolitical narratives clients may be living with was a key tool used in these conversations. Victim-blaming and rape myth related narratives were described as a key component of trauma for survivors which needed to be externalised and contextualised at a societal level and, in so doing, re-framed. Other narratives associated with race, gender, sexuality and ability were described as just as important to externalise even when not directly related to the violent trauma, due to the compounding effects of marginalisation and oppression on experiences of shame and trauma. Participants described using validation often and described a witnessing stance involving a *being with* and witnessing injustice alongside survivors. Participants also collaboratively re-framed experiences to centre strengths and resistance instead of deficit or pathology. These findings suggest that narrative therapy therapeutic skills such as externalising and re-storying are useful in the process of holding sociopolitical conversations (Combs & Freedman, 2012), and align with literature highlighting the importance of an active witnessing stance in social justice approaches to trauma and therapy (Barak & Stebbins, 2017; Reynolds, 2020).

Non-neutrality was a tool used repeatedly to validate experiences of injustice and highlight sociopolitical narratives at work, which aligned with literature highlighting the necessity of taking up a non-neutral stance to resist the harmful status quo (Brown & Walker, 1990; Goodman, 2015; Linklater, 2020). This sat alongside a broader sharing of self often involved in these conversations. Participants described a nuanced and deliberate approach to self-disclosure, highlighting the risks involved and multiple instances of sharing their political analysis, background or emotions when considered beneficial to the survivor. This involved exercising reflexivity on what was useful in the moment and their own power in the room. Participant narratives highlighted risks involved when sharing identities, such as losing curiosity or making assumptions, and with less knowledge when an experience is not shared. In line with research around the turn toward an intersectional approach to understanding identity in therapy

(Ertl et al., 2019; Hung et al., 2023; Watts-Jones, 2010), this highlighted the need for an intersectional approach to this work and to conversations of sociopolitical context. Findings showed how exploring therapist personal privilege was necessary for undertaking this work.

Outcomes for Clients

Findings shed light on how therapists understood survivors experienced these conversations and how they benefited from them. Outcomes of these conversations centered around removing or transforming shame and self-blame. Findings emphasised that shame was central to survivors' experience of trauma, and inherently political and tied to both victim-blaming narratives, but also previous and ongoing experiences of marginalisation and oppression. This highlights the need for therapists to be equipped and skilled in exploring sociopolitical context in order to target the core aspects of trauma and its effects. In externalising and exploring sociopolitical context, narratives also described a building of agency through politically empowering survivors. More possibilities for understanding of self and the world were opened up, as well as more possibilities for action. This was balanced alongside a reflection of how exploring sociopolitical context may perpetuate a sense of powerlessness. This finding was significant in that it highlights how these contextualising conversations can build agency, which counters a narrative that suggests that exploring contexts out of clients' direct individual control may not benefit the client. A further outcome of these conversations was a sense of connection and involvement in communities of resistance or activism, highlighting how these conversations bridge a gap between individual and collective-level social justice actions. It also suggests that therapists should be equipped to help clients connect to communities of resistance as one avenue of healing.

Framework of Reflective Questions for Sociopolitically Contextualised Trauma Therapy

In reflecting on findings and associated literature, it became clear to me that developing any rigid 'guideline' for discussing sociopolitical practice would contradict the findings themselves, which emphasised the relational and in-the-moment awareness which was needed. Instead, as I explored the implications of the narratives shared, questions emerged both in participant narratives and in the associated literature, which may help practitioners in developing their practice in this area. Below, these questions are in three sections which broadly follow the three discussion sections in this study.

1) In developing a contextual practice which honours all context, and in developing abilities to contain and hold clients safely to explore this context, reflective questions include:

   - *Which sociopolitical topics am I comfortable discussing with clients and which am I not? Why?*
   - *In what situations and with what topics can I stay entirely in the relational moment, and what topics/areas make me default to using set frameworks? Why might this be?*
   - *Does my focus on a particular type of distress (e.g., a specialisation) bias me to centre that context and not see sociopolitical context as important?*
   - *Does my desire to be an expert in an area hinder my ability to see what context is important to the client?*
   - *Does my desire to be an expert relate to discomfort with uncertainty and being the non-knower?*
   - *How could I cultivate my ability to be the curious non-knower in therapeutic practice and how could I use these skills to explore sociopolitical context?*
   - *Did my professional training prioritise sociopolitical context as equally valid to explore with clients? How might my training affect my practice today as to what is prioritised or left less explored?*

2) When building skills to explore shame and sociopolitical context, build agency within these conversations and consider links to communities of resistance, reflective questions include:

- *What compounding political experiences and social locations are informing this person's experience of trauma and their meaning-making about themselves and their experience?*
- *How is the shame my client holds linked to broader social narratives about who they are and the identities they hold? What existing experiences of oppression trauma could have made my client more susceptible to holding shame?*
- *How is my client experiencing any conversations we have which explore sociopolitical context? Is it empowering? Is it part of a pattern of removing agency from the self, which has been influenced by trauma? If so, how might I honour my client's politicised experience and context while also honouring the agency they do hold?*
- *How do our conversations about sociopolitical context link my client to bigger communities and modes of resistance? Is this something they want?*
- *What meanings did I suggest, and what did I introduce in this session? How are my own beliefs shaping my client's development of new meanings and stories about themselves and the world? Am I transparent about my contribution to this? Am I allowing enough space for my clients own meaning-making process?*

3) Reflective questions, including those below, help develop intersectional awareness, cultivate self-awareness of power and privilege, and explore when self-disclosure is appropriate in these conversations. Some questions are adapted from Reynold and Hammoud-Beckett (2017) and Mahalik (2000).

