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EXPLORING DOMESTIC VIOLENCE AND MENTAL HEALTH

Section A: What are women's experiences of being subjected to mental health coercion in the context of domestic violence? A review of the literature.

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Section B: "*Where is the help for me here?*": Female domestic violence survivors' narratives of navigating secondary-care mental health services.

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Summary of MRP Portfolio

Part A: Part A is a systematic review of published literature on women's experiences of mental health coercion in the context of domestic violence. Six online databases were systematically searched for relevant articles and thematic synthesis was used to synthesise the studies. Thirty-two papers were identified as relevant to the review question. Analysis identified five central themes: 'Creating an environment of confusion', 'Positioning women as crazy', 'Narratives of blame', 'Abuses of power', and 'Gendered expectations'. The findings suggest that 'mental health coercion' should be integrated into understandings of coercive control to increase awareness, validate survivor experience, and inform service provision.

Part B: Part B is a qualitative study of female domestic violence survivors' narratives of navigating secondary-care mental health services. Seven participants were interviewed about their experiences of navigating secondary-care mental health services with the aim of informing service practice and provision. The voice-centred relational method and thematic analysis was used to analyse women's narratives. Analysis of the women's interviews identified three main narratives: 'Missing the connection(s)', 'Missing windows of opportunity', and 'Finding a safe haven'. Results suggest that mental health professionals consistently missed the connection between abuse and women's presenting distress. The structure of mental health services was not conducive to supporting survivors of domestic violence and resulted in superficial interventions and relationships. This meant that windows of opportunity for appropriate support were consistently missed.

Part C: Appendices of supporting material

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MAJOR RESEARCH PROJECT

Section A: Literature Review

What are women's experiences of being subjected to mental health coercion in the context of domestic violence? A review of the literature.

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Abstract

Introduction: Coercive control is a central aspect of domestic violence and became a criminal offence in 2015. Recently attention has focused on the specific role of abusive tactics targeted towards an individual's mental health. The term 'mental health coercion' has been suggested: attempting to undermine a survivor's mental health, preventing access to, or interfering with treatment, controlling medication, or using their mental health status to discredit them for example in interactions with police or in child-custody decisions. As yet few papers have examined this issue in the peer-reviewed literature.

Method: Qualitative research has the potential to increase understanding of the breadth of experiences of domestic violence and coercive control. Studies were analysed using thematic synthesis (Thomas & Harden, 2008).

Results: The current review identified 32 studies which included reports by female survivors of mental health coercion in the context of domestic violence. Five themes were highlighted: 'Creating an environment of confusion', 'Positioning women as crazy', 'Narratives of blame' 'Abuses of power', and 'Gendered expectations'.

Conclusions: The results suggest that 'mental health coercion' was used to create confusion, denigrate, threaten, undermine, and control women, within the context of domestic violence and should be integrated into understandings of coercive control to increase awareness, validate survivor experience, and inform service provision.

Implications: The adoption of a trauma-informed approach within health, social care, family court, and emergency services is recommended.

Key words: Coercive control, Domestic abuse, Mental health, Trauma

Introduction

In the United Kingdom in 2015, the legal term 'Coercive and Controlling Behaviour' was introduced to recognise the central role of 'coercive control' in domestic violence. This has been crucial in moving from the 'physical incident model' to considering the insidious pattern of behaviour and control that defines domestic violence (Stark & Hester, 2019). In the United Kingdom one in four women will experience domestic violence in their lifetime and in England and Wales two women a week are killed by a current or ex-partner. Furthermore, the number of domestic-abuse-related crimes recorded by the police has increased year on year since 2015/16 (Office for National Statistics, 2022). Although domestic violence manifests in emotional, psychological, sexual, and economic forms of abuse, physical violence has received the most attention within the academic literature and has shaped dominant societal discourse. This has meant that nonphysical incidents have been viewed as less important, or less severe forms of abuse, resulting in a lack of professional support or intervention. This is despite high levels of co-occurrence between coercive control and other types of abuse, the significant impact coercive control has on mental health, and the prominent presence of coercive control in domestic homicide trajectories, often continuing post-separation (Crossman et al., 2016; Daw et al., 2022; Dutton et al., 1999; Pico-Alfonso, 2005; Safelives, 2019). Although anyone can experience domestic abuse, women typically experience more severe physical and sexual violence, and coercive control, with wide-ranging implications for their mental health. This review will therefore focus on women's experiences of domestic abuse (World Health Organisation, 2019).

Terminology

The literature reviewed uses a range of terminology to refer to domestic violence, coercive control and mental health problems. However, it is acknowledged that different terms may be

used in different contexts and individual preferences may vary. Table 1 explains how terms are used in this review.

Table 1.

Definitions of terms used in this review

Term	Definition
Domestic violence	The terms 'domestic abuse' and 'domestic violence' are both used in the literature and will be used interchangeably here. Domestic violence can be defined as ‘an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer’ (Women’s Aid n.d.) The abuse can encompass, but is not limited to: psychological, physical, sexual, financial, emotional abuse, and coercive control.
Coercive control	<p>'Coercive control' has been argued to be the defining feature of domestic violence, resulting in a "condition of unfreedom" experienced as entrapment (Stark, 2007, p. 205). Although there is no consistent definition, ‘coercive control’ has been argued to consist of a complex pattern of exerting power to maintain control over another which can include psychological/emotional abuse, economic control, and social isolation and has been argued to be the ‘golden thread’ in risk assessment and identification of domestic abuse (Myhill & Hohl, 2019; Stark, 2007). Throughout the literature the terms ‘psychological abuse’, ‘emotional abuse’ and ‘coercive control’ have been used interchangeably to describe forms of domestic abuse other than physical violence. For the purposes of this review, the term ‘coercive control’ will be used as an umbrella term to include psychological and emotional abuse but where possible explicit descriptions of behaviours will be outlined (Safelives, 2019). The legal terms of coercive and controlling behaviour are displayed below:</p> <p>Coercive behaviour is defined as “an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim” (Home Office, 2015, p. 3). In the context of domestic abuse coercion can involve financial, psychological, physical, sexual, and other kinds of abuse to undermine and control a partner or ex-partner, family member or carer.’</p> <p>Controlling behaviour is defined as “a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour” (Home Office, 2015, p. 3).</p>

Mental health problems	The literature uses a range of terminology to refer to ‘mental health problems’. These include ‘mental ill health’, ‘mental illness’, ‘mental health problems’, ‘mental health challenges’, ‘emotional distress’, ‘psychological distress’, ‘mental distress’ and ‘mental disorders’. Where required for clarity, the terms used by the included literature have been retained: otherwise, the term ‘distress’ has been used to reflect the trauma-informed approach taken to the research and the social constructionist and feminist positionings of the researcher (Sweeney et al., 2018).
Women who have experienced domestic abuse	The terms 'women', 'survivors', and 'victims' are used in this study to refer to individuals who identify as women (cis- and transgender) and have experienced domestic violence.
Perpetrator	The term 'perpetrator' refers to those who perpetrate domestic violence.

Mental health coercion

Domestic abuse is a significant precipitant of psychological distress in women (Golding, 1999; Khalifeh et al., 2015a; 2015b). The relationship between domestic violence and mental health is complex and multi-faceted as individuals may experience distress before, during, or after experiencing abuse. Individuals who have received a mental health diagnosis have also been shown to be more likely than the general population to experience domestic abuse (Khalifeh et al., 2015a; 2015b). It has therefore been argued that there is a bi-directional relationship between domestic violence and mental health. Less well-researched, however, are how perpetrators of abuse engage in coercive tactics specifically related to their partner’s mental health (Warshaw & Zapata-Alma, 2020).

Warshaw and Tinnon (2018) introduced and defined mental health coercion as:

Abusive tactics targeted towards a partner's mental health as part of a broader pattern of abuse and control. This often involves the use of force, threats, or manipulation and can include deliberately attempting to undermine a survivor’s sanity, preventing a survivor from accessing treatment, controlling a survivor’s medication, using a survivor’s mental

health to discredit them with sources of protection and support, leveraging a survivor's mental health to manipulate police or influence child custody decisions, and/or engaging mental health stigma to make a survivor think no one will believe them, among many other tactics (p.5).

Women's Aid (2021) have suggested that perpetrators often target women who have received a mental health diagnosis or are experiencing distress due to their perceived vulnerabilities. Warshaw et al. (2014) explored the use of "mental health coercion" within intimate partner violence in a survey (n =2,741). They found that perpetrators frequently told women they were crazy, did things to make them think they were going crazy, and threatened to tell others they were crazy. Half of participants who sought assistance for their mental health reported that their partners had attempted to interfere in treatment. In a survey conducted by SafeLives (2019), 48% of women (n=405) reported that the perpetrator regularly accused them of being mentally unstable, denied abuse, and made them doubt their thinking. Women's Aid (2021) reported that the stigma, shame, and negative consequences associated with being diagnosed or seen as 'mentally ill' is used by perpetrators to shift the focus from the abuse and discredit survivors.

Stereotypes of women being 'crazy', 'hysterical', 'emotional', and 'unstable' have long existed in society (Ussher, 2011; Women's Aid, 2021). Mental health coercion can be therefore understood as gendered tactics that are used to undermine women's credibility. Sweet (2019) has argued that these techniques are so effective because they exploit the existing power differential within structural gender inequality and use gender stereotypes to discredit women. It has been reported that this tactic is widely used to discredit women as mothers, most notably within family courts and interactions with social services (Epstein &

Goodman, 2018; Women's Aid, 2021). It functions as an effective tool to silence women, discredit their testimonies, and create and maintain control. Survivors can therefore experience a referral to mental health services as further confirmation of the perpetrator's narrative that they are 'crazy', and reinforce feelings of shame and blame, exacerbating distress.

Aims

Although the use of mental health coercion as a tactic of abuse has been described within the literature under the umbrella of coercive control, it has rarely been explored in its own right within the peer-reviewed literature. Systematic reviews can synthesize the effects of individual studies to overcome the limitations of single studies. To the author's knowledge, no review has previously sought to systematically explore how mental health coercion is used as a tactic of abuse, as reported by survivors, within the peer-reviewed literature. The current review, therefore, aims to fill this gap, to collate evidence about how female survivors of domestic violence describe their experience of mental health coercion, and to consider implications for institutions that provide care.

Methods

Design and positioning

A qualitative design, thematic synthesis, was considered most suitable to address the research question. This is an effective way of synthesising literature while preserving individual study context and complexity, as well as of integrating understandings across studies, and offering novel interpretations to inform knowledge, policy, and practice (Thomas & Harden, 2008). The lead author approached the review as a cisgender, heterosexual, white woman who had previously worked within the domestic violence sector and was training to be a clinical

psychologist. It is recognised that these experiences, together with the authors social constructivist, and feminist standpoints may have influenced the interpretation of evidence and the development of concepts.

Developing the protocol

Initial literature scoping searches revealed that mental health coercion was often included as a theme, subtheme, or sentence. Few studies focused specifically on this area. Search terms were therefore broadened to capture the appropriate literature. Silence and power are central to experiences of abuse, so it was deemed important to amplify survivor experiences in their own words. Therefore, the review focused on survivor accounts. Search terms were developed by reviewing papers on similar topics (e.g., Dokkedahl et al., 2022; Howard et al., 2013) and the language used by specialist organisations (e.g., SafeLives, 2019; Women's Aid, 2021).

Inclusion and Exclusion criteria

Inclusion and exclusion criteria were devised using the SPIDER framework for qualitative systematic reviews (Cooke et al. 2012; Table 2). Individuals who identified as women of any sexual orientation were included in the review. Quantitative studies were excluded as the review aimed to explore women's accounts of their experiences. Mixed-methods studies with separate qualitative elements were included. Studies that collected data using qualitative methods, but did not use qualitative analysis methods were excluded due to the lack of detail provided in the results. Studies with no primary data (e.g., literature reviews) were also excluded. No existing reviews in this area were found, so no date limitation was set.

Table 2

A table outlining inclusion and exclusion criteria using the SPIDER framework (Cooke et al., 2012).

<i>SPIDER</i>	<i>Inclusion criteria</i>	<i>Exclusion criteria</i>
Sample	Adults identifying as women (cis- and transgender) who have experienced domestic violence. Participants are over 16 years old.	Samples that include perpetrators accounts of abuse. Participants reflecting on childhood experiences of domestic violence (retrospective). Studies where the majority of the sample are not survivors (e.g., studies which include both survivors' and healthcare professionals' experiences).
Phenomenon of Interest	Explicit focus on domestic violence, coercive control, emotional, psychological and financial abuse. Studies which explicitly explored how mental health was used as a tactic of abuse.	Studies where tactics of abuse are described by others (e.g., family, friends, professionals). Studies that exclusively examine the impact of domestic violence on survivor mental health or healthcare experiences.
Design	Qualitative data collection and analysis. Mixed-method studies where the qualitative data is presented separately.	Quantitative studies Qualitative systematic reviews, meta-analysis, literature reviews.
Evaluation	Experiences of domestic abuse	Intervention-based studies
Research type	Qualitative or mixed method. Peer reviewed Available in the English language	Grey literature, studies without an analysed account of service users' experiences (primary data): editorial, commentary, viewpoint, review, conference abstract.

Data sources

The following electronic databases were searched: ASSIA, PycINFO, Medline, Embase, Web of Science, CINAHL in October 2022. Following this, a hand search of reference lists from relevant papers was conducted.

Search strategy

The search was conducted by combining terms for ‘domestic abuse’, AND ‘mental health,’ AND ‘qualitative’ (Table 3).

Table 3.

A table outlining the search terms used in the systematic search.

Search terms	Phenomena
Domestic abuse	domestic abuse OR domestic violence OR intimate partner violence OR intimate partner abuse OR spousal abuse OR spousal violence OR relationship abuse OR relationship violence OR psychological abuse OR psychological violence OR emotional abuse OR emotional violence OR coercive control OR intimate terrorism OR nonphysical abuse
Mental health	"mental health" or "mental*" or "crazy" or "insan*" or "mad*" or "unstable"
Qualitative	qualitative* OR interview* OR "thematic*" OR ethnograph* OR "grounded theory" OR phenomenolog* OR experiential OR "focus group*" OR discourse* OR "conversation analysis" OR "framework analysis" OR "narrative*" OR "lived experience*" OR account* OR hermeneutic OR "mixed method*" OR "mixed-method*" OR "semi-structure*" OR "semi structure" OR IPA OR "interpretative*" OR "content analysis" OR "guided discussion*" OR "group discussion*" OR open-ended OR "open ended".

Quality Assessment Tool

The Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative research was used to appraise the quality of included studies. To ensure the review was person-centred, the CASP was modified to include intersectionality and client involvement (Hermaszewska et al.,

2022; Sweeney et al., 2019). The legitimacy of excluding studies based on quality assessment in qualitative research has been questioned, partly due to the subjectivity that is involved in determining ‘good versus bad’ studies and because excluding 'lower quality' studies has been argued not to effect overall review findings (Sandelowski et al., 1997; Thomas & Harden, 2008). Therefore, all identified studies were included in the analysis. Quality considerations informed assessment of strengths and weaknesses in the overall evidence base.

Synthesis

Studies were analysed using thematic synthesis (Thomas & Harden, 2008). Relationships between studies were determined by comparing the findings relevant to the research question. The results sections of studies were read in-depth, and analysed line-by-line to develop initial codes using ‘in vivo’ and process coding. This allowed ‘translation of concepts from one study to another’ (Thomas & Harden, 2008, p.5). Descriptive themes were then developed by exploring patterns of shared meaning across initial codes. Descriptive themes were then reviewed, defined, and named to produce broader analytical themes in relation to the review aims. Reciprocal translation across studies was conducted using a table (Excel; Appendix B), with each study entered into a separate column, and themes and subthemes in separate rows, showing the studies where descriptive themes and subthemes appeared (Hermaszewska et al., 2022). Constant referencing back to the original in-vivo and process codes further grounded the synthesis in the data. Themes and sub-themes were then reviewed within supervision. “In-vivo” participant data were prioritised in developing and refining themes given the review aim of prioritising survivor voices (Hermaszewska et al., 2022).