- *Where do my own identities and life experiences intersect and differ with my clients, and in what ways may this impact our work together? Am I making assumptions about their experience based on my own?*

- *Where do I hold power and privilege and in what ways have I experienced marginalisation or oppression? How do each of these impact my work with clients and what I may be more or less comfortable discussing?*
- *How can I work to embrace the discomfort in recognising my privileges and areas of lived experience and identity where I struggle with emotional reactions?*
- *What people, groups or organisations can I work with to explore power and privilege in trauma-informed therapy?*
- *Would more sharing of myself help my client in their therapeutic process and our relationship in this moment, or could it bring them out of their process or overwhelm them?*
- *How might narratives around professionalism or my discomfort be hindering my ability to practice in liberatory ways?*

Implications for Training

Many of the most critical findings from this research relate to the training of therapists. Findings highlighted that participants felt that trauma and sociopolitical context was not well integrated into training. Psychologists, in particular, described an ongoing dominance of assessment and medicalised narratives over trauma, process or more contextualised practice in their training. Their practice of contextualising conversations within a broader sociopolitical context was something they did despite their training, rather than because of it. These findings imply that psychologists in Aotearoa still have much work to do to integrate issues of sociopolitical context and social justice, and even trauma generally, into training. Given the dominance of the medicalised model described, findings suggest that the training of therapists must include sharing critical analysis of the medical model, and to position it culturally and historically, to give students the full context and understanding of it, and to be able to use it flexibly amongst more contextualised approaches.

Findings corroborated that of other researchers who have argued that training in social justice and cultural competency often focuses on content about specific marginalised group but lacks a focus on

process and power oriented skills (e.g., Morrison et al., 2022; Treichler et al., 2020). Findings suggest that training models must include ongoing self-reflection around issues of power and privilege and group discussions which can unpack areas of discomfort. Training must have this self-reflexive and intersectional focus to avoid essentialising, othering and perpetuating assumptions about the people therapists work with. Practising these contextualising conversations was also an important learning and could be more integrated into training. Training could include reflecting on these practice conversations, which should focus on the relational and in-the-moment power awareness, which was described as essential in appropriately discussing sociopolitical context.

Findings also suggest that key specific content in training programmes is essential to therapists being able to contextualise trauma effectively. Therapists need to have developed knowledge about rape culture and relevant social narratives key to the post-trauma experience. Other vital knowledge for contextualising trauma included how existing experiences of marginalisation and oppression compound experiences of trauma and associated shame. Where this is not occurring, this learning should be integrated into training. Findings also suggest that externalisation and other tools involved in narrative practices may be particularly useful for therapists in exploring sociopolitical context and could be developed in training. Finally, results show that therapists having the skills to link clients with communities and groups which engage in collective action is another skill which was in use in these conversations and should be included in training.

Limitations and Future Research

The main limitation relates to the voices not heard in this study. As someone committed to social justice, I have reflected throughout my research process on the important voices that were absent in this process and must be heard in the conversation. In developing my methodology and research aims, I wanted to hear from therapists across modalities in their stories of holding these conversations and I was interested in the therapists describing their work and experience and and the tools and strategies they used.

One group of voices that was not heard was therapy users and people with lived experience. Future research could explore similar questions about these politically contextualised conversations with survivors or clients in therapy generally. This will be an essential element in providing a greater depth of knowledge around the practice of exploring the sociopolitical context of trauma, particularly concerning outcomes of these conversations experienced by survivors which was discussed in the findings in the current study. Participants in this study averaged an older age, so future research exploring new graduate therapist practices would also be useful.

As discussed previously, there were no Māori participants in this study. As this research took place in Aotearoa in the context of a colonised land, this is an obvious limitation. Future research could explore Māori therapists' experiences of exploring sociopolitical context specifically, which would hold much valuable knowledge about Māori experiences of working in the trauma therapist role and in situating trauma within Aotearoa's unique history and culture. Māori therapists and clients' voices on the outcomes and suggestions for what is involved in these conversations would be important in adding validity to their applicability to work in Aotearoa.

A further limitation was the size and scope of the study. The relatively limited sample of ten participants enabled a deep exploration of narratives, but is also limited, especially given that it included therapists across different professions. Future research could look at social justice practices in therapy across more participants from different mental health fields. Also, the framing of this study resulted in exploring the views of participants who are committed to contextualised conversations and social justice broadly. Future research could focus on a wider range of therapists' practices more generally where there is less commitment.

There were many findings which could be studied in more depth. For example, the critiques of specialisation within therapy and its effects on social justice practice and working contextually has relatively little associated literature and could be explored more. Questions which arose from this research include how much specialising in an area of distress might obscure our view of other contexts

and experiences as equally important. Also, how much is practitioner discomfort, or the need to feel like the expert and have certainty, related to specialisation and not working with sociopolitical context?

Training models that incorporate the suggestions made in the previous section should be studied for their effectiveness and outcomes. Findings also highlight that further research into students' experiences and perceptions of faculty social justice knowledge and competencies may also be useful and how this impacts trainee outcomes. The intersection of social justice training and existing abuses of power within programmes would also be an important area for future research.

Conclusion

This study sought to explore therapist stories of engaging in therapeutic work which contextualises trauma within sociopolitical factors with survivors of interpersonal violence. A thematic narrative inquiry methodology was used and ten counsellors, psychotherapists and psychologists shared their stories and reflections. Results showed how power-aware practice was at work across these therapeutic conversations. A commitment to seeing all contexts of trauma puts therapists in a position of resistance to mainstream practice and, for psychologists, their own training. Outcomes for clients from these conversations included reducing or transforming shame and self-blame, increasing options and agency, and fostering collective resistance. Tools used by therapists included externalising conversations, validation and witnessing, and reflexive self-disclosure. An intersectional approach and self-reflection on power and privilege were necessary to avoid the risks involved with these conversations. Overall, results emphasised how a relational, power-conscious practice is needed in social-justice-centered conversations, prioritising relationship in the moment over prescribed rules or frameworks.

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Appendix A – Study Advertisement

Seeking research participants- He Pānui Rangahau

TALKING ABOUT THE SOCIOPOLITICAL CONTEXT OF TRAUMA IN THERAPY

Tēnā koe!

*Are you a **trauma-informed registered counsellor, psychotherapist or psychologist** who works with survivors of sexual or interpersonal violence?*

*Have you had conversations with survivors, as part or your therapeutic practice, about the sociopolitical factors involved with their experience of trauma, such as exploring the role of **oppression or discrimination** based on gender, ethnicity, disability, sexuality or class?*

I am seeking participants to be involved in research exploring therapist experiences of navigating the inclusion of sociopolitical context in their therapeutic conversations with survivors of sexual or interpersonal violence. Interviews will be approximately one hour and participants will receive a $40 gift voucher for participating.

If you are interested in taking part or have any questions, contact **Jessie Dennis**
jessie.dennis.2@uni.massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 21/62

Appendix B – Information Sheet for Participants

Study Information Sheet

He aha te kaupapa ō tēnei rangahau? - What is this research about?

Addressing sociopolitical context in therapy with survivors of sexual and interpersonal violence: Aligning trauma-informed and social justice praxis.

Who is conducting this research?

Kia ora, my name is Jessie Dennis. I am undertaking this research project in partial fulfillment of the requirements of a Doctorate of Clinical Psychology at Massey University. You can find more information about me in the contact section below. This project is being supervised by Dr Clifford Van Ommen (primary supervisor), Dr Andrea LaMarre and Dr Simon Bennett (Te Arawa, Ngā Puhi, Kai Tahu).

What is this research about?

It is widely acknowledged that sociopolitical context, such as experiences of oppression or discrimination due to gender, ethnicity, socioeconomic status or sexuality, plays an important role in the experience of, and healing from, trauma, including sexual and interpersonal violence (SV/IPV). However, there isn't much research around therapists' experiences of holding conversations with clients which explore how these sociopolitical factors have impacted their experience of trauma. This research is interested in trauma informed therapists experiences of such conversations with clients; what influences their decisions to and ability to have these conversations and what techniques they use in these discussions, when and why they think such conversations have helped clients, and how their own life experiences and training has prepared them for this element of their work.

This research focuses on these therapeutic conversations about sociopolitical context as one place where therapists enact social justice in their practice, and findings of this study will provide recommendations for providing therapy which attends to the sociopolitical context of sexual and interpersonal violence and trauma. Such recommendations will assist mental health workers across disciplines in providing best practice trauma-informed care.

What will participants be asked to do?

For my study, I want to talk to trauma-informed therapists who work or have worked with survivors of SV/IPV about their experiences. I am interested in hearing your stories of conversations with survivors about the sociopolitical context of trauma and your thoughts around these conversations. This might be stories about conversations where you have worked with a survivor to explore or understand the role of sexism, rape culture, racism, colonisation, or another experience of marginalisation, in their experience of trauma and distress, or how it impacts their recovery. I am interested in your reflections on these conversations, what has worked well and what hasn't, and how your training and life experiences have influenced how you carry out these conversations.