Results

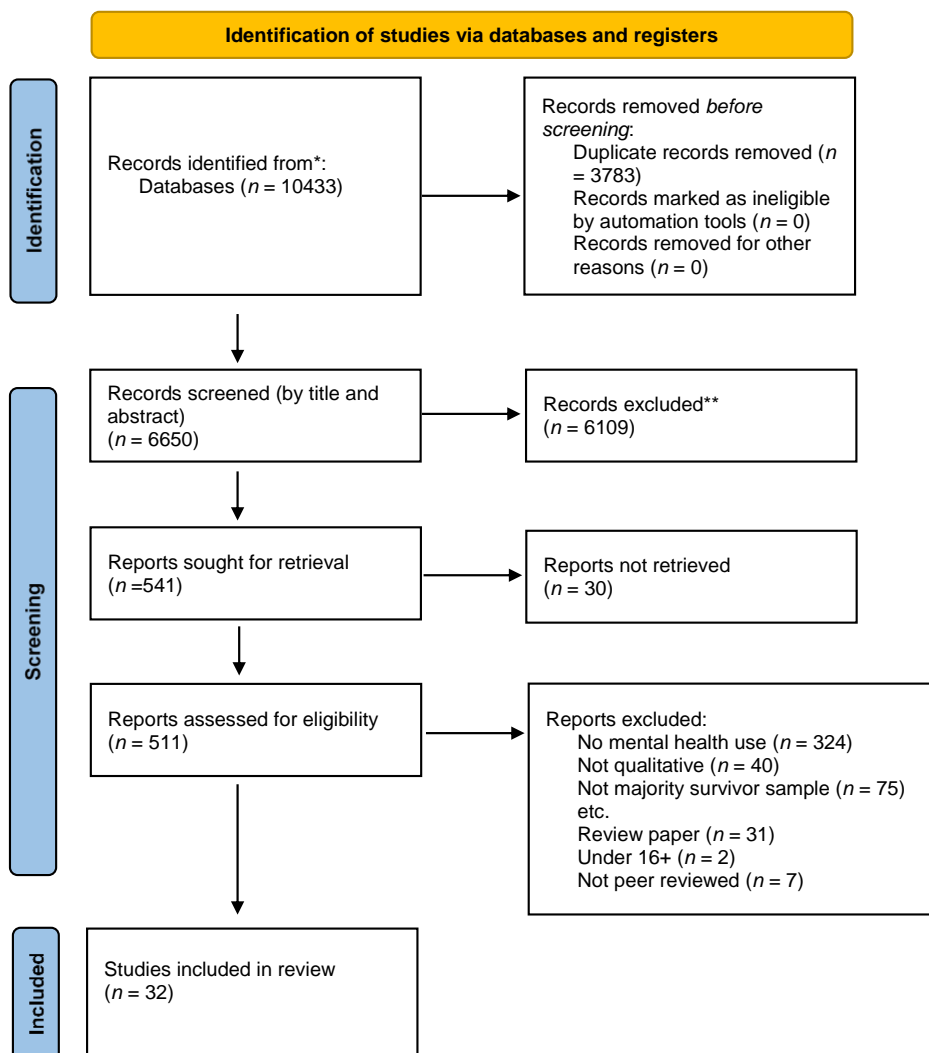
Study selection and screening

A Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Page et al., 2021) flow diagram was used to outline the systematic search stages (Figure 1).

Following the database search, duplicate articles were removed using duplication tools and manual screening. Titles were then screened. Following this, abstracts were screened, and full articles that appeared to meet the inclusion criteria were reviewed for eligibility. Thirty-two studies were eligible for inclusion (Table 4).

Figure 1.

PRISMA (Page et al., 2021) Diagram Detailing Stages of the Review Search Process



Characteristics of included studies

Included studies are summarised in Table 4. For clarity going forward, all papers will be referred to by their assigned number in Table 4 e.g., (1). Sample sizes ranged from five to 301 participants, with an overall sample size of 827 women. All papers focused on male-perpetrated violence against women. All papers described abuse in an intimate partner relationship, however several studies also discussed collusion or facilitation of abuse from family members. Only one woman identified as transgender. Two women identified as lesbian (13), and 25 participants were described as 'not identifying as heterosexual' (31): the majority of participants were therefore cisgender, heterosexual women. Twenty-one studies did not report information on participants' ethnicity; however, three studies recruited specific ethnic groups (e.g., Latino, Krygyz). Two studies, within court and child-contact centres settings included majority samples of black and minoritised women. The included studies explored a range of experiences (e.g., intimate partner sexual violence, emotional and psychological abuse) from a variety of populations. Data collection was in various study locations, and recruitment occurred mostly within specialist domestic violence services, refuges, and health and social care facilities.

Table 4.*Study Characteristics Table*

No.	Author/s, (Date),	Design	Location	Participants (N, Age)	Population	Experiences	Data collection	Data analysis
1	Bhattacharya, A. (2021).	Qualitative	India	N = 11	Women who were living in a 'half-way home' following discharge from an inpatient unit in India who had received a diagnosis of schizophrenia, schizoaffective, or bipolar disorder.	Experiences of domestic violence and 'mental illness'	34 in-depth open-ended interviews.	Narrative analysis (Riessman, 1993)
2	Bryngveisdottir & Halldorsdottir (2022).	Qualitative	Iceland	N = 22	Adult women aged 23-56 years.	Experiences and obstacles to post traumatic growth in female survivors of intimate partner violence.	Semi-structured interview.	Vancouver School of Doing Phenomenology (Halldorsdottir, 2000).
3	Childress, et al. (2021).	Qualitative	Kyrgyzstan	N = 16	Women living in Kyrgyzstan following the fall of the Soviet Union.	Experiences of violence and the complexities surrounding decision making about leaving violent relationships.	Open-ended, semi-structured interviews.	Grounded theory (Oktay, 2012).
4	Copel. (2006).	Qualitative	United States of America	N = 25	Women with physical disabilities who had	Experiences of abuse for women with physical disabilities.	Open-ended interviews.	Phenomenological methodology Colaizzi (1978)

					experienced abuse for 5-15 years.			
5	Crandall et al. (2005).	Qualitative	United States	N= 24	Russian-speaking women who had migrated to the United States often within the context of 'mail-order brides'.	Experience of domestic violence and experiences of access to and satisfaction with domestic violence services.	Focus groups and individual semi-structured interviews.	Participatory Action Research
6	Daw, J., et al. (2022).	Qualitative	United Kingdom	N =12	Women who had experienced psychological abuse.	Experiences of psychological abuse and how this contributes to the risk of domestic homicide and victim suicide.	Semi-structured interview.	Framework Analysis
7	Donovan, et al. (2021).	Qualitative	United Kingdom	N =21	Women who worked as doctors and were mothers. Job roles ranged from GP to consultant, F1/F2 doctor, and registrar.	Experiences of domestic abuse, barriers to seeking help, and the impact on their work.	Semi-structured interview.	Thematic analysis.
8	Doyle, J. L. (2020).	Qualitative / mixed methods	Northern Ireland	N = 63	Adult women aged 18-70 years.	Experiences of intimate partner violence across four dimensions: psychological, economic, physical, and sexual IPV.	Semi-structured interview.	Qualitative themes and prevalence data. Not named.
9	Enander, V. (2011).	Qualitative	Sweden	N = 22	Adult women aged 24-61 years.	Experiences of women's emotion work in the context of male-to-female intimate partner violence and, in the context of leaving violent men.	Semi-structured interview.	Hermeneutic (Kvale, 1996). Specific analysis not named.

10	Harris, B., & Woodlock, D. (2021).	Qualitative	Australia	N = 13	Women who lived in rural and remote geographical locations.	Experiences of digital coercive control.	Semi-structured interview and focus group.	Thematic analysis (King and Horrocks, 2010).
11	Harrison, C. (2008).	Qualitative	United Kingdom	N = 70	Women managing child contact in the context of domestic violence.	Experiences of supported and supervised contact centres in contact arrangements when there had been domestic violence.	Questionnaires and semi-structured interviews.	Unclear, presented as thematic categories.
12	Lammers, et al. (2005).	Qualitative	New Zealand	N = 7	Women who were in emotionally abusive heterosexual relationships where no physical abuse was reported.	Experience of emotional abuse in intimate relationships.	Focus groups.	Memory work (Haug, 1987)
13	Lapierre, S. (2010).	Qualitative	England, United Kingdom	N = 26	Adult women who were mothers.	Experiences of mothering in the context of domestic violence, and the challenges and difficulties that women face in regard to their mothering.	Focus group and interview	Participatory (Kelly et al., 1994; Maynard, 1994),
14	Larance et al. (2018).	Qualitative	United States	N = 12	Women who had not accessed formal support from domestic violence support services.	Experiences of women agency in navigating spousal violence.	Interviews	Unspecified (TTM model and themes).
15	Lazenbatt et al. (2013).	Qualitative	Northern Ireland	N = 18	Women in older age living and coping with domestic violence (aged 53-72). 71% were still in a relationship with the abusive partner.	Experiences of coping with longer term domestic violence (>30 years).	Semi-structured interview.	Thematic analysis.

16	Labronici, L. (2012).	Qualitative	Brazil	N = 5	Adult women who had experienced domestic violence.	Experiences of resilience in women victims of domestic violence.	Open interviews.	Phemenologica I (Merleau-Ponty)
17	McCarthy et al. (2017).	Mixed method (only qualitative data presented)	United Kingdom	N = 15	Adult women with learning disabilities.	Experiences of domestic violence and the impact of the violence on them and their children, their coping strategies and help-seeking behaviour.	Semi-structured interview	Thematic analysis [IPA]
18	McGarry, J., & Hinsliff-Smith, K. (2020).	Qualitative	United Kingdom	N = 6	Adult women.	Experiences of healthcare encounters and domestic violence.	Focus group	Narrative analysis / unclear.
19	Montminy, L. (2005).	Qualitative	Quebec, Canada	N = 15	Women in older age.	Experiences of psychological violence in their marital relationships.	Semi-structured interview	Manifest content analysis (L'Écuyer, 1990)
20	Moulding, et al. (2021).	Mixed-methods: qualitative findings presented only.	Australia	N=17	Adult women.	Experiences of IPV across their life course.	Life story interviews	Narrative analysis (Connell, 2005)
21	O'Doherty et al. (2016).	Qualitative	Australia	N = 14	Adult women aged 30-50 years.	Experiences of identity and explored how social identity relates to help-seeking within health care settings.	Semi-structured interview.	Thematic analysis
22	Pilowsky, J. E. (1993).	Qualitative	Canada	N = 8	Spanish-speaking Latin American women who had migrated to Canada.	Experiences of support available to them when they attempted to leave their	Open-ended and semi-structured interview.	Grounded theory

						abusive partners in the context of spousal abuse.		
23	Rathus et al., (2019).	Qualitative	Australia	N = 10	Women who are mothers in the family law system.	Experiences of the family report writing process following experiencing intimate partner violence.	Semi-structured interview.	Not specified but development of themes (Ryan & Bernard, 2003).
24	Redding et al., (2022).	Qualitative	North Carolina, United States	N = 89	Women applying for domestic violence protective order cases.	Experiences of nonphysical violence within the context of intimate partner violence.	Domestic Violence Protection Order case files	Thematic Analysis (Braun & Clarke, 2006)
25	Reina et al., (2014).	Qualitative	Iowa, United States	N = 10	Latina women who had migrated to the United States.	Experiences of domestic violence service outreach.	Focus group and semi-structured interview.	Use of themes Arcury and Quandt (1998)
26	Shaheen et al., (2020).	Qualitative	Palestine	N = 20	Adult women living in Palestine.	Experiences of women's attitudes towards and experiences of disclosure in a health setting.	Semi-structured interview.	Thematic Analysis (Braun & Clarke, 2006).
27	Snyder, B. L. (2018).	Qualitative	United States	N= 5	Women with a diagnosis of dissociative identity disorder.	Experiences of coping processes of women with a diagnosis of dissociative identity disorder who have experienced intimate partner violence.	Semi-structured	Grounded theory
28	Tarzia, L., & Hegarty, K. (2023).	Qualitative	Australia	N = 38	Women within heterosexual relationships.	Experiences of co-occurring sexual violence and psychological abuse.	Unstructured interviews.	Reflexive thematic analysis (Braun & Clarke, 2019, 2021)

29	Thakur, A., & Rangaswamy, M. (2019).	Qualitative	India	N = 6	Adult women.	Experiences of domestic violence and understanding the meanings that survivors ascribe to the identified idioms of distress.	Semi-structured interview.	Thematic network analysis.
30	Thiara, R. K., & Humphreys, C. (2017).	Qualitative	United Kingdom (inferred)	N = 45.	Adult women who were mothers.	Experiences of post-separation violence on the mother-child relationship in the context of domestic violence.	Semi-structured interview.	Thematic analysis
31	Thomas et al., (2015).	Mixed-methods	United States	N = 301	Adult women aged 18-50 years.	Experiences of seeking safety and the impact it had on their lives in the context of domestic abuse.	Survey	Conventional content analysis
32	Towns, A. J., & Adams, P. J. (2016).	Qualitative	New Zealand	N = 20	Adult women.	Women's experiences of being silenced when speaking of domestic violence.	Semi-structured interview	Discourse analysis (Wetherell (1998))

Quality of included studies

Research aims were clearly stated in 89% of study introductions (Figure 2). Comprehensive information on methodology and recruitment was provided in 97% of papers. The various study locations represented varying cultural narratives about domestic violence, strengthening the review. Adequate rationale and explanation of analysis was provided by 53% of studies. However, 22% of papers failed to report a particular form of analysis citing either hermeneutic or phenomenological approaches or that ‘themes were developed’ (4, 9). The lack of reporting of participant demographics was a consistent limitation across studies, with five studies not reporting demographic information. Of the papers which did report some demographics (75%), information regarding ethnicity, sexual orientation, gender identity, religion, and ability was rarely provided or attended to (e.g., the experiences of LGBTQ+ women being grouped as ‘not heterosexual’). This limited the consideration of how these factors may intersect with women's experiences of domestic violence. Reflexivity was limited across studies, only three reported the author's relationship to the research area and theoretical and cultural positioning. Only 13% of studies showed good survivor involvement, defined as designing and conducting the study to ground the analysis and conclusions in participants' experiences, and actively involving participants in the study design, conduct, or data analysis (Hermaszewska et al., 2022). Two studies developed their research questions alongside an 'expert by experience' panel, which was a significant strength (5, 6, 17). Data collection that addressed the research question was completed by 91% of studies. However, ethical considerations varied across studies, with 34% of studies excelling in this by developing safety protocols, using a trauma-informed approach, working alongside specialist agencies, providing sensitivity in terms of choice of interview location, type (individual or focus group) or interviewer gender. Limited attention was given to ethics and safety in 47% of studies, with six not attending to ethical approval or informed consent.

Figure 2.

The CASP (2018) grid of quality appraisal: Green = Present; Red = Not present; Yellow = Partially considered.