If you are interested in participating, we will arrange a time to meet for an interview, in person or online, based on your preference. I will arrange this for a place and time that is convenient to you. The interview will take approximately 60 minutes, and you are welcome to bring a support person along. The meeting will begin with introductions and a chance to ask any questions you may have prior to beginning the interview proper. At completion of the interview, participants will receive a $40 grocery voucher in acknowledgment of their participation.

Prior to the interview, I will send you some more information on some questions that I may ask. Your comfort will be the top priority throughout, and interviews can be stopped or paused at any time. If this interview raises issues for which you feel you need further support, I can work with you to find an appropriate support service and provide any contact details where necessary.

Who can take part?

I am inviting any therapist to take part who identifies as taking a trauma-informed approach to their work and works with survivors of SV/IPV as part of their work. For the purposes of this study, 'therapist' will include any counsellor, psychotherapist, or psychologist (any scope) who is registered with the appropriate professional body. The only other criterion is that participants have held conversations with their clients about the sociopolitical factors involved with trauma and distress (such as, but not limited to, current or historical issues of sexism, rape culture, racism, colonisation, classism, ableism, heterosexism, cissexism, etc.).

How are participant's identities and information protected?

I will do my best to respect participant confidentiality in the handling of data. This means that names will be changed, and no information that could identify you will be included in my thesis. You will be offered a chance to check the transcript for any information you want removed (this will take around 30 minutes). Transcripts will only be accessible to myself (Jessie) and my supervisors. I will not provide any information you give me to anyone else without your consent.

What will happen to the information given in the interview?

The audio recordings and interview transcripts will be held in anonymised, password protected files on a password protected computer and used to prepare my Doctoral thesis. After my thesis is completed, I will provide anyone who has participated in my research with a summary of my findings. The full thesis will be available on the University website and can be shared with interested participants. In addition, my supervisors and I hope to prepare further publications from the research in order to reach a wider audience, these publications can also be shared with you. Finally, all personal information and transcripts that have been stored, will be destroyed after five years.

What are my rights as a participant?

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- ask any questions about the study at any time during participation;
- withdraw from the study at any point until 6 weeks after your interview without reason or penalty;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given a summary of the project findings after the research has concluded.

Project Contacts

I, Jessie Dennis, am the primary researcher for this study. I am a 34 year old pākehā cisgender woman. I grew up in Ōpōtiki and Kawerau and have spent a lot of my adult life in Te Whanganui a Tara, Wellington. I now live in Ōhawe, South Taranaki. Before returning to study to undertake my Doctorate in Clinical Psychology, I worked in community and advocacy fields for around 12 years. I have worked for most of these years in either climate change advocacy or in services that work with survivors of sexual or gendered violence.

You may contact me or my supervisor at any point if you have any questions about this project, or to discuss concerns or give feedback. Contact details are provided below:

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This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 21/62. If you have any concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83570, email humanethicsouthb@massey.ac.nz .

Appendix C – Consent Form

Addressing sociopolitical context in therapy with survivors of sexual and interpersonal violence: Aligning trauma-informed and social justice praxis.

PARTICIPANT CONSENT FORM

I have read and understand the Information Sheet. I have had the details of the study explained to me, my questions have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time until 6 weeks after my interview.

1) I understand that the interview will be audio recorded, or in the case of an online interview, video may also be recorded.
2) I agree to participate in this study under the conditions set out in the information sheet.
3) I understand that my participation in this study is confidential and that no material which could identify me personally will be used in any reports on this study.
4) I know who to contact if I have any questions about the study in general.
5) I wish to receive a copy of the summary of findings (please circle one) Yes No
6) I wish to receive a copy of the full thesis once completed (please circle one) Yes No

I _____ _____[print full name]_ hereby consent to take part in this study.

Signature: _____ Date: _____

Appendix D – Interview Guide for Participants

Interview Guide for Participants

I will begin by getting to know you and sharing some things about my own background and some whanaungatanga (introductions and sharing process). I will check in with you about your rights as a participant and allow time for any questions you might have.

The conversations will be guided by you as much as possible and I am interested in knowing what is most important to you around this topic. I will start by asking you about what led you to this work, and why you decided that discussing sociopolitical factors of trauma would be part of your therapeutic practice.

I will then ask you to share with me any stories that stand out for you around conversations you have had with clients which places their trauma within a broader sociopolitical context. These might include stories about how you have worked with a survivor to explore or understand the role of marginalisation (which can include sexism, rape culture, racism, colonisation, ableism, queerphobia, classism or another experience) in their experience of trauma and distress and how you believe this conversation has impacted their recovery.

As relevant, I will also ask about what you feel has been effective in these conversations and any particular techniques and tools you tend to use or have used. I am also interested in hearing how you feel your own life experiences and professional training has equipped you for or influenced how you hold these conversations.

Appendix E- Research Case Study: Reflections on Sociopolitical Aspects of Trauma Within Practice

Jessie Dennis

DClinPsych Candidate, Massey University Clinical Psychology Intern

2023

This case study represents the work of Jessie Dennis during her internship in 2023 at the Child and Adolescent Mental Health Service, Te Whatu Ora, Taranaki. Clinical Supervision was received during the assessment for the individual described within this case study. Names and other identifying information within the case study have been changed to protect the privacy of the client.