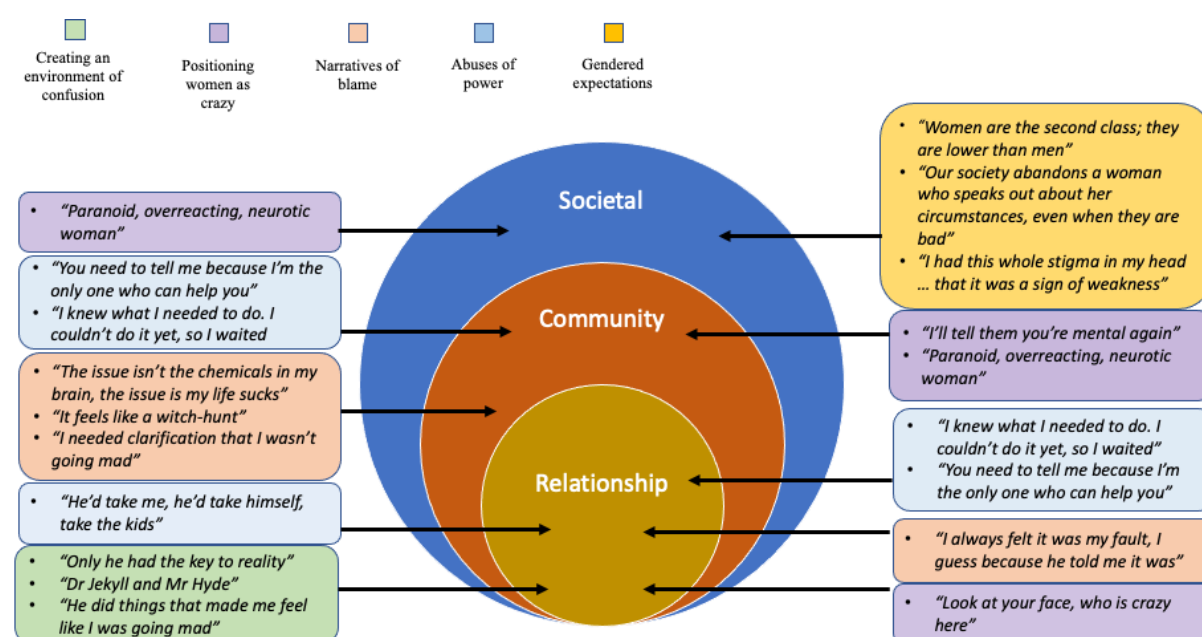
	Aims	Methodology	Design	Recruitment	Data collection	Reflexivity	Ethical issues	Analysis	Findings	Value	Intersectionality	Survivor involvement
1	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
2	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
3	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
4	Green	Green	Yellow	Green	Green	Red	Yellow	Green	Green	Green	Yellow	Green
5	Green	Green	Green	Green	Green	Red	Green	Red	Green	Green	Green	Green
6	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
7	Green	Green	Yellow	Green	Green	Red	Yellow	Green	Green	Green	Yellow	Green
8	Green	Green	Green	Green	Green	Red	Green	Yellow	Yellow	Green	Green	Red
9	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Red	Red
10	Yellow	Green	Green	Green	Green	Red	Yellow	Green	Red	Red	Yellow	Red
11	Green	Yellow	Green	Green	Green	Red	Green	Red	Red	Red	Yellow	Red
12	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Red	Red
13	Yellow	Green	Green	Green	Green	Green	Green	Green	Green	Green	Yellow	Green
14	Yellow	Green	Yellow	Green	Green	Red	Green	Red	Yellow	Green	Green	Red
15	Green	Green	Green	Green	Green	Red	Green	Red	Green	Green	Red	Red
16	Green	Green	Green	Green	Green	Red	Green	Red	Yellow	Green	Red	Red
17	Green	Green	Yellow	Green	Green	Red	Green	Red	Green	Green	Red	Red
18	Green	Green	Green	Green	Green	Red	Yellow	Red	Green	Green	Red	Red
19	Green	Green	Green	Green	Green	Red	Red	Green	Green	Green	Red	Red
20	Green	Green	Green	Green	Green	Red	Green	Red	Green	Green	Red	Red
21	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Yellow	Red
22	Green	Green	Red	Green	Green	Red	Green	Yellow	Yellow	Green	Red	Red
23	Yellow	Green	Green	Green	Green	Red	Green	Yellow	Green	Green	Red	Red
24	Green	Green	Green	Green	Green	Red	Red	Green	Red	Green	Red	Red
25	Green	Green	Green	Green	Green	Red	Green	Yellow	Green	Green	Yellow	Red
26	Green	Green	Red	Green	Green	Red	Green	Green	Green	Yellow	Red	Red
27	Green	Green	Red	Green	Green	Red	Green	Yellow	Yellow	Green	Red	Red
28	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Red	Red
29	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Red	Red
30	Green	Green	Yellow	Yellow	Yellow	Red	Yellow	Green	Green	Green	Yellow	Red
31	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Yellow	Red
32	Yellow	Green	Green	Green	Green	Yellow	Green	Yellow	Yellow	Green	Red	Red

Synthesis findings

Thematic analysis of selected papers identified five central themes: ‘Creating an environment of confusion’, ‘Positioning women as crazy’, ‘Narratives of blame’ ‘Abuses of power’, and ‘Gendered expectations’. Sixteen subthemes were identified and are presented as bold underlined ‘in vivo’ quotes to centre the voices of survivors. Supporting participant quotes are presented in the text, the corresponding study number is provided (Table 4). Themes and subthemes were organised around a socio-ecological framework to highlight individual, community, and societal narratives and the role of power and structural inequality within women’s narratives (Bronfenbrenner, 1979; Figure 3). A summary table providing a description of the themes and subthemes is presented below (Table 5).

Figure 3.

A visual representation of the subthemes organised into the socio-ecological model (Bronfenbrenner, 1979). Subthemes are colour-coded with accompanying themes. Individual subthemes may be presented multiple times to reflect their presence at multiple levels of the socio-ecological model.

**Table 5.**

A summary description of the themes and subthemes.

Theme	Subtheme	Description
Creating an environment of confusion		Women described covert attempts by the perpetrator to destabilise their mental health in a context of fear and isolation, which meant they experienced confusion and began to question their sanity. This laid the foundation for further abuse as it made denigration, threats, and accusations more powerful, as self-doubt had already been fostered by the perpetrator.

<i>"Only he had the key to reality"</i>	Women described how their reality was largely dictated by the perpetrator who decided what was right or wrong and constantly changed 'the rules' of the relationship which created a sense of confusion. This was accompanied by repeated accusations and blame of women.
<i>"Dr Jekyll & Mr Hyde"</i>	Participants described how perpetrators initially presented as charming in the relationship but then became increasingly abusive. They described a duality in terms of how perpetrators presented in public versus at home and described 'walking on eggshells' due to the unpredictability of their behaviour, which further increased women's sense of confusion.
<i>"He did things that made me feel like I was going mad"</i>	Women described how perpetrators engaged in covert strategies to make them question their sanity and judgement, which made them feel as though they were 'going mad'. This differed from more overt strategies that developed later in the relationship. These covert strategies were used to make women doubt their own thinking.
Positioning women as crazy	Following the initial stages of increasing confusion and creating an environment in which women questioned their sanity, perpetrators often engaged in more overt strategies of mental health coercion. This involved explicit denigration of their mental stability, threats to tell others they were crazy, and active attempts to undermine women's credibility.
<i>"Look at your face, who is crazy here?"</i>	Women described a process in which perpetrators denigrated them in relation to their mental stability as part of mental health coercion.
<i>"I'll tell them you're mental again"</i>	Perpetrators often threatened to tell others that they were 'crazy' as a tactic of control and mental health coercion.
<i>"Paranoid, overreacting, neurotic woman"</i>	For many women threats from the perpetrator that they would tell others they were crazy became a reality. Perpetrators undermined their credibility to others, often when women showed autonomy and the perpetrator experienced a loss of control which influenced women's ability to access support.
Narratives of blame	Women were consistently blamed by the perpetrator as a tactic of mental health coercion. However, they also experienced blame in their

	<p>interactions with health and social care, and the family court. It was therefore very important for women to experience alternative narratives in interactions with professionals that validated their distress and placed it in the context of abuse.</p>
<p><i>"I always felt it was my fault, I guess because he told me it was"</i></p>	<p>Women reported internalising blame due to the perpetrator consistently positioning them as crazy. Women therefore often blamed themselves for the abuse they were experiencing or saw themselves as the 'one with the problems' which some recognised as a strategy they had developed to survive.</p>
<p><i>"The issue isn't the chemicals in my brain, the issue is my life sucks"</i></p>	<p>This subtheme described the experience of being disbelieved and judged by healthcare professionals when women sought help for their distress due to mental health coercion. Professionals' focus on 'mental health symptoms' rather than the reasons for their distress often reinforced women's perceptions of abuse being their fault or as a problem within themselves. This made the perpetrator invisible and reinforced the abuse narrative.</p>
<p><i>"It feels like a witch hunt"</i></p>	<p>This subtheme largely described women's experiences within the family court and child-contact process in which they were positioned as hostile and unstable by both the perpetrator and social care professionals. Women described how being positioned as either 'mad' or 'bad' deterred them from seeking help and paralleled and exacerbated their experiences of abuse. Mental health coercion was used within these settings to undermine women's credibility as competent mothers.</p>
<p><i>"I needed clarification that I wasn't going mad"</i></p>	<p>Women emphasised the importance of alternative narratives when interacting with both informal and formal support systems. Women recognised that the perpetrators' behaviour needed to be identified and named as abuse to challenge the narrative that they were 'going mad'.</p>
<hr/> <p>Abuses of power</p>	<hr/> <p>Perpetrators frequently attempted to interfere in women's healthcare. Attempts to leave the relationship were often met with perpetrator threats to end their life, which was understood by women as a method of control. Perpetrators also exacerbated women's distress and encouraged</p>

	<p>them to end their lives. These tactics were understood by women as abuses of power that prevented them from leaving the relationships and accessing support.</p>
<p><i>"You need to tell me because I'm the only one who can help you"</i></p>	<p>Perpetrators frequently blocked access to or interfered in women's access to support, particularly in relation to mental health support as a tactic of mental health coercion.</p>
<p><i>"He'd take me, he'd take himself, take the kids"</i></p>	<p>Perpetrators exacerbated women's distress as a tactic of mental health coercion by encouraging them to kill themselves or using information from past traumatic experiences to trigger them into a constant state of distress. Perpetrators also regularly used threats to end their own life as a method of control, to keep women within the relationship and to incite fear.</p>
<p><i>"I knew what I needed to do. I couldn't do it yet, so I waited"</i></p>	<p>Despite these abuses of power, women described ways they engaged in strategic resistance, for example planning children's care, managing the relationship by 'maintaining the illusion', accessing counselling, and focusing on career development to gain the financial resources to leave.</p>
<p>Gendered expectations</p>	<p>Women's experiences of mental health coercion were grounded in the existence of structural gender inequality. Stigma, patriarchal expectations, and stereotypical assumptions about mental health and who can experience domestic abuse operated as barriers to leaving abuse and accessing support and facilitated mental health coercion as an effective strategy of abuse.</p>
<p><i>"Women are second class, they are lower than men"</i></p>	<p>Women described how domestic violence was normalised and accepted within their communities as a normal part of marriage that they needed to tolerate. This was reinforced by cultural discourses that domestic abuse was a "private family issue". Women described how expressions of anger or other deviations from expected feminine roles were seen as unfeminine and evidence of their 'mental illness' which increased the power of mental health coercion.</p>
<p><i>"Our society abandons a woman who speaks out about her circumstances, even when they are bad"</i></p>	<p>Women expressed fear of the societal stigma of being labelled "mentally ill", of being a survivor of domestic abuse, and of being divorced. This stigma intersected with other aspects of women's identity</p>

(e.g., immigration status, disability). Women also feared that 'if you have a mental health diagnosis, you are less likely to be believed' which increased the effectiveness of mental health coercion.

"I had this whole stigma in my head...that it was a sign of weakness" This subtheme describes the internalised stigma that women experienced following mental health coercion with many feeling that they 'should have known better'. Women described fearing others would find out about their 'mental health problems' and this would be used against them. The experience of shame was particularly significant.

Creating an environment of confusion

Women described implicit and explicit attempts by the perpetrator to destabilise their mental health in a context of fear and isolation, which meant they experienced confusion, and began to question their own sanity.

"Only he had the key to reality"

Survivors reported that perpetrators frequently controlled their sense of reality, resulting in constant confusion (1, 2, 3, 4, 6, 11). Denial of abuse coupled with accusations of blame and constantly changing the parameters of what was 'right or wrong' left survivors unsure of their sense of judgement. Women often experienced hopelessness and exhaustion as no matter what they did, 'they were never right'. Many described how their confusion was exacerbated by the gradual development and intangibility of abuse, particularly when physical abuse was absent (6, 20). Many women, therefore, retrospectively reported that they did not recognise they were experiencing abuse at the time (12, 25, 32). Women highlighted that technology meant that abuse 'had no boundaries', making it 'omnipresent' in their lives (3, 8, 10).

“[It] left me unable to make decisions and left me completely confused. I felt like (and he told me) I was crazy as my reality was being persistently challenged and things I had seen and heard were dismissed and I was given a new reality” (6).

“I didn’t know whether I was right or wrong or—just bewildered y’know” (32).

“Dr Jekyll and Mr Hyde”

Participants described the disconnect between how perpetrators presented in public versus their abusive behaviour at home. They described this duality as exacerbating their sense of confusion and uncertainty within their relationship, while also maintaining their sense of hope that the ‘good side’ of their partner would return (11, 15). In the early stages, women reported that their partners presented as ‘charming’, and the relationship was often fast-moving and intense (6, 23). Some participants reported that abusive behaviours gradually appeared however, if they attempted to leave, “Mr Nice Guy” would reappear, which exacerbated the lack of confidence in their judgement and perpetuated the cycle of abuse (9, 28). In contrast, other women reported that the perpetrator frequently shifted between ‘Jekyll and Hyde’, creating a sense of unpredictability and fear (6). One woman described this experience as ‘walking on eggshells’ (12).

“He’s like two people, this man, the most proper, kind, sweet, and oh, so charming fellow. He’s Dr Jekyll and Mr Hyde . . . Amazing, completely different people, you can’t even imagine how they can wear the same clothes” (9).

“He did things that made me feel like I was going mad”

The pervasive nature of these strategies coupled with isolation from sources of support led many participants to question their sanity, as they tried to make sense of what was going on. Women spoke frequently about how their mental ‘stability’ was specifically targeted by the perpetrators (5, 6, 11, 12, 28).

“I felts I was nuts . . . He would always say, you are wrong, it did not happen, you said this . . . over and over, until I could not work out whether I had said it or not”. (12).

“You end up feeling you’re crazy...he’s so kind and sweet, on the one hand, and then all of a sudden, he can change into someone completely different... you wonder: ‘How can such a nice, kind bloke turn into someone like that? Well, perhaps it’s because of me then” (12).

Positioning women as crazy

Women described a process in which they were denigrated in relation to their mental stability. Perpetrators often threatened to tell others that they were ‘crazy’ as a tactic of control. For many these threats became a reality with perpetrators undermining their credibility to others, often when women showed autonomy and the perpetrator experienced a loss of control.

“Look at your face, who is crazy here”

Perpetrators often placed ‘the problem’ within their female partners. This often took the form of accusations of ‘madness’ and ‘instability’ both during the relationship and post-separation. Women reported being regularly labelled as 'crazy', 'sick', 'mad', 'paranoid', 'unreliable', and 'inconsistent', (27) or that their mental health diagnoses and disabilities were used to

denigrate them (27). For women with disabilities, these insults were accompanied with attacks on their physical and learning disabilities (4, 17). Women also reported that perpetrators attempted to undermine the mother-child relationship, by coercing children to collude with accusations of madness. These accusations significantly impacted participants' self-worth as mothers (12,13, 30).

“He used mental health stuff in a really serious way... and I think that is a common tactic. Because I had self-harm and eating disorders and stuff, I had been foolish enough to tell him when I first met him, he would just drag that up all the time... That meant I was a bad mother and disturbed and unfit and all the rest of it...I really just began to believe him at the end...if someone is telling that stuff enough” (13).

“He used to tell him, ‘Your mummy is thick, she doesn’t know anything, she is mad, uneducated’” (30).

If participants expressed anger at how they were being treated, this was routinely used as evidence of their irrationality and instability (12). Perpetrators convinced participants that they had 'all these problems' and should be seeking medical help. This was understood by women retrospectively, to refocus attention away from the perpetrator's abusive behaviour, and instead to their mental state. These accusations were particularly powerful when the perpetrator was a health professional (7).

“I mean I considered myself to be really argumentative and had a bad temper... but I mean I don't know why...it was a really strange shift from me seeing myself as... normal... to see myself as the one with all the problems” (32).

“We decided that I had an anger management problem. I think I was just at my wits end” (21).

“I'll tell them you're mental again”

Participants described how perpetrators often encouraged disclosures about women's mental health histories, which were later used as a tactic of control (e.g., by threatening to tell family, friends, or services). Perpetrators frequently threatened to tell others that their partners were 'crazy'. For women with insecure immigration status, these threats were particularly powerful, and were often accompanied by threats of deportation by the perpetrator (5). For others they were accompanied by threats that social services would become involved (2). Given women's negative views of social services, and their fear of having their children removed from their care, this was a powerful and effective threat (13).

“You're going to a psychiatrist... they're going to label you...mental. Even if we decide to get divorced the kids will come to me because they will say you're not stable” (21).

One woman, who worked as a GP reported that her partner, also a doctor, threatened her professional credibility by accusing her of being 'mentally ill'. She feared these accusations would hold more weight given her partner's professional role (7).

“He said ‘I might have to tell the GMC [general medical council] about you because you’ve got all these problems’” (7).

The use of these threats functioned as a barrier for women who wanted support for their distress but feared the repercussions if their partner found out. Additionally, women were frequently told, and believed, that no one would believe them if they disclosed abuse, because of their mental health diagnoses.

“Paranoid, overreacting, neurotic woman”

For many, threats to discredit their ‘stability’ became a reality. Perpetrators undermined participants by telling informal and formal support systems that they were ‘mad’. This often happened in the later stages of the relationship, when they were attempting to leave, seek help, or disclose abuse. It significantly impacted women’s ability to seek support from emergency services (e.g., contacting the police), particularly for women not living in their country of birth and for whom English was not their first language (5, 22). Indeed, a language barrier increased women’s isolation and consistently impeded access to support (22). Perpetrators consistently used language implying mental instability to discredit women’s testimonies in contacts with health and, social care services, and the family court.

“He applied for an order to try and get the children returned to him in, saying that... he thought I had postnatal depression and I’d probably become psychotic and that’s why I’d left him” (7).

“All established GPs and consultants, standing up in court and saying they believe he couldn’t have done any of these things, how great he is and what a wonderful father he is”
(7).

“My husband told my clients, “Oh, she is in the nuthouse... . Don’t call her, she is a fool”
(3).

“They [police] talked to my partner because he speaks English . . . and my partner told them I was crazy....so they left” (25).

Narratives of blame

Women were consistently blamed by the perpetrator as a tactic of mental health coercion. However, they also experienced blame in their interactions with health and social care and the family court. It was therefore very important for women to experience alternative narratives in interactions with professionals that validated their distress and placed it in context.

“I always felt it was my fault, I guess because he told me it was”

The consistent positioning of women as crazy created narratives of blame which – as with the accusation of being mentally unstable - was often internalised. Some women recognised self-blame as a strategy they had developed to survive, whereas for others it was the only way that they could make sense of what was happening. Women with physical disabilities reported that the self-blame contributed to feelings of entrapment, as for many their partners were also their carer’s. Older women reported that the relentlessness of abuse and projection of blame over such a long duration meant they reached a point where they felt unable to leave as they

did not want to 'betray' their partner (19). The constant striving to maintain peace resulted in a 'loss of identity' for many (11, 20). For several women, the sense of 'not being good enough' and 'inadequacy' was so pervasive that they experienced intent to end their life (2, 6, 17).

“When you are told over and over how stupid, ugly and insane you are you really believe it” (15).

“I think I just became obsessed with getting out of my relationship with [him], and at that point I could only see suicide as the way [out], so I became obsessed with killing myself” (12).

“The issue isn’t the chemicals in my brain, the issue is my life sucks”

Women who did access services (e.g. healthcare, police, family courts) faced repeated experiences of disbelief. Some women (e.g., health professionals) experienced unhelpful stereotypical assumptions about who could be subjected to abuse. General practitioners and mental health services often prescribed medication without providing opportunities for women to discuss abuse. Some women reported that mental health services took disclosures of abuse as confirmation of their ‘mental illness’, and ‘paranoia’, leaving their distress unaddressed (1). Participants generally reported a sense of inaction from health services; however, those who did disclose abuse often felt they were not taken seriously or ignored (15, 17, 26). Professionals’ focus on ‘mental health symptoms’ rather than the reasons for their distress often reinforced women’s perceptions of abuse being their fault or as a problem within themselves. This made the perpetrator invisible and reinforced their narrative. When they were believed, women felt judged by professionals for not leaving the relationship and

as though they were wasting professionals' time. Women with learning disabilities reported that professionals were often aware of the abuse, but did not act because women did not explicitly ask for help (17). Those that did disclose abuse reported a lack of adapted support (e.g., number of therapy sessions offered), which led to a further sense of isolation, hopelessness, and fear.

“The very first time I mentioned it [to my GP], there was a definite, “Oh yes, that wouldn't happen to you” — probably...because..., yes, I'm a middle-class doctor and that doesn't happen to middle-class doctors” (7).

“I am his carer, my medical practice has been more helpful and supportive to my husband and his illnesses and is not interested in helping me ... even though they are fully aware of how I have to live with distressing violence” (15).

“It feels like a witch-hunt”

Women who accessed formal support also reported being positioned as 'hostile', particularly within social care and family court settings. They felt responsibility was placed on them to leave the relationship to keep their children safe, yet when they did leave, they were often expected to facilitate child contact with the perpetrator; however, if women raised safety concerns, they were framed as being "obstructive" to the contact arrangement. Indeed, several participants mentioned that despite the perpetrator's abusive behaviour being the reason for supervised contact, their mothering was scrutinised, and they had to behave within set boundaries established by social workers to avoid punitive interventions. For some women, these conditions replicated the abuse dynamics (11). Others reported that if they raised safety concerns about the child-contact arrangements, they were positioned as “irrational, anxious,

hysterical, difficult women”, or that their concerns indicated an ‘unhealthy maternal enmeshment’ (23). The focus on women’s mothering abilities rendered the perpetrator’s abusive behaviour invisible, with the perpetrator's fathering ability often being considered separate from the abuse. Women described how this paradox and positioning as either ‘mad or bad’ deterred them from seeking help. Where the perpetrator was a doctor, participants reported that the perpetrator received better treatment by professionals, because of their status. For many women, the family court process and collusion of social services with the perpetrator's narrative significantly increased their distress. Many felt that they had to prove they were not 'a liar' before being listened to, or felt positioned as a defendant rather than the one who had sought support.

“The father’s supported a lot more than we are and...if we’re concerned, it’s seen as obstructive. If we’re worried or anxious, we’re very often made to feel like you’re being this kind of bitch, trying to sabotage the contact” (11).

“The system is not welcoming you... to have to settle things with your perpetrator, sitting there beside him, confronting him, talking to him, trying to find a solution there and describing the violence in your relationship, they just didn’t care” (2).

“The first time I ever met a social worker... they turned round and said, “I want your GMC number; I want to see your appraisal” (7).

“I needed clarification that I wasn’t going mad”

Women emphasised the importance of alternative narratives when interacting with both informal and formal support systems. Several women described positive experiences,

particularly within GP consultations. Consistently women identified that the perpetrators' behaviour needed to be identified and named as abuse. For women from minoritised and migrant communities, many shared how helpful it was to receive culturally-sensitive support that could be provided within their first language to increase their feelings of safety. Participants also emphasised the power of being believed and treated with respect, compassion, and humanity.

“I did go there [counsellor’s clinic] with the hope of clarity.... Clarity for the relationship, for myself. My sanity. I needed clarification that I wasn’t going mad, that it wasn’t normal to be treated like he treated me” (21).

“I explained everything to her and she was like, “this is — you know — domestic abuse; this isn’t normal... It was a massive relief... because I don’t think I knew what on earth was going on” (7)

“He [GP] was very matter of fact and there’s a problem, we’re going to fix it. It’s not in your mind, it happens” (21).

Abuses of power

Perpetrators frequently attempted to interfere in women’s healthcare. Attempts to leave were often met with perpetrator threats to end their life, which was understood by women as a method of control. Women also experienced frequent exacerbation of mental health and encouragement to end their lives. These were understood by women as abuses of power that prevented them from leaving the relationships and accessing support.

“You need to tell me because I’m the only one who can help you”

Perpetrators frequently blocked access to or interfered in support, for example by sharing misinformation about participants' mental health history (1). Several women described partners who were doctors, abusing their power by enforcing psychiatric medication (6, 15). One participant shared how, after speaking to her partner, healthcare professionals became concerned that her pregnancy may affect her mental health, and referred her to a specialist unit without her consent (18).

“He would follow me...all around the house asking what I talked about in therapy. Saying things like, “You need to tell me because I’m the only one who can help you... she [therapist] doesn’t know you and she doesn’t care about you” (27).

“He convinced me that I was mentally unstable and was able to prescribe me medication himself, which I, unfortunately, took” (6).

“He’d take me, he’d take himself, take the kids”

Women described numerous ways perpetrators incited fear and trapped them within the relationship, and then exacerbated their resulting distress by punishing it, or encouraging participants to kill themselves. Perpetrator also used slurs and names associated with past traumas to trigger women into a constant state of distress (10).

“I’ve been very suicidal myself...and if I think about all the times he [abuser] told me I should do it [kill myself] or how he would do it [kill me]...it feels like a jackhammer in my brain” (27).

“I suffered from post-natal depression, but he often hit me if I cried. I think I was very severely depressed for years and had to hide these feelings” (15).

Perpetrators threatened to end their own life if women attempted to seek help or leave the relationship. This evoked feelings of fear, guilt, and blame. Threats of suicide were therefore used as a method to regain control.

“He would threaten to ... kill himself if I tried to end the relationship... and put himself in dangerous situations so that our friends would come and get me because I was the "only one" who could help him” (6)

“I knew what I needed to do. I couldn’t do it yet, so I waited”

Despite these abuses of power, women described ways they engaged in strategic resistance, for example, planning children's care, managing the relationship by 'maintaining the illusion', accessing counselling, and focusing on career development to gain the financial resources to leave. Women also described 'keeping up appearances' and 'remaining hidden' when accessing services until it was the right time to leave. Older women who felt unable to leave due to long abuse durations and financial dependence on the perpetrator, developed support strategies that allowed them to “tough it out”, including prayer, physical activity, maintaining friendships and volunteering (19). In summary, women were agentic in keeping themselves safe, constantly weighing up the options available to them. Leaving the relationship was a carefully informed strategy, often precipitated by 'turning point' events such as an increase in risk to themselves and their children.

Gendered expectations

Women's experiences were grounded in the existence of structural gender inequality. Stigma, patriarchal expectations and stereotypical assumptions about mental health and who can experience domestic abuse operated as barriers to leaving abuse and accessing support, and facilitated mental health coercion as an effective strategy of abuse.

“Women are the second class; they are lower than men”

Throughout their narratives, participants acknowledged that patriarchal norms and gender inequality were at the root of the abuse they experienced (19). Women described how domestic violence was normalised and accepted within their communities as a normal part of marriage that they needed to tolerate. Therefore, they were often prevented from speaking out by family or community members. For some, this was reinforced by cultural discourses that domestic abuse was a “private family issue”. Women living in small rural communities described feeling more visible due to overlapping social and professional networks in their communities and were confronted with "going public" with the violence (10). Family and cultural beliefs about the sanctity of marriage, their roles as a wife and a mother, and their responsibility to preserve the family (5) were essential to many women's identities but also placed expectations on what mothers 'should do'.

Additionally, women described how expressions of anger or other deviations from expected feminine roles were seen as unfeminine, inappropriate, and evidence of their ‘mental illness’, and led to increased abuse. (32).

Domestic violence is a normal thing. It is part of the destiny, and you have to tolerate it.”

(5).

“I could have left my husband . . . but I could never abandon my own children . . . no mother has done that ever. I could not give him a divorce. What would I do with a divorce? (1).

“Our society abandons a woman who speaks out about her circumstances, even when they are bad”

Women expressed fear of the societal stigma of being labelled “mentally ill”, of being a survivor of domestic abuse, and of being divorced. This stigma intersected with other aspects of women’s identity (e.g., immigration status, disability). Fear of judgement, blame, and being ostracised was apparent throughout women's narratives, together with shame about disclosing their experiences of domestic violence (2). Women also expressed fear of stigma about their mental health. This stigma acted as a significant barrier to accessing support as women were often reluctant to seek help for fear of being labelled 'mentally ill'. They feared losing their credibility as competent wives or mothers, and possibly losing custody of their children (2). After leaving a violent relationship, awareness of this stigma was sometimes a barrier to seeking psychological help for themselves or their children (26). Women also feared that 'if you have a mental health diagnosis, you are less likely to be believed' (21). The data highlighted the cultural taboo of women speaking out against their husbands and affecting their family’s honour. The stigma of divorce often kept women within their relationships, particularly when “traditional” patriarchal, gender, and family values were present (10).

“Listen, a divorced woman is always the one blamed. No matter what. They don’t say that the man was no good, no it’s the woman fault. You should have been patient. You should have tolerated it” (26).

“It’s torture. You put yourself through a ridiculous amount of pain...everyone wants to save their marriage and they want to do it for their kids” (21).

“I had this whole stigma in my head ... that it was a sign of weakness”

Many women internalised the stigma, telling themselves that they “should have known better” (2). Women also described grappling with their sense of identity in that they “were not the type of women who experienced abuse”. Many reported high levels of shame. This was particularly pronounced for older women and those from more patriarchal communities who often felt a sense of guilt for not fulfilling expected gendered roles (26) For some, however, having lived experience of abuse allowed them to challenge their stereotypical preconceptions of ‘who’ can experience domestic violence, with several doctor-survivors reporting that this improved their clinical practice. Many feared others learning about their distress or diagnoses, and this being used against them by the perpetrator, their families or communities, reflecting wider societal attitudes about women’s ‘mental weakness’ and ‘emotionality’(29).

“We’re not supposed to be vulnerable; we are supposed to be intelligent, strong women who are not vulnerable. And there is an element of — that I think — you should have known better” (7).

“I didn’t picture myself as a woman... who would ever be in such a relationship. That’s why I couldn’t think of it as a violent relationship at the time. And all I felt was just feeling of shame, a shame of being in this situation” (2).

I think it's the same feeling by all people who have suffered violence, you blame yourself, you are afraid that no one will believe you and you are afraid of the reaction you will get. And in some cases, you are right to feel that way. There is still so much prejudice out there" (2).

Discussion

This review sought systematically to explore survivors' experiences of mental health coercion in the context of domestic abuse.