Positioning

Within the qualitative methodological standpoint which my research sits within, researcher influence over the research and its findings is considered inevitable. It is important to me to situate myself within my work from the outset, in order to both make myself visible in the work and therefore be accountable to and reflective of the process through which I am involved in the creation of knowledge.

I am a Pākehā cisgender and able-bodied woman and hold multiple levels of power and privilege. Living in a white body enables me to benefit from the power which white supremacy holds in our society, as well as having a lineage of ancestors who have held this privilege. I hold privilege in other ways too; identifying as the gender I was assigned at birth means I conform to societies binary and transphobic ideas of who a woman is. I also hold privileges as an able-bodied person, and because of my tertiary-level education. I have also grown up as a woman, in a financially struggling single-parent home and my life, and my family's intergenerational story, is one which has been impacted by sexual and interpersonal violence. My own story and those around me led me to paid work which focused on activism and advocacy around gendered violence, feminism, environmental justice and anti-racism. Having worked for

over 10 years in the fields of institutional and systemic change, it felt natural to me, when I began my research in the field of psychology, to bring this perspective. My experience both personally, professionally and as an activist has influenced the perspective I bring to this research, the way I have approached it and the meanings I co-construct from it.

Background of Research and case for study

Sociopolitical context of SV/IPV

It is now widely accepted that sociopolitical systems and conditions are inextricably linked with the prevalence and experience of sexual violence (SV) and interpersonal violence (IPV). A person's position to power, mediated by discourses around gender, race, ability, sexuality, as well as economic resources, affects both a person's likelihood of experiencing violence, as well as their access to appropriate resources for recovery (Tseris, 2019). Experiences of discrimination and oppression, as well as a culture of rape and victim blaming, compound the effects of violent trauma, making recovery a more complex and difficult journey (Cockburn, 2004). Trauma theory and trauma-informed practice is now mainstream, and were, in part, developed out of a desire for the recognition of context instead of the location of the deficit in the individual (Goodman, 2015). Mainstream understandings of trauma demand a questioning of ‘what happened to you’’ instead of “what is wrong with you?”. A growing body of literature is developing ecosystemic understandings of trauma, such as areas of research devoted to intergenerational trauma, collective trauma and discrimination trauma (Muldoon, 2020 Lawson te-Aho & Liu, 2010 Goodman, 2015).

Trauma-informed guidelines, along with professional code of ethics for most mental health professions, including psychologists, include calls for understanding of social justice and how inequities affect our clients' lives (Hailes et al., 2020). They also call for these understandings to be incorporated into practice. New Zealand TIC guidelines have emphasised the need for trauma-informed care to take into account the processes of colonisation and dispossession, which impact experiences of trauma for Māori (Donaldson, 2018). The Code of Ethics for Psychologists working in New Zealand calls for ‘addressing and challenging unjust societal norms and behaviours that disempower people at all levels of

interaction' and demands that ''Psychologists are sensitive to the needs, current issues, and problems of society and take account of these needs in their work" (Code of Ethics Review Group, 2012, p. 25). The New Zealand Association of Counsellors Code of Ethics (2020) promotes social justice as a core principle, and calls for counsellors to "support their clients to challenge the injustices they experience" (New Zealand Association of Counselors, 2020, p. 5).

Critical trauma researchers have suggested that despite its promise to embrace context and reduce pathological understandings of clients, trauma discourse has been co-opted to fit within medicalised understandings of distress (Tseris, 2019). The rise of trauma-related diagnoses such as PTSD has been criticised for their potential to pathologise reasonable responses to violence, and for locating deficit within the survivor (Burstow, 2003). Many researchers suggest that despite the widespread acknowledgement of the importance of sociopolitical context, assessment practices still widely exclude exploration of collective, systemic and transgenerational context and impacts (Kira, 2001, Frazier et al, 2009).

Despite the growing calls for socially just practice, some scholars have suggested that the trend is, in fact, towards less politicised and more individually focused practice (Gold et al., 2017; Pare, 2014). The reasons for this are complex and multifaceted, but some suggested factors involved include practitioners struggling to balance both medicalised and more ecosystemic frameworks and discourses within their work, and insufficient training in areas of social justice (Burnes & Singh, 2010; Treichler et al., 2020).

Despite the ever-growing demands to incorporate trauma-informed and socially just practice into therapeutic work, including with survivors of SV and IPV, there is little research on how practitioners enact this in practice. There is sparse research on the experiences of therapists who engage in conversations with clients about such unjust societal norms and behaviours, what influences their choice to engage in them, and what experiences, skills, and training they draw on to incorporate them into clinical practice (Sutherland et al., 2016). As demands for social justice-informed trauma practice increase

across disciplines of therapeutic practice, more knowledge is needed about therapists' trauma-informed practices as they occur in therapy (Pemberton & Loeb, 2020).