Key findings

The review found that perpetrators routinely weaponised mental health as a tactic of domestic abuse, by targeting existing mental health difficulties or exacerbating distress caused by the abuse to coerce women. The review findings, therefore, not only support but extend that of Warshaw et al., (2014), who found that perpetrators attempted to undermine their partner's sanity, interfere with their treatment, control their medication, sabotage their recovery, and discredit them with friends, family, professionals, and the courts. The current review deepens the understanding of the tactics involved in coercive control and how this may impact psychological wellbeing. It highlights how perpetrators used mental health coercion to create confusion and denigrate, threaten, and control women over time, significantly impacting their interactions with services and subsequent opportunities for support. The review findings indicate that 'mental health coercion' should be routinely considered within definitions of coercive control.

Terminology

These findings can be understood within the complex pattern of tactics that constitute ‘coercive control’ and ‘psychological abuse/violence’. There is much discussion in the literature regarding term definitions. Some authors use ‘psychological abuse/violence’ as an umbrella term that includes coercive control, whereas others use ‘coercive control’ as the umbrella term that includes psychological abuse/violence. An explanation for this discrepancy considered by Dokkedahl et al. (2022) is that the relationship between coercive control and psychological abuse/violence is a continuum in which psychological abuse is present early in the abuse in the form of insults, denigration, and denial. They argue that psychological tactics are then used as a method of coercion and control in later stages of abuse. This aligns with the review findings in which perpetrators initially used covert strategies to create an environment of confusion in which women began to question their reality. This provided the foundation for more overt accusations of madness and threats, creating a sense of fear and uncertainty and maintaining control. This led to a wider pattern of coercion and control which included threats of suicide, control of medication, prevention of access to mental healthcare, or encouragement of mental health treatment as further evidence of women's madness. Discrediting women by telling others that she was ‘crazy’ to reduce her testimony often occurred at later stages of the relationship or post-separation in an attempt to regain control. This supports a similar trajectory of psychological abuse and coercive control within domestic homicide timelines (Daw et al., 2022).

Structural inequality

Throughout participants' narratives, a clear interrelationship existed between the relationship, community, and societal ecosystems, reflecting the often complex, intersecting, and omnipresent nature of power in survivors' lives. The review findings, therefore, align with the ideas of Ptacek (1999), who conceptualised domestic violence as a form of ‘social

entrapment' with three dimensions: The social isolation, fear, and coercion that the perpetrator's controlling behaviour creates in the victim's life; the indifference of powerful institutions to the victim's suffering; and the exacerbation of domestic abuse by the structural inequalities associated with gender, race, sexuality, class, and disability. Women's experiences interacted with and were exacerbated by societal and institutional narratives regarding the (lack of) believability and credibility of women and stereotypes about who can be a victim of domestic abuse. Being positioned as 'mad' or 'crazy' was often used by perpetrators to reduce women's credibility and was reinforced by pervasive societal stigma associated with mental health diagnoses (Ussher, 2011).

Experiences of services

Services often colluded with or replicated women's experiences of abuse. Similar to previous reviews, women were often disbelieved or unheard during interactions with GPs, mental health professionals, and social services. They were also often placed in positions of responsibility by professionals (e.g., to leave the relationship) in the absence or access to appropriate resources (Tarzia et al., 2020; Trevillion et al., 2014). Health and social care professionals have reported a lack of knowledge, confidence, and understanding about domestic abuse (Nyame et al., 2013; Trevillion et al., 2012). The review findings echo Trevillion et al. (2014), who found that mental health professionals failed to inquire about experiences of domestic violence and often questioned the credibility of service users' disclosure of abuse in light of their "mental illness". Within the current review, societal and internalised stigma surrounding mental distress, domestic violence, and divorce acted as significant barriers to women accessing support. This stigma was at the forefront of survivors' minds as to whether they 'would be believed' when accessing services. This was notable within women's family court experiences, in which many had to 'prove they were not

a liar' despite being the ones who had accessed support. The review findings, therefore, support Hunter et al. (2020), which called for family court and child-contact reform.

Despite these challenges and barriers, women described constantly assessing the options available. They engaged in strategic planning while considering the potential repercussions of disclosure to professionals, such as escalating violence or experiencing judgmental attitudes (Gondolf & Fisher, 1988). Professionals should, therefore, consider the strategic steps women are likely taking to keep themselves and their children safe, and greater understanding from professionals is needed regarding the complexities of leaving an abusive relationship.

Strengths and limitations

To the author's knowledge, this is the first review that has explored the use of mental health coercion as a tactic of domestic abuse. The depth of the findings highlights the value of qualitative research and survivors' narratives in enhancing understanding of the breadth of women's experiences of domestic abuse and coercive control. The current findings build upon existing knowledge about coercive control but also suggest how abuse can be replicated at all levels of society and is grounded in structural inequality.

The sample primarily reflected cis-gender women's experiences of abuse within heterosexual relationships. Therefore, the experiences of lesbian, gay, bisexual, trans- and queer (LGBTQ+) women, and non-binary people's experiences of coercive control may differ. Indeed, threats to 'out', or verbal abuse about an individual's LGBTQ+ identity are also tactics of coercive control that may be used alongside mental health coercion (Bornstein et al., 2006; Harden et al., 2022). Furthermore, information on Black and minoritised women's experiences was limited. Their experiences of mental health coercion may therefore differ, particularly as Black and minoritised individuals are more likely to be sectioned and

prescribed medication for their mental health compared to White individuals (Thiara & Harrison, 2021). The two studies that included majority samples of Black and minoritised women were within court and child-contact centres settings. This was not anticipated and perhaps reflected the structural inequality, discrimination, and additional barriers to support that Black and minoritized women face within these settings (see review by Thiara & Harrison, 2021).

There was little consideration of ethical issues within the included studies. Given the power involved in conducting research, actively involving survivors in the design and data analysis may have allowed new insights and increased research validity by centring survivor voices (e.g., by reviewing transcripts, shaping the analysis) and prioritising participant safety (Perot & Chevous, 2018).

Psychiatric categorisation and the medical model are largely Western concepts, which may have limited this review's utility and relevance to other cultural contexts. This was perhaps underpinned by a search strategy biased towards Westernised or Eurocentric literature (Thiara & Harrison, 2021). It is important to consider how tactics of coercive control may present globally and across cultures, and this should be the subject of further review.

The researcher completed the search and analysis independently, with no corroborative rating. Findings may, therefore, reflect their biases and motivations for this research. The researcher's positioning is provided, and readers are invited to consider this when drawing their conclusions. Despite this, the analysis was discussed routinely in supervision to support reflection about theme and subtheme development, particularly what codes were being prioritised or less attended to. This involved referencing back to the original in-vivo and

process codes to ground the synthesis in survivors own words and reviewing the mental health coercion definition proposed by Warshaw and Tinnon (2018). This was helpful, for example, in finding that perpetrators often encouraged women to end their own lives, which the researcher had not explicitly considered in the context of mental health coercion prior to the review.

Implications

This review highlights the complexity and breadth of strategies deployed within coercive control. These are often gradual, resulting in confusion and self-blame (Williamson, 2010). The current findings could helpfully be integrated into understandings of coercive control to increase awareness, validate survivor experience, and inform service provision. Staff training within mental health, social care, and the family courts, is indicated to increase knowledge and understanding of mental health coercion and how it may be employed to deter women from or interfere with accessing support. This would increase awareness of how certain practices across public services may increase survivor distress, collude with the abuse, and be experienced by survivors as re-traumatising. This could be supported by greater partnerships between mental health and domestic abuse services, sharing knowledge, creating clear referral pathways, and increased awareness of mental health coercion for individuals presenting with suicidal ideation. Mental health coercion could also be considered within mental health assessments (see Warshaw and Tinnon (2018) for guidance). Policy change is required at a national level to create systemic change across mental health, social care, and the family courts to support the integration of trauma-informed care into organisational cultures. An attachment-approach to risk assessment regarding child-contact in the context of mental health coercion within the family courts is also indicated. This review also highlights the power of professional roles in perpetrating domestic violence. Recently attention has been

drawn to police conduct and the perpetration of violence against women, and it is recommended that this public scrutiny is also drawn to healthcare (UK Government, 2020).

Implications are considered further in Table 5.

Recommendations for future research

Future research should explore the experiences of Black and minoritized people and communities, including people who identify as LGBTQ+, to explore their experiences of mental health coercion. It would also be important to gain prevalence data on perpetrators who occupy professional roles such as medicine, mental health, social care, and the police, given the significant power these professional roles hold. Future research could also explore health and social care professionals' understandings of coercive control and how providers' perspectives on gender and mental distress, including their motivations, shape their work (Bhattacharya, 2021). The review found that perpetrators consistently use mental health coercion as a tactic of abuse. These findings therefore have practical implications due to the interference and involvement of perpetrators in women's mental healthcare. It is, therefore, important to explore survivors' experiential narratives of navigating mental health services, specifically as existing literature has primarily focused on the experience of abuse disclosure and routine enquiry.

Table 6.

Clinical Implications

Implications	Description
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Adoption of a trauma-informed approach	<p>The review's findings highlight how the process of accessing services was consistently re-traumatising for survivors. Adopting a trauma-informed approach within health, social care, family court, and emergency services, given the prevalence of contact with survivors, is therefore strongly indicated (Sweeney et al., 2016). A trauma-informed approach is 'a process of organisational change aiming to create environments and relationships that promote recovery and prevent re-traumatisation' (Sweeney et al., 2018, p.321). It is acknowledged that numerous systemic barriers prevent individual staff from being able to engage fully in trauma-informed approaches, such as austerity, underfunding, lack of resources within services, high staff turnover, and burnout amongst the workforce (Sweeney et al., 2016). However, women and children experience harm in addition to the direct effects of domestic violence if their attempts to seek help are met with inappropriate responses (Laing et al., 2010). Failure by health services to respond appropriately to domestic violence, either by discounting the violence or by misdiagnosis and inappropriate treatment, can place women at risk of ongoing and escalating violence and increased distress (Laing et al., 2010). This, therefore, indicates that policy change is required at a national level to create systemic change across public services to support the integration of trauma-informed care into organisational cultures and increased understanding of mental health coercion and how it may be employed to deter women from, or interfere with accessing support. For a full review, see Sweeney et al. (2016; 2018).</p>
Domestic abuse and suicide	<p>Threats of suicide were consistently reported as a tactic of control, however, the pervasive nature of abuse pushed many survivors to consider taking their own life. A recent review found that women who experience domestic violence are three times more likely than others to attempt suicide, and that individuals who have experiences of systemic inequality (e.g., poverty, racism, disability) are at increased risk of both domestic violence and suicidality (Agenda Alliance, 2023). This has implications for mental health services in prioritising domestic abuse in risk assessments for self-harm and suicidality and engaging with professional curiosity in response to individuals presenting with suicidal thoughts or attempts of suicide (Taylor, 2020).</p>
Power of professional roles	<p>Given that one in four women will experience domestic violence in their lifetime, it is likely that many victims and survivors are working in health and social care settings and that many perpetrators will also work within these trusted professional roles. Dheensa et al. (2022) reported that a higher proportion of healthcare professionals experience abuse than people in the general population. This has implications for 'who' society considers can perpetrate and be subjected to domestic violence and the additional power and protection those professional roles can provide. Recently attention has been drawn to police conduct and the perpetration of violence against women, and it is recommended that this public scrutiny is also drawn to healthcare (UK Government, 2020).</p>
Adopting an attachment-based perspective to risk assessment	<p>Increased understanding of mental health coercion and post-separation abuse and how child-contact and the family court may facilitate this is crucial. Adopting an attachment-based perspective that considers the static and dynamic risk factors of contact to both mother and child is recommended. Despite the known harms of domestic violence to children, and the overlap between domestic violence and child abuse being widely reported (Callaghan et al., 2018), family courts reportedly continue to adopt a "contact at all costs" philosophy. The notion that fathering ability is separate from abusive behaviour has been argued to harm both mother and child (see Hunter et al., 2020 for a full review). This</p>

highlights that systemic change is required, with implications for law, policy, and practice. Ensuring all professionals involved have the required knowledge, understanding, and appropriate attitudes regarding domestic abuse and mental health coercion is essential to prevent secondary victimisation by services (Women's Aid, 2021).

Integrating support	Recognition of the social determinants of mental distress is essential to integrating understandings of domestic abuse and mental health as public health issues. The World Health Organisation (2019) has long acknowledged the centrality of violence against women to improving women's mental health worldwide. Integrated care systems represent an opportunity for health and social care services to work alongside and learn from the expertise and knowledge of the domestic violence sector. Integrating domestic violence advocates into healthcare settings has shown success (Halliwell et al., 2019; Laing et al., 2010). Integrating knowledge may also support the shifting of discourse from 'individual trauma' into the social and political realm, which could have significant implications for policy and practice.
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Conclusion

Perpetrators systematically used mental health coercion to denigrate and control women, impacting all aspects of their lives and preventing opportunities for support. Mental health coercion should be integrated into understandings of coercive control to increase awareness, validate survivor experience, and inform service provision.

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MEGAN WEBB, MSci (Hons)

MAJOR RESEARCH PROJECT

Section B: Empirical Study

“Where is the help for me here?” Female domestic violence survivors' narratives of navigating secondary-care mental health services.

Word Count: 7999 (415)

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Abstract

Introduction: Mental health services are in a unique position not only to contribute to the identification of domestic violence but also to provide appropriate support. Survivors of domestic violence regularly access secondary-care mental health services. What limited literature there is exploring their experiences has focused on the experience of disclosing abuse or the acceptability of routine enquiry in these settings. This study explores domestic violence survivors' narratives of navigating secondary-care mental health services.

Method: A qualitative study was undertaken with seven women who had experienced domestic violence. The Voice-Centred Relational Method was used to analyse women's narratives, together with thematic analysis.

Results: Results suggest that mental health professionals consistently missed the connection between abuse and women's presenting distress. The structure of mental health services was not conducive to supporting survivors of domestic violence and resulted in superficial interventions and relationships which meant that windows of opportunity for support were missed.

Conclusion: Women's experiences of secondary-care mental health services often paralleled their experiences of abuse, which was experienced as re-traumatising.

Implications: Adoption of a trauma-informed approach, increased domestic abuse training for mental health professionals, and availability of alternative conceptualisations of distress to diagnosis is indicated.

Key words: Domestic abuse, Mental health, Narrative, Survivor, Trauma-informed care

Introduction

Domestic violence and abuse (DVA) is a form of gender-based violence that disproportionately affects women and is recognised as a global public health issue (World Health Organisation, 2019). In the United Kingdom, one in four women will experience DVA in their lifetime, and in England and Wales, two women a week are killed by a current or ex-partner (Office of National Statistics, 2022). The impact of DVA on psychological wellbeing has been well-documented and is associated with various presentations of distress, including anxiety, depression, post-traumatic stress, eating distress, psychosis, and substance use (Herman, 2015; Humphreys et al., 2022; Khalifeh et al., 2015a; 2015b; Oram et al., 2013; Trevillion et al., 2014; Women's Aid, 2021). Research has identified a bi-directional relationship between DVA and mental health (MH) in which experiencing DVA increases the likelihood of a later MH diagnosis, and individuals who receive a MH diagnosis are more likely than others to experience abuse (Khalifeh et al., 2015a; 2015b). One reason for this bidirectionality may be that perpetrators use women's MH status to threaten, undermine, and denigrate their sense of self and credibility (Webb, 2023; Women's Aid, 2021). Although anyone can experience DVA, women are more likely to experience repeated severe physical and sexual violence, coercive control, and domestic homicide (Hester, 2013; Women's Aid, 2021). This study, therefore, focuses on female survivors.

Attention has turned to how healthcare services meet DVA survivors' needs consistent with the UK Government's (2021) 'Tackling Violence against Women and Girls' strategy (Halliwell et al., 2019). MH services are uniquely positioned to identify DVA and provide appropriate support (Department of Health, 2010; 2017). However, MH services have been consistently criticised for ignoring the political and social context of abuse and responses dominated by biomedical frameworks (Humphreys & Thiara, 2003).

Terminology

The literature reviewed uses a range of terminology to refer to DVA, coercive control and mental health problems. It is acknowledged that terms may be used in different contexts and individual preferences may vary. Table 1 explains how terms are used in this study.

Table 1.

Definitions of terms used in this study

Term	Definition
Domestic abuse and domestic violence	The terms 'domestic abuse and 'domestic violence' are used interchangeably in the literature; the same approach will be taken here and the acronym 'DVA' will be used where appropriate. Domestic abuse can be defined as 'an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer' (Women's Aid n.d.). The abuse can encompass but is not limited to: psychological, physical, sexual, financial, emotional abuse, and coercive control.
Coercive control	In the United Kingdom (UK) in 2015, the legal term 'Coercive and Controlling Behaviour' was introduced to recognise that 'coercive control' is a core type of domestic abuse. Coercive behaviour is defined as "an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim". Controlling behaviour is defined as "a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour" (Home Office, 2015, p. 3). Throughout the literature, the terms 'psychological abuse', 'emotional abuse' and 'coercive control' have been used interchangeably to describe forms of DA other than physical violence. For the purposes of this study, the term 'coercive control' will be used as an umbrella term to include psychological and emotional abuse (Safelives, 2019).
Mental health problems	The literature uses a range of terminology to refer to 'mental health problems'. These include 'mental ill health', 'mental illness', 'mental health problems', 'mental health challenges', 'emotional distress', 'psychological distress', 'mental distress' and 'mental disorders'. Where required for clarity, the terms used by the included literature have been retained: otherwise, the term 'distress' has been used to reflect the trauma-informed approach of the research and the social

constructionist and feminist positionings of the researcher (Sweeney et al., 2016).

Women who have experienced DVA	The terms ‘women’, ‘survivors’, and ‘victims’ are used in this study when speaking about women who have experienced domestic violence.
Perpetrator	The term 'perpetrator' refers to those who perpetrate domestic violence.
Narrative and story	It is also acknowledged that the terms ‘narrative’ and ‘story’ can be seen as problematic within survivor movements because of possible implications that survivor accounts are ‘fiction’. In this study, the term ‘narrative’ will be used when referring to methodology, and where possible, the terms 'account', 'experience', and 'journey' will be used when discussing survivor experience (Perot & Chevous, 2018).

Experiences of MH services

Despite evidence of co-occurrence and mandates to ask about DVA (‘routine enquiry’), MH services have shown limited engagement in identifying or responding to DVA (Nyame et al., 2013; Trevillion et al., 2016). Policies across healthcare have sought to address these concerns: including the Pathfinder project (Standing together, 2020), the UK Government’s (2022) ‘Tackling Domestic Abuse Plan’ and the development of a National Institute for Care Excellence (NICE; 2016) quality standard for responding to DVA. Despite this, accounts from female survivors who have accessed MH services have been generally negative (Marsden et al., 2021; Sweeney et al., 2016). Women have reported being consistently disbelieved and unheard within healthcare settings (UK Government, 2022; Sweeney et al., 2019). In a review of experiences of disclosing DVA in MH settings, Trevillion et al. (2014) found that MH services did not consider the role of DVA in precipitating or exacerbating distress. This is consistent with reports that MH services are ‘not conducive to the disclosure of DVA’ (Rose et al., 2011, p. 189) and that following a disclosure, experiences of DVA are rarely considered within care plans.

Biomedical dominance and trauma-informed approaches

Biomedical approaches dominate Western mental healthcare narratives (Adame & Knudson, 2007). The biomedical model assumes that ‘mental disorders’ are biologically-based brain diseases and emphasises pharmacological treatment to target presumed biological abnormalities (Deacon, 2013). Literature has focused on the MH consequences of abuse regarding the likelihood of receiving various psychiatric diagnoses (Howard et al., 2010; Oram et al., 2017). However, the language and principles of the biomedical model have profound implications for how people make sense of their distress, life experiences, and overall identity (Adame & Hornstein, 2006; Lawrence et al., 2021). Survivor movements and trauma-informed theorists have sought to provide an alternative narrative to the medicalisation of distress. Humphreys and Thiara (2003) and Sweeney et al. (2016) have argued that many ‘disorders’ are better understood as understandable responses to trauma and that conceptualising these responses as ‘mental illnesses’ or ‘MH problems’ creates an individualistic focus that ignores the wider social context and perpetrator actions. The focus of interventions within MH services can, therefore, become about treating ‘the illness’ separate from the experience of DVA. This can result in inappropriate interventions that exacerbate women’s distress, compromise their safety, and fail to meet their needs (Laing et al., 2012).

Rationale and aims

The National Health Service (NHS) provides MH services in the UK. Services are organised into primary, secondary, and tertiary care. Primary-care is often the first point of contact and includes GPs and Improving Access to Psychological Therapies (IAPT) services. Secondary-care MH services typically involve a referral from a GP and include community and inpatient MH care. Tertiary-care includes highly specialised MH services.

Research exploring survivors’ experiences of navigating secondary-care MH services has been limited (McGarry & Hinsliff-Smith, 2020). There is a lack of evidence exploring how DVA

survivors experience MH services beyond the experience of routine enquiry and abuse disclosure. Secondary-care services typically provide care to individuals experiencing long-lasting and high levels of distress. This includes many who receive a diagnosis of 'emotionally unstable personality disorder' (EUPD). This diagnosis is highly associated with experiences of abuse and is disproportionately given to women (Pico-Alfonso et al., 2008, Ussher, 1991).

Individuals accessing secondary-care MH services are two to eight times more likely than others to experience DVA (Khalifeh et al., 2015a; 2015b). Mantovani and Allen (2017) found that 49% (n=167) of people accessing a community MH team in Southwest London had experienced DVA. They concluded this was likely to be an underestimate, given that routine enquiry did not occur within the service. The lifetime prevalence of DVA in inpatient and outpatient MH services is 30-60% and 33% respectively (Howard et al., 2010; Oram et al., 2013).

The main aim of this study was to explore DVA survivors' narratives of navigating secondary-care MH services in order to understand survivors' needs further. Critically, this study sought to inform MH service provision by listening to survivors' narratives.

The research questions are therefore:

- a. What are DVA survivors' narratives of seeking help from secondary-care MH services?
- b. What are DVA survivors' narratives of interactions and relationships with secondary-care MH staff?
- c. What are DVA survivors' narratives of navigating the MH system when they have experienced MH coercion?
- d. What are DVA survivors' narratives of receiving a MH diagnosis and how has this shaped their identity?

Method

Positioning

Feminist and social constructionist positions informed the current study approach. Feminist research seeks to centre the lived experiences of women and girls, challenges dominant sources of knowledge, and places the lives of women and other marginalised groups at the centre of analyses (Burgess-Proctor, 2015). A further principle of feminist methodology is advancing social justice and achieving social change. Accordingly, the current research prioritised survivor voices to inform service provision (Montgomery, 2015). I undertook the study as a cisgender, heterosexual, white woman and approached the research from my experiences of womanhood, and how this has impacted my life. My research motivations arose from previously working within the DVA sector and supporting survivors in secondary-care MH services as part of my training as a clinical psychologist. Within these roles, I observed how DVA was approached differently in these two settings. I witnessed a high prevalence of DVA within secondary-care MH services, but limited knowledge, and acknowledgement amongst MH professionals (MHPs). This prompted the development of this study.

Design

The study adopted a qualitative, narrative approach to enable in-depth exploration of survivors' narratives of secondary-care MH service experiences (Patterson, 2002; Squire, 2008). The Voice-Centred Relational Method (VCRM) was used to analyse semi-structured interview data (Brown & Gilligan, 1992). VCRM aims to amplify voices that have been marginalised and silenced by dominant cultural frameworks and explores questions related to the nature of experience. It originated as a feminist method with a relational ontology, recognising that individuals are often embedded in a complex web of intimate and larger social relations (Hutton

& Lystor, 2021). It therefore aligned with the study's aims, to centre and prioritise the voices of survivors (Ballantine, 2021).

VCRM explores individual narrative accounts through four readings. Firstly, reading for the plot and the readers' response to it; secondly, individual's relationships to themselves; thirdly, their relationships to others; and fourthly, their relationships to the broader social, structural, and cultural contexts (Mauthner & Doucet, 1998). Given that the study aimed to inform clinical practice, and this was an explicit motivation for participation, a fifth reading was conducted. This involved a thematic analysis that synthesised the data into a more readily accessible form (see also Frost, 2008; Mauthner & Doucet, 1998; Montgomery, 2015). By listening for different 'voices' (through multiple readings of individual transcripts), VCRM arguably delays the reductionist stage of coding, helping to centre the ideas of participants rather than 'confirming what the researcher knows' (Hutton & Lystor, 2021, p.20). This can maintain differences across participants by considering their contexts and provide insights that may not have emerged in a thematic approach alone (Gilligan et al., 2003). VCRM recognises that narratives are crucial in constructing and maintaining self-identity, and understands that interview data is a co-construction between interviewer questions and what participants choose to share (Enosh & Buchbinder, 2005).

A key aim of feminist and narrative approaches is to reduce 'power-over' relationships between researchers and participants (Ballantine, 2021; Burgess-Proctor, 2015). Given the topic, a trauma-informed approach to research was implemented to reduce the risk of harm and avoid recreating abuse dynamics (Isobel, 2021). To achieve this, the project design was informed by the 'Survivors Voices' 'Turning Pain into Power' charter (Perot & Chevous, 2018) and the Women's Aid (2020) 'Research Integrity Framework' which set out criteria for working with survivors to ensure safe participation. The researcher met with a national DVA charity's lived

experience panel and held discussions with survivor researchers and national DVA services regarding the study's aims and design.

Participants

Seven participants were recruited from three third-sector DVA services in Southern England. A purposive sampling strategy was used to identify women who met the study's inclusion criteria (Table 2). Four women approached did not meet the inclusion criteria, two provided contact details but did not respond, and four women's circumstances changed, which meant participation was no longer appropriate.

Table 2.

Study inclusion criteria.

Inclusion Criteria	Description
Population	Individuals who identify as a woman (cis- and transgender).
Age group	Aged 18 years and above.
Experience	Have experienced domestic violence (including physical, financial, emotional/psychological, and sexual abuse) and coercive control.
Services accessed	Have accessed secondary care MH services (e.g., adult MH teams, community MH teams, assessment and treatment services, crisis teams, early intervention teams, assertive outreach teams, inpatient services) in the United Kingdom.

Ethics

Ethical approval was obtained from Canterbury Christ Church University's Ethics Committee. The research followed the British Psychological Society Code of Human Research Ethics (2021). The potential for causing distress, the capacity to provide informed consent, and participants emotional and physical safety were carefully considered, supported by discussions

with women and DVA staff. Recruiting women through third-sector DVA services meant skill and expertise were available in supporting risk assessment and supporting participants post-interview if required. A support worker from the recruiting service was available to women during the interview for additional support. A standard operating protocol was developed and discussed with participants before the interview. Participants were given a £10 gift voucher for participation. Travel expenses were also offered up to £10.

Procedure

Recruitment took place over 12 months. DVA staff identified potential participants. Those interested in participating were contacted by their specified safe contact method (text, phone, or email). Following initial contact, a phone call was arranged to discuss the nature of the study and what participation would involve. Information and consent forms were provided, and it was emphasised that participation was voluntary. Individuals were given time to review the information; if still interested in participating, a phone call was arranged to agree a safety plan, interview location and answer any further questions. The option to have the interview questions in advance was provided and it was recommended that participants considered what they felt comfortable sharing ahead of the interview. It was explained that participants were not expected to talk about or answer any questions they did not wish to, and they would not be asked directly about their experiences of abuse. Interviews took place in safe and confidential spaces: for six participants, this was within the DVA service building as this was their preference, and for one participant, this was an online videoconferencing platform. At interview, participants were reminded of processes regarding confidentiality, their right to withdraw at any time and were given the opportunity to ask any further questions. Written consent was obtained before starting the interview.

Data collection

Women participated in one face-to-face interview in the style of narrative inquiry for 45-90 minutes. Participants were asked to recall, in their own words, ‘what brought them into contact with secondary-care MH services for the first time’ and whether they felt that their experiences of DVA may have impacted their experiences of care. Participants were given space to speak freely: however, when their narratives came to a natural pause, prompts such as “what happened next” and “can you tell me more about that” were used to gain an in-depth understanding of their experiences (Anderson & Kirkpatrick, 2016). Following this, if areas of interest concerning the research question were not included within their initial narratives, participants were asked more specific open-ended questions about their journey through services to gain clarity and to elicit detailed accounts of their story (Appendix E; Lawrence et al., 2021). A debrief was provided at the end of each interview (i.e., about how participants found the interview process and if they felt they needed further support). All participants were signposted to local services and encouraged to contact their DVA worker if they required support post-interview. Interviews were audio recorded, and data stored according to ethical guidelines and data protection. Recordings were transferred to an encrypted memory stick, and anonymised transcripts were password protected. Participants were given the opportunity to review their transcripts and the analysis summary before project completion.

Data analysis

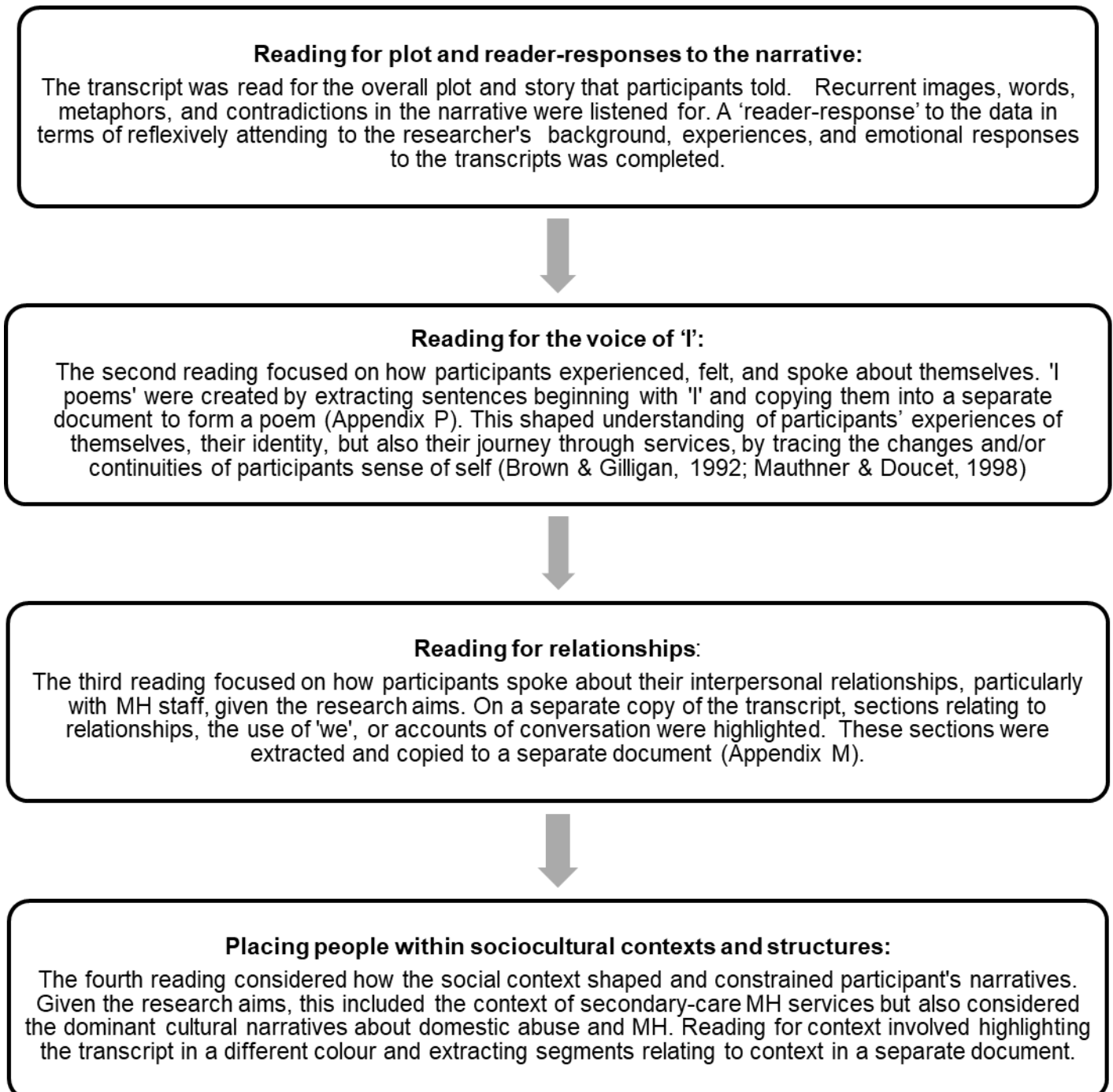
Interviews were transcribed verbatim and analysed in two distinct phases (see Mauthner & Doucet, 1998; Montgomery, 2015).