Research aims

My research explores therapists' stories of engaging in therapeutic work which contextualises trauma within sociopolitical factors with survivors of interpersonal violence. I used a thematic narrative inquiry methodology to explore the stories of therapists who engage in conversations with survivors of violence about the historical, political, cultural and gender factors related to trauma. This included exploring what they feel influences these conversations, being effective or not, including techniques used and personal and professional learning, along with barriers or challenges they face in doing this work. With the widespread demand for a socially just and aware approach to trauma-informed practice outlined above, more knowledge about clinicians' experiences facilitating and navigating these discussions will help therapists adopt such an approach. Knowledge gained from exploring these stories may also help inform researchers and practitioners incorporating such a focus into training programmes.

Theoretical approach and method

This research was underpinned by a social constructionist understanding of knowledge. Social constructionism argues that relationships and social interaction are the sites of knowledge production (Schwandt, 2003). Through language and social exchange, knowledge is negotiated and contested. In opposition to essentialist and empirical approaches to knowledge, which see it as something 'out there', to be discovered. The social constructionist approach does not dismiss observable or biological differences, but rather emphasises the meanings we assign to and create for these differences, how they are constructed through language and interaction, and who they serve. Importantly for my project, social constructionism is also linked to an exploration of the use of power, in that positions of power within society influence whose constructions of knowledge are socially accepted and deemed as 'truth' (Burr, 2015).

Within this understanding of knowledge creation, I chose to use narrative inquiry method in my research. Narrative inquiry approaches focus on narrative as the process and form through which humans

make sense of the world (Murray, 2021). Narratives draw together the past, present, and future to form meaning, contextualised by social and cultural influences (Riessman, 2008). This focus is particularly relevant for this project, where therapists may be viewed as part of the narrative sense-making around trauma that occurs within therapy and influence how and if sociopolitical factors feature in these processes. Narrative research is also well suited to research situated in critical and social justice informed theoretical frameworks, as it enables a focus on the cultural and social contexts of narrative and experience (Andrews, 2004).

Recruitment and Participants

My criteria for recruitment was that participants are therapists registered with an appropriate professional body, and work with clients who have experienced sexual or interpersonal violence trauma. For the purposes of my study, I defined 'registered therapists' as including those registered as Psychologists, counsellors or psychotherapists. Participants must also have held conversations with clients about the sociopolitical factors involved with their trauma, including but not limited to gender, cultural, historical factors and experiences of discrimination and marginalisation. In describing the background of the study, I expected that participants would be therapists who find this element of their work particularly important. This was borne out in the participants who volunteered to be involved, most of whom were particularly passionate about the topic, and about the importance of taking a stance in therapy which acknowledges the importance of the sociopolitical experience of clients.

I interviewed 10 therapists. Five of these were Clinical Psychologists, three were counsellors and two were psychotherapists. Eight identified as women and two as male. Seven identified their ethnicity as Pākeha/NZ-European, one as Malay-Indian, one as Indian, and one as Asian-Pasifika/Pākehā. Their ages ranged from 33-60.

Reflections on sociopolitical context of trauma as an Intern

In January 2023 I began my internship with Te Whatu Ora based in New Plymouth hospital. Half of my time is spent working with the Child and Adolescent Mental Health Service (CAMHS) and half with Adult Community Mental Health. The CAMHS team works with children and young people aged 0-18 with moderate to severe mental health needs, while the Adult Community Mental Health (CMH) team is an outpatient service which works with those with moderate to severe mental health needs. A majority of those tanagata whaiora seen in the CMH psychology team also have a keyworker who works alongside them. In CAMHS, Psychologists also work as keyworkers for the clients they see. In both teams, Psychologists are involved in a mixture of therapeutic and diagnostic assessment cases.

The sociopolitical Context of the distress: A case description and reflection

'When we create relationships of respect and dignity, we truly meet people where they are at and their acts of resistance become visible, inviting a witnessing of their intelligence, strength, and courage. We do not diagnose people as mentally ill, and we do not accuse them of being self-sabotaging, but enter their world where their actions towards dignity and safety become visible to us.' (Reynold, 2020, p. 14)

I have been privileged to work alongside Tangata Whaiora on a wide range of presenting issues and areas of distress during my internship. I have often reflected on the crucial role that my clients' sociopolitical context, and the societal narratives which they have absorbed about their identities and experiences, have played in the development of the mental health issues which they present to services with. To illustrate this with an example, I present a case composite from my intern experiences.