1. The ‘Voice-Centred Relational Method’ of data analysis involved four readings of individual transcripts, following the guidelines of Hutton and Lystor (2021): the first for the plot and reader-response; the second for the individual's relationships to themselves; the third for their relationships to others and the fourth for their relationships to broader social, structural, and cultural contexts. Figure 1 outlines the analysis process.

2. A further fifth reading included a thematic analysis of the data following Braun and Clarke (2006). Individual narratives were read in-depth and analysed line-by-line to develop initial codes using 'in vivo' and process coding, supported by software programme Nvivo. Descriptive themes were developed by exploring patterns of shared meaning across initial codes. Narratives were compared to identify links, similarities, and differences in their content using a spreadsheet. Descriptive themes were reviewed and defined to produce broader analytical themes that captured the data in relation to the study aims. Themes were identified based on points of connection and difference across narratives and their capacity to speak to aspects of experience that had not been captured in the literature before. Theme development was discussed in supervision. Member checking also shaped the final results.

Figure 1.

A flow diagram to show the VCRM analysis process.



Quality appraisal

Reflexivity is a significant aspect of narrative research (Burgess-Proctor, 2015; Riessman, 2008). VCRM acknowledges that however participant-led research may be, the researcher retains a significant role in initiating, facilitating, and constructing meanings within the data. However, transparency about researcher decision-making regarding what data is presented, what analytic choices are made, and reflections on researcher beliefs, knowledge, and identities can help make decisions around analysis, presentation of data, and the co-construction of narrative more explicit. Therefore, several strategies were adopted in an ongoing reflective process to consider my pre-existing beliefs and positioning relevant to the research, including a reflective diary, individual summaries, a bracketing interview with a narrative researcher, and regular supervision (see Appendices N; O; R; Tufford & Newman, 2012).

Results

Participant information

To minimise the possibility that women might become identifiable, only age groups and services accessed were associated with pseudonyms (Table 3). All seven participants were White British, and their average age was 42 years. Length of contact with MH services ranged from 1-19 years, with an average of eight years. Five women had left their employment due to their experiences of abuse. Two women were working part-time, and two were receiving benefits. Three women were living in refuges, one in temporary accommodation, and three in private accommodation. Five were mothers, and two had had their children taken into care. All had experienced DVA within heterosexual relationships from a male partner; one participant had also experienced DVA within her family of origin. The abuse lasted from ten to 27 years. All women had separated from their partners at the time of interview (four within the last year); however, many still had contact with the perpetrator through child-contact or legal proceedings.

Table 3.*Participant Information*

Pseudonym	Age group	Services accessed
Louise	40-49	Crisis and home treatment team; DV refuge.
Caroline	50-59	Community mental health team (CMHT); Private psychology; DV service.
Lauren	20-29	CMHT; Crisis team; Inpatient service; DV refuge.
Alice	50-59	CMHT; IAPT; Crisis team; DV service.
Amy	40-49	CMHT; private psychiatry & psychology; IAPT; DV service.
Demi	30-39	Crisis team; DV refuge.
Phoebe	40-49	CMHT; Crisis house; Crisis team; DV refuge and service.

Findings

Analysis identified three main narratives: ‘Missing the connection(s)’, ‘Missing windows of opportunity’, and ‘Finding a safe haven’. Ten subthemes described women’s accounts and have been presented in bold, italics, and underlined throughout the text (Figure 2). Additional quotations are provided in Appendix K.

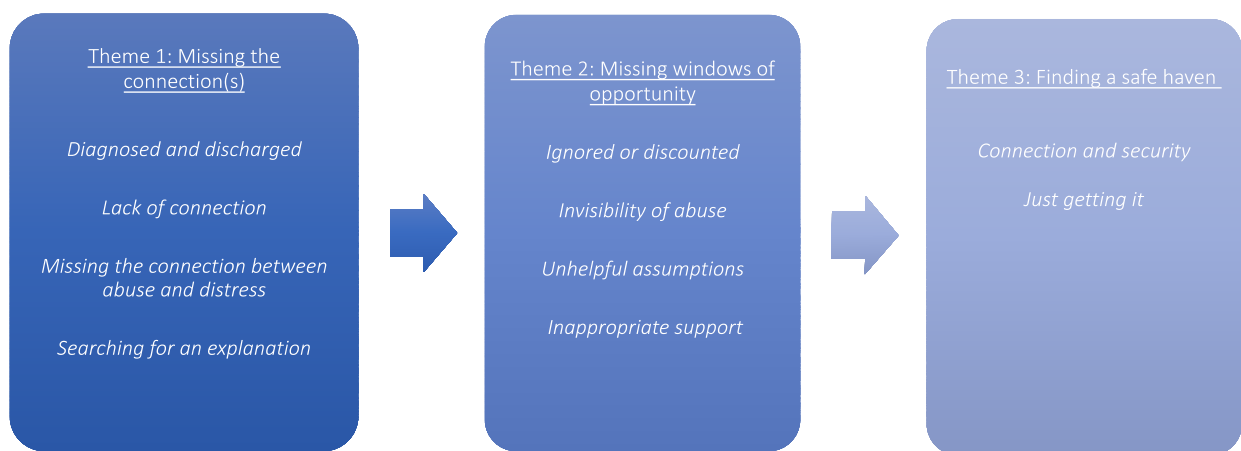
Theme development

By deliberately attending to participants’ contexts, relationships with staff, and self-identities through multiple readings for different voices, the VCRM centred participants voices and maintained differences across narratives. The four initial readings informed thematic codes and the creation of I poems allowed the tracing of individual journey’s through services, a key study aim. This supported the development of analytical themes. Completing a reader-response to each narrative as part of the VCRM, reflecting on my emotional response, and what I was or was not attending to, facilitated immersion in the data. This facilitated a deeper understanding

of each person's journey, reflection on my involvement in the analysis, and recognition of points of connection and disconnection between narratives which provided critical insights when developing codes and themes.

Figure 2.

A figure to show the organisation of themes and subthemes and a depiction of women's journeys of navigating services¹.



Missing the connection(s)

Throughout women's narratives of navigating services, there was disconnection between their episodes of care, relationships with MHPs, and between their experiences of DVA and distress. Women, therefore, described searching for an explanation for their distress.

Women faced consistent barriers to accessing and re-accessing support. Many described how high thresholds for accessing support resulted in long waits; however, they were quickly discharged, on access. Despite experiencing significant distress, women reported being 'left' by services, with no follow-up care or onward referrals for support. Interactions with services were

¹ The ordering of themes indicates how they were perceived to be sequenced across women's narratives of their journeys through services.

experienced as disconnected, with little consideration of longer-term care planning or integrated support. Instead, women reported being **'diagnosed and discharged'** following psychiatric medication prescription. Following this, women had to fight to re-access support, often in the context of gatekeeping by services. Women, therefore, felt as though they were 'going round in circles' and were not being listened to.

"When I got released from there, that was it. Had no aftercare. No follow ups.... Nothing at all until I then next overdosed and woke up in hospital". [Lauren].

"You try and kill yourself... You then get put on to the crisis team, they're there with you like intensively for a couple of weeks and then it's like 'thanks for coming it's been emotional, see you later' after the two weeks, nothing". [Louise].

Women reported that the brevity of appointments and time-limited support offered no opportunity to form meaningful, trusting relationships with staff, which resulted in a **'lack of connection'**. This was exacerbated by high staff turnover. Phoebe described having to ring reception and ask for a call back, rather than being able to contact a MHP directly, which enhanced this disconnection. Women also described not feeling held in mind by MHP's as they always had to reach out for support, rather than check-ins being provided.

"I just...didn't connect with the psychologist, it was a guy... when you're going through domestic violence its quite difficult to open up to a male...and he was just asking me questions, like, from a piece of paper and just like ticking a box...I didn't connect with him. So I wasn't able to disclose everything that I wanted to disclose to him" [Phoebe].

Women reported a general lack of curiosity from MHPs about why they were distressed and described interactions with staff as feeling like a 'tick box exercise'. There was often a focus on completing questionnaires or attending online groups rather than having face-to-face interactions. This exacerbated participants' isolation and disconnection. Women often felt that their difficulties were taken at 'face value' without professionals 'looking deeper'. All acknowledged that this reflected the current NHS context where high demand and limited resources resulted in brief, superficial interactions with professionals.

"There should have been a breakdown...with the crisis team... how I got to that stage where I wanted to hang myself and...throw myself out of the window. Like, why? What happened in the run up to this point, you know, but they weren't interested in that. They were just interested in ticking boxes." [Demi].

Professionals often **'missed the connection'** between women's experiences of DVA and their presenting distress. Women described how a context of terror, walking on eggshells, and firefighting impacted their interactions with professionals. Women who had not disclosed abuse described the significant risk and vulnerability involved, and how conditions of safety and trust were necessary for disclosure to occur. Women often tested the water with professionals by leaving hints or 'being vague' in the hope that professionals would notice. Women reflected that the culture of MH services meant professionals focused on presenting issues and 'diagnoses'. Caroline explained that this meant the 'root of the problem' was unaddressed, resulting in a 'revolving door' of re-access. MHPs consistently showed a lack of understanding and knowledge regarding DVA.

"I just felt scared. I felt maybe they wouldn't believe me. Maybe they thought I was just going crazy... I was scared in case if he found out that I was telling people our business what

he would do to me. It was the stigma around it as well. I felt guilty, I felt ashamed... I just wanted somebody to say to me like "like, what is going on?... that's what I wanted, but that didn't happen so." [Phoebe].

Demi reflected on what she wanted from MHP's:

"Someone to unpick it and ask me what is going on? We can see by your records that you've got worse over the years, what's happened? She didn't use to have a drinking problem... What the fuck has happened for her now to be drinking a litre bottle of vodka a day?... Why can they not put two and two together with this? They need someone to be able to look at that and think that screams domestic abuse." [Demi].

The experience of abuse led all women to experience significant distress. Many women, however, reported not recognising the connection between their experiences of abuse and instead 'searching for an explanation' for their distress when they initially accessed services. For many, this was due to the ambiguity, isolation, and confusion created by coercive control tactics. Women reported a sense of 'something not being right' but could not identify what this was, therefore considering themselves 'as the problem'. Amy recounted not wanting her husband to be at the birth of their children and expressed to staff that she wanted him removed as her next of kin in mental capacity decisions. Despite not explicitly recognising the abuse then, Amy reported that there must have been 'something wrong' for her to make these requests. The experience of being called 'mad', 'crazy', 'paranoid freak', and 'nutcase', meant many women questioned their sanity. Many, therefore, reported initially welcoming a mental health diagnosis as it provided an explanation for how they felt and countered the perpetrator's narrative that they were going mad.

"Having the diagnosis obviously doesn't heal you...but I now know, right, okay, I'm not feeling great. So what's going wrong? Whereas before, I just thought 'he's right, I'm going mad... And I didn't have that real understanding of what's happening to me.'" [Lauren].

"When I was diagnosed...it was a feeling of 'okay, so I do have something'. So I'm not entirely crazy, because I thought I was going mad. So when I was given the anxiety, depression, and emotionally unstable personality disorder..., it was like okay, I do get those feelings and this is why I feel the way I feel and...it was kind of refreshing to hear that I did have something, because I just thought that I was just going crazy." [Phoebe].

However, Phoebe later reported questioning:

"Sometimes I sit here and think if I didn't go through what I went through, would I have these diagnoses? If this never happened to me, would I be like this?" [Phoebe].

Louise described searching to understand of 'why she was the way she was'. She found not receiving a diagnosis invalidating, as MHP's offered no alternative explanation for her distress.

"I wasn't saying, 'Oh, I've got bipolar' ... I suppose in a way...you want to be labelled...but you don't. But you want a reason to be like, 'Why am I?'...Clearly there is something wrong with me." [Louise].

Several women reflected that MH services rejected complexity and were more interested in categorising and 'washing their hands' of them rather than considering how their difficulties might intersect. Demi described her experience as 'being thrown in a box' and professionals 'throwing away the key'. Many women reported that professionals consistently missed the connections between substance use and MH (i.e., the former being a coping strategy to numb

the pain'). Several women described self-medicating with substances due to a lack of service provision but later being denied MH services due to substance use. Gatekeeping between services meant women felt there was 'no help out there for them'.

"I was in a bad relationship with domestic violence, I was using... to try and numb the pain... it makes you feel unworthy as a person because you're a substance abuser, that our mental health is totally just put down to substance abuse... the mental health comes from the abuse and the substance abuse. It's just a triangle of shit, you know?" [Demi].

"If you're going through domestic abuse and use drugs...you're instantly looked at as bad. And they don't really look deeper as to why you're actually using them. What are you trying to hide? What pain are you trying to heal by yourself but not getting the help?" [Lauren].

Missing windows of opportunity

Missing the connection(s) had several consequences: Women reported that professionals often ignored the abuse, held unhelpful assumptions about DVA that impacted their care, and offered interventions that were inconsistent with their needs. Windows of opportunity for meaningful support were, therefore, consistently missed. For many women, this resulted in losing faith, trust, and disengagement with the MH system. Women's narratives conveyed a sense of loss and 'what could have been' if they had received appropriate support when they needed it.

"I just wish that somebody would have noticed the signs. Noticed the bruises...the really bad MH. Noticed the weight loss... the weight gain... the self-harm... the self-medication...the alcoholism... the cannabis use... and maybe ask me, 'Are you okay?', 'Is everything okay?' [Phoebe].

"I feel like if I'd got the help earlier, I wouldn't have had to go through this nightmare for so long. And in the time that I wasn't being treated successfully, it just spiralled." [Alice]

For some women, overt disclosures, explicit hints, or documentation of abuse within their care records were **'ignored or discounted'** by professionals. The lack of interest from professionals regarding the context of their distress was experienced as active avoidance and a lack of care. They felt that staff could not be bothered or did not wish to learn more about their circumstances. Women wanted professionals to ask them about abuse explicitly rather than being expected to bring it up themselves.

"They just ignored what I was saying, they... didn't really factor [DVA] in as a main cause or understand it or help me understand it, or they didn't act on it" [Amy].

"I'm not blaming them for it, but it was blatantly obvious what was going on...they never said... 'is there anybody you want to speak to?'" [Louise].

The lack of responsiveness and silence from services meant many women reached breaking point. They reported feeling abandoned by services, which exacerbated their sense of isolation created by the abuse.