Samantha is a 30-year-old Māori woman who was referred following a psychotic episode. After our first session, an entirely different picture emerged of Samantha's experience than what one might assume based on the diagnoses that were listed in her referral. Samantha was in a 10-year-long abusive relationship from the ages of 20-30 and has one child. Her (now ex) husband subjected Samantha to physical, sexual and emotional abuse throughout this time. Samantha felt fearful that her child would be

taken from her if she left, and her husband used various power and control tactics to keep her in a constant state of fear, confusion and hyperarousal. She, understandably, struggled with depression at various points during this relationship, but otherwise had relatively stable mental health. Eventually she left her husband, but there were various stresses involved in doing so, with little support for financial stresses. She also found that many close friends did not understand intimate partner violence or the signs of power and control, and did not believe or support her. Samantha's memory of her period of distress which involved psychotic experiences, is still relatively patchy, though memories have begun to return as we have worked together. Within the space of a few weeks, Samantha was hospitalised under the Mental Health Act, and her child went to live with family. Samantha is struggling to come to terms with the aftermath of this period. Samantha is struggling to get out of bed and do daily tasks of living. She also struggles with feelings of guilt about ending her relationship, wondering if perhaps she had just stayed, she wouldn't have had this episode and would have therefore kept her child living with her. Samantha is not connected to her own whānau or her Iwi for various reasons, which she was when she was younger, and says this was a happier period of her life. She has few social supports.

Working with Samantha has been one of many experiences in my internship which has highlighted the vital importance of acknowledging the role of sociopolitical context and discourses in our clients' lives. Samantha has been described in medical records as someone various which carry significant social stigma. Leaving aside the diagnostic accuracy of these descriptions, Samantha may also be described as someone who experienced a decade of abuse and fear at the hands of an abusive partner. Following a courageous decision to end this relationship, she was then left financially struggling and subject to her ex-husband using his financial wealth as a continued weapon of power and control. Following these many years of immense stress, she experienced an episode involving psychotic experiences. When this occurred, she was hospitalized against her will, and given a diagnosis which she strongly feels is incorrect. She expressed that she now thinks that many healthcare workers she has interactions with are simply trying to get her to get on with things, and do not understand the immense loss involved with this time, which, for Samantha, still feels like a living nightmare.

Intersections of gendered violence, colonisation, poverty and medicalisation and pathologisation have played an important role in Samantha's story and in her distress, and have led to her power over her own life and circumstances being reduced at many levels. Firstly, Samantha is a survivor of long-term intimate partner violence. Not only was she subject to this abuse, but she also received little support, hearing victim blaming narratives as her partner worked to alienate friends from her. After internalising the message that this abuse was her fault or that she was making it up, these internalised victim-blaming narratives have resurfaced as she faces the fall out from her episode of psychotic experiences, wondering if she should have just stayed with her husband. Instead of receiving supportive messages within society when she left her husband, she was faced with a new reality of barely being able to make ends meet and put food on the table for her young child. Then, after a severely distressing episode, the first of her life and coming after sustained immense stress, she has received messages of pathologisation, locating deficit squarely within her, and heard narratives of needing to 'get over' what has happened and 'move on'. From her descriptions, it seemed clear that many of these experiences were also influenced by racism. The institutions in society which should have been there to support her when she left her relationships failed her, and the healthcare system failed to make her feel seen as a human being in the most distressing time of her life. These events occurred on top of a background of intergenerational trauma. Samantha proudly told me of her whānau's whakapapa to great chiefs. Sadly, the historic and ongoing injustices of colonisation are a part of the story of Samantha's current disconnection to her Iwi, something which we explored in later sessions.

I have reflected a lot on the enormous strength and courage Samantha has shown in her life to endure intimate partner violence and leave her husband while raising her young child, and to now be continuing to get help in efforts to rebuild her life following this distressing episode. When Samantha came to her first session, she was very withdrawn and answered questions with brief, sometimes one-word answers. As a new clinician I felt anxious about my ability to work with her. She could have easily been labeled within the system I am working in, as I have seen occur with other clients, as someone 'not ready to engage'. I reflected on my first session with my supervisor, who focused on one of the few things

Samantha had shared with me- that she had felt misunderstood and not heard by other healthcare workers and family. My supervisor emphasised that she was giving me very important information about her experience and what she needed. This led me to reflect more deeply on the multiple layers of disempowerment Samantha has faced. I reframed my role and decided that I would go into my next session with no agenda or plan, I needed to see and hear Samantha as a person, to not let my anxious beginner-clinician role get in the way of creating a space where Samantha might actually be able to begin to have an experience different to the ones she had described.

Our second session was completely different, and Samantha chose to focus primarily on her many years of abuse and shared many stories of what she experienced. I have found validating the stress she was under, and that the abuse and experiencing distress as a result of this was not her fault, to be an important part of our work. Acknowledging that she knows her experience better than any healthcare worker who may have met her once or twice has been an important part of rapport building. Like participants shared in my research, the importance of sharing the sense of injustice I have felt about her experience has been, in my opinion, some of the moments where I have felt Samantha's sense of being heard, and perhaps a sense of safety, increase. These moments, where injustice is acknowledged, and where victim blaming is directly countered, have been crucial.

From one lens, progress in our sessions could have been described as slow. I had to actively resist thoughts and feelings which arose in myself that suggested that our work must not be 'useful' during this time because there were no obvious 'results'. Instead, I reminded myself that my repeated witnessing of Samantha's story in sessions, my repeated validating of the structures which had compounded her trauma, was contributing to a building of trust and relationship. In talking with my supervisor about Samantha's ongoing problems with what might be framed within a CBT framework as 'behavioural activation' I reflected on Vikki Reynold's (2020) work highlighting the importance of reframing so called 'symptoms' as resistance, and in taking a stance of 'witnessing'. Samantha's refusal to accept new 'tools' to try at the beginning of our work, could be viewed as an act of resistance to the invalidation of her story she had experienced, as a response to the violence she had experienced, and as using power in the area where she

still had it. She had felt from other healthcare workers that the violence and trauma she had experienced, particularly in losing custody of her children, had not been acknowledged and that instead they had been sent to tell her how to 'move on'. Samantha was signalling, through her actions, a resistance to this invalidation, a desire to have her pain acknowledged —if by no one else, then at least by herself. She was also using her own power to resist feeling the emotions which had resulted from her trauma.

Barriers to meaningfully engaging with sociopiltical context with clients

My research has helped me to reflect on how our clients' position to power and wider sociopoltical context impacts their experience of trauma and mental distress. It has also helped me to consider and reflect on the barriers that I have faced to incorporate this wider context into my work meaningfully, and to work in ways which I consider to be upholding principles of social justice. As has been reflected in my research and in comments by participants, the medicalised system within which mental health work is has been one such barrier. Often, clients are referred with existing diagnoses or are often diagnosed with multiple disorders while in the Te Whatu Ora system by Psychiatrists. These diagnoses can be helpful for clients and provide a sense of validation and self-understanding which allows them to reduce self-blame. In the CAMHS service, diagnoses can also provide parents with more knowledge and acceptance of their child, and even access to resources and financial support in some cases.

However, working in a system built around a diagnostic model has also provided challenges when attempting to work in socially just ways which acknowledge and consider the sociopolitical context of clients in both formulation and treatment. I have found the CAMHS service to generally be one which attempts to work in trauma-informed ways and resists diagnosis as an absolute necessity for service. However, there are limits to this. In just one of many examples, accessing some external resources, such as a service which assists young people struggling at school for health reasons (including mental health), requires a diagnosis. I have witnessed how this can become a focus for a client or their family, where figuring out what 'it' is can become a key goal in accessing services. This is, of course,

understandable; however, working within and alongside these diagnostic processes can pathologise clients and what have often been very rational and understandable responses to family, environmental and social stresses and trauma.

It has been interesting for me to reflect on what was raised in my research around what 'counts' as trauma, and what experiences are visbilised as relevant and important and which are not. An example of this is evident in assessment templates used within services. Within the CAMHS service, it is clear to me that clinicians have spent considerable effort to ensure trauma-informed approach is included. Areas covered include family history, and questions about adverse childhood experiences. Further, a formulation is included at the end and no formal diagnosis is required within the assessment template. I have, at times, reflected on how differently we might carry out assessment if our assessment documents included areas for covering culture, the family's history with the healthcare system, or relevant experiences of discrimination based on race, gender, ability etc. Of course, clinicians may gather this information later in treatment, but I have wondered how our approach and view of clients challenges may be altered if gathering this information as part of initial assessment was proceduralised and prioritised.

As an intern psychologist, another barrier I have faced in incorporating more socially just practices into my work is mental load and capacity. As an intern I was learning to get the basics right, learning the processes and systems I am obliged to follow, learning about appropriate assessment, about each new area of distress I work with and how to help each new client, often in areas which I have not yet worked with. I was also preparing for exams, writing 6 case studies throughout the year and ensuring my skills were sufficient to pass the training I've spent eight years working towards. Within that, I have felt at times like incorporating different ways of working, which may be beyond the more medicalised status quo, is a significant challenge. Without any formalised time within training which is set aside for prioritising reflections on power, privilege and social justice in our work, it can fall off the to-do list for the sake of getting through the week. However, I have at times in the year challenged myself to not begin practice in ways that do not align with my values. It has become clear to me that finding ways to express

my values in my everyday work will be one of the keys to avoiding burnout and finding sustainability within a system which is almost at breaking point.

The severe resource shortages faced by the services I work within has been striking. Waitlists are incredibly long, and a cursory glance at this waitlist highlights the fact that due to the growing demands on the service, what must now be deemed 'moderate' are often in fact incredibly serious mental health conditions. Within this environment, clinicians are under considerable pressure to use time wisely. As keyworkers for all clients, Psychologists must often cancel client appointments to attend to other clients in crisis or to meet duty crisis demands when the team requires it. I can see the tension my colleagues feel around this, and how this may be detrimental to the therapeutic processes they are involved in with their clients. In the context of the pressure of increasing demand, increasing severity of presentations, and not enough resources, I have seen how the challenges to work in socially just ways are further increased. Decisions must be made around resources which priortise current risk which may clash with values. However, I have been incredibly lucky to work within a service with many clinicians who continue to emphasise the politicised context of our clients lives and see them within this context and who refuse to locate deficit within our clients.

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