"I reached out to Crisis team saying that I was mad...I was seeing things, I was manic, ...I was scared. Somebody rang me back..., and just said to reach out to A&E in the next 4 to 8 hours. And I was like, I can't get myself to hospital...I was too afraid to even leave my house. So I overdosed. " [Lauren].

When professionals missed the connection between abuse and distress, this exacerbated women's sense of being undeserving of support and perpetuated the '*invisibility of abuse*'. A lack of professional understanding about DVA and focus on the 'presenting problem', meant that the intervention became 'all about them' rather than the perpetrator and the abuse.

"The MH couldn't even see it. And if somebody else can't see it, then why should I deserve to get help?" [Phoebe].

The invisibility of the abuse meant that professionals ignored Louise's requests for her medication not to be given to her partner. This resulted in him using access to psychiatric medication as another method of control:

"They passed it [medication] on to the abuser to give him full control of my tablets. Even though I said I didn't want that but...to them, I'm the nutcase... who just keeps trying to kill herself... that was totally ignored.... it comes across like they don't give a shit" [Louise].

Alice felt blamed by a psychiatrist for 'not letting her thoughts go in and out'. Although understood as a mindfulness technique, due to ignoring the context, Alice experienced this as invalidating due to being at risk of harm from the perpetrator.

"He undermined me and didn't take me seriously and was basically saying it was my fault that I was having so many thoughts because I wasn't doing the right things...he made me feel just like my abuser did, that it was my fault" [Alice].

Amy described how, despite disclosing abuse, she was diagnosed with EUPD after her partner reported that she was fabricating illness in the children. The psychological abuse perpetrated by

her partner created such distress that it acted as confirmation for a personality disorder diagnosis. Professionals then viewed Amy's rejection of this diagnosis as further evidence of 'personality disorder'. This was experienced as collusion with the abuse.

"Because the level of what he was doing was so psychologically, like tormenting...it looks like extreme anxiety, it looked like mood instability... It wasn't, it was fear... he created the symptoms he wanted them to see" [Amy].

"It makes you think that it's your fault. That actually there's something wrong with you. ...that what's going on at home was fine..., and that you're overreacting... or you're assessing it wrongly... Especially trying to pull it down to personality disorder. That was that was the worst" [Amy].

As women received information about DVA, which made their experiences more visible, their relationships to diagnosis changed.

"I'd had such a number done on me...I thought I was accessing things for anxiety and flipping, whatever...it was because of him. He was never going to...go 'Oh, actually, I think you should go to [DVA service] because I've been abusing you for the last 15 years mentally and emotionally' ... You know, it was it was an agenda that was pushed on me" [Caroline].

"I just wish that somebody would have said to me... you're going to be okay. You're feeling like this because you're being abused. Not because you have emotional personality disorder, not because you're depressed, not because of your anxiety..., because of what you're going through... I didn't have any of that" [Phoebe].

The power that MHPs held in 'labelling' women's experience of reality resulted in some women feeling trapped in unhelpful and inappropriate services, paralleling their experience of DVA.

"Once you engage with services...for a certain thing...it's like a bit of a runaway train...I don't think they...kind of go 'oh no hang on a minute, we've got this completely wrong and actually she was being abused'... it's just very hard once you get those things on your medical record, to then change the way people are viewing a situation" [Caroline].

Despite being wrongly seen as the problem, some women kept the abuse 'invisible' for their safety, strategically managing interactions with MHPs due to a lack of trust.

"It used to break me because I thought 'oh my god, I just want to tell you... it's on the tip of my tongue'. And no, I was just like 'nah, it's just not worth it" [Lauren].

A lack of understanding often meant professionals made 'unhelpful assumptions' about DVA. For example, some professionals repeated societal narratives about leaving a relationship being a simple problem and failed to acknowledge the difficulties women faced in accessing support within the current system. Women, therefore, often felt blamed and judged by professionals, which hindered the development of trust and safety.

"Why did you not come to us sooner? If you have been getting abused for seven years?...Why is that important? I'm here now. Why are you judging me on not coming? Can you help me now?" [Lauren].

MHPs were reported to respond negatively when women were vocal about what they needed. Women were also aware of the potential consequences if they made complaints or were seen as ‘difficult’ (i.e., being labelled). Lauren reported being over-medicated in an inpatient ward as she was considered ‘argumentative’. Amy reported being warned that she may be labelled with a ‘narcissistic personality disorder’ diagnosis by the CMHT if she continued to challenge the potential diagnosis of EUPD.

A lack of professional understanding or exploration about the context of women's distress often resulted in ***‘inappropriate support’***. All women had been given medication as the initial intervention. Lauren described the irony of being denied MH care due to substance use but then being over-medicated with psychiatric drugs:

“‘We can't help you because you still have drugs in your system'. But...you just keep medicating me. How am I ever meant to get off drugs when all I ever know is to have some sort of medication or drug in my system?’” [Lauren].

Lack of availability of appropriate support led to women being offered inappropriate, superficial interventions to ‘tick a box’. Louise described being told she needed to self-refer to therapy but feeling unable to do this alone, and ‘to make herself a cup of tea’ by the crisis team when in suicidal crisis.

“Oh, there is counselling, if you need that it's a self-referral'...'but just to give you the heads up...the waiting list is extremely...long, so if you do have the funds, we would recommend...paying privately' ... You ain't going home and telling a violent partner 'I need money to go get counselling'...It's basically saying “We're offering you this help with the left hand, however, we're taking it straight back with the right hand” [Louise].

Alice was offered an online psychoeducation group. However, when she declined, fearing it would exacerbate her distress, and asked to meet a professional face-to-face, this was interpreted as her not being open to exploring support options. Alice later described trying a new medication due to feeling listened to by a psychiatrist and found it helpful. This highlighted the importance of MHPs taking time to build trusting relationships rather than rushing to blame individuals for 'not engaging'.

"I didn't think it was going to help. But... I kind of trusted him. Because he listened" [Alice].

Finding a safe haven

All women eventually found a 'safe haven' where they felt heard, understood, and supported. For most women, this was outside of NHS MH services and within specialist DVA services or private practice. Phoebe, however, found meaningful support after moving to a new MH service.

Women described the importance of **'connection and security'** in their safe haven. The opportunity to build consistent relationships was highly valued and crucial to a sense of safety. For many women, one professional relationship had been pivotal in shaping their journey. Women described the importance of professionals investing and being alongside them rather than telling them what to do. For all women, being seen and treated with compassion, respect, and humanity increased their sense of connection. Caroline's private clinical psychologist engaged in 'gentle awareness raising' at her own pace so that she could reach her own conclusions.

"There was no pressure on her...to kind of tick boxes or...try and cram everything in and then end the therapy" [Caroline].

For Phoebe, the consistent relationship with her DVA advocate was crucial to her survival:

"If I didn't speak to [DVA advocate], I don't think I'd be here now...it was the way she spoke to me. She was very caring and very worried for my safety that I actually felt heard and listened to the first time in a long time" [Phoebe].

Phoebe reported that her new MH team was characterised by connection and availability of support: MHPs followed through with what they said, and there was consistency in being 'listened to' and 'treated with kindness' by every professional she interacted with. For some women, peer support (i.e., therapeutic groups, refuge) alleviated the sense of 'it just being them'. Others described how advocacy was valued when they felt completely alone.

"Being abused, you get told that nobody's ever going... believe you ...so you really feel like there's nothing out there for you. But the staff here and the people I've met here...you don't think that they even exist when you're in that madness you know? So that's been the biggest support" [Lauren].

For many, the context of abuse meant that they often had to access services repeatedly due to fluctuations in their safety. Caroline reflected that having choice and flexibility over her care was essential to her feelings of security. Women also described professionals holding a sense of hope that things would improve as essential to their ability to keep moving forward.

Women expressed relief at professionals *'just getting it'* and not having to explain themselves repeatedly. Understanding the dynamics of abuse and providing resources and information put women's distress into context, named the abuse, and alleviated feelings of self-blame and isolation. Furthermore, DVA staff's intuition, understanding, and expertise allowed women to feel safe in non-blaming, non-judgemental environments and put their distress in context. Women described the importance of connecting their experiences of abuse with their distress and the power of recognising that it was not their fault as an essential step on their journeys.

"I actually feel like a human. I feel like people listen to me. And here, I'm never judged... you feel like you've actually got a voice and someone's listening to you, and someone understands you. You don't feel alienated at all...and I'm starting to realise...that it's not my fault" [Demi].

Discussion

This study explored DVA survivors' narratives of navigating secondary-care MH services. It is the first to explore women's experiences in secondary-care beyond the acceptability of routine enquiry and experience of abuse disclosure. The study supports and extends findings that secondary-care MH services are not currently conducive to supporting DVA survivors' and that the structure and culture of services not only replicate the dynamics of abuse but can also exacerbate risk and harm (McGarry & Hinliff-Smith, 2020; Trevillion et al., 2014; 2016).

Key findings

At the practitioner level, women perceived MHPs as uncaring and disinterested to their needs. MHP's lack of knowledge and understanding about DVA resulted in judgement, blame, retraumatisation, and, for some, collusion with the abuse, supporting the findings of Marsden et al. (2021), Trevillion et al. (2014), and Rose et al. (2011). Healthcare professionals have been

reported to lack confidence when enquiring about DVA (Tarzia et al., 2021). MHPs also projected unhelpful societal assumptions about expectations to leave the relationship, and the credibility of women who have a MH diagnoses and use substances. Women frequently reported not being taken seriously or listened to in their requests for help, despite making multiple attempts to end their lives. The study therefore extends the findings of Mackenzie et al., (2019) who found that women's readiness to leave a relationship, substance use, and MH difficulties negatively influenced GP's perceptions about women's 'worthiness' for receiving support'.

At an organisational level, women felt that the structure and culture of MH services allowed MHPs no time or resources to deal with anything beyond the presenting problem (Gerbert et al., 1997). A lack of appropriate support caused them to feel ignored and abandoned. The dominance of the biomedical model also intersected with these constraints to reduce curiosity about the context and alternative explanations for distress. These issues have been widely reported (see Hudspeth et al., 2022; Oram et al., 2022) and have arguably been exacerbated by a political climate of austerity and funding reductions (Cummins, 2018).

Parallel process

Women in this study described how the power differential and lack of control intrinsic to their abusive relationships was often replicated in their interactions with MHPs, enabled by organisational cultures. Smith et al. (1989) argued that “when two or more systems - whether these consist of individuals, groups, or organisations - have significant relationships with one another, they tend to develop similar affects, cognition, and behaviours, which are defined as parallel processes” (p.13). The MHP role as the 'expert' within MH services arguably replicates a power differential survivors' have faced in their abusive experiences (Sweeney et al., 2019). In the current study, it was apparent that the MH system's unpredictability, uncertainty, lack of

responsivity (silence), and enforcement of arbitrary conditions around care, paralleled women's experiences of domestic abuse. Furthermore, the structural barriers identified in the current study may mean that MHPs relied on power rather than the ability to relate to and work alongside survivors. 'Power-over' relationships disregard women's knowledge and expertise and take decisions and control away from survivors (Sweeney et al., 2018). This is supported by findings that readiness to ask about DVA improves when staff are supported by a collaborative team and a resourceful health system (Hegarty et al., 2020). MH services may be more at risk than other healthcare services of enacting parallel processes due to the power of the biomedical model in shaping identity and use of MH coercion as a tactic of abuse (Warshaw et al., 2014). Humphreys and Thiara (2003) argue that emphasis on allocating diagnoses places 'the problem' within women, keeps the abuse invisible, and results in fragmentation in relation to care.

Trauma-informed care (TIC)

Given the existence of parallel process, alternative ways of organising and delivering MH services have been described (Bloom et al., 2010; Sweeney et al., 2016). TIC is a process of organisational change that seeks to prevent re-traumatisation and replication of abuse within services (Sweeney et al., 2018, p. 323). Despite TIC being recommended within MH service policy (NHS England, 2019), in practice, system-wide change has rarely been enacted (Oram et al., 2022). Sweeney et al. (2018) and Elliot et al. (2005) argued for creating healing environments that are based on safety, respect, and dignity and the promotion of 'power-with' rather than 'power-over' relationships within MH services. This supports the current study findings, as women repeatedly cited the importance of caring, consistent relationships in navigating services, despite system constraints. This builds on established findings that interventions that take power away from women are not conducive to healing and 'RICH' relationships with staff (i.e., relationships that provide respect, information, connection, and hope) can make all the difference (Elliot et al., 2005; Herman, 2015; Tarzia et al., 2020).

Clinical Implications

The current findings have clinical implications that echo the wider literature (Oram et al., 2022; Trevillion et al., 2014; 2016). Most notably findings support calls for systemic change within MH services, including adopting trauma-informed approaches, and providing alternative conceptualisations of distress beyond diagnosis (e.g., Allen et al., 2007; Johnstone et al., 2018; Sweeney et al., 2016).

The findings also support calls for policy change and more integrated care across DVA, drug and alcohol, and MH services (Halliwell et al., 2019; Humphreys et al., 2022; Laing et al., 2012). Failure by inpatient and community mental health services to respond appropriately to domestic violence, either by discounting the violence or by misdiagnosis and inappropriate treatment, can place women at risk of ongoing and escalating violence and increased distress (Laing et al., 2010). Where possible, opportunities for meaningful intervention should be seized, following the principles of TIC. Currently, there is a gap in provision for individuals who experience DVA and who also experience long-lasting and high levels of distress and/or use substances and/or alcohol (Laing et al., 2010). As reported in this study, this can result in fragmented care for those trying to access support. Integrated care systems represent an opportunity for health and social care services to collaborate, share knowledge, and create clear referral pathways with DVA and drug and alcohol services. Integrating DVA advocates into healthcare settings has shown success (Halliwell et al., 2019; Laing et al., 2012), and similar models have been used to integrate NHS and third-sector services in the UK within the homelessness sector (Williamson & Taylor, 2015). Integrating knowledge across services may also shift the discourse from 'individual trauma' into the social and political realm, which could have significant implications for policy and practice and reduce a medicalised response that has been shown to be consistently unhelpful for DVA survivors.

Adoption of an advocacy approach when considering DVA within secondary-care mental health services may also shift staff pressure to ‘intervene and fix’, and instead encourage MHPs to sit alongside, listen, and consider survivors’ expertise in what support would be valuable (Hegarty et al., 2020; Tarzia et al., 2021).

Women reported wanting to be explicitly asked about abuse so that windows of opportunity for appropriate support were not missed. This supports calls for the adoption of routine enquiry about DVA in MH services (Trevillion et al., 2016). MH services are well-placed to explore this within initial assessments and, compassionate enquiry should be particularly considered when supporting those who have attempted to end their lives. The involvement and collaboration with DVA survivors and professionals in the co-construction of policy and MH service development is strongly recommended.

As one in four women experience DVA in their lifetime, MHP’s will have regular contact with individuals who have experienced or are currently experiencing DVA (Office for National Statistics, 2022). The findings, therefore, support calls for DVA training for MHPs to increase understanding and confidence. Training which focuses on non-physical types of DVA, including MH coercion, and the intersections with alcohol and substance use is indicated. Training should also seek to increase practitioner confidence in responding to DVA disclosures appropriately (Trevillion et al., 2016). The findings also reflect MHPs power in shaping women’s journeys; one relationship can make all the difference. Therefore, it is important to emphasise within training opportunities the existing interpersonal and clinical skills that MHPs have that enable them to be well-placed to support DVA survivors, and to provide thoughtful and compassionate support. It is also recommended that MHPs reflect on their power, privilege, and assumptions about DVA, and substance use and how this may impact the care they provide (Oram et al., 2022). Participant recommendations are provided in Table 4.

Table 4.*Participant recommendations for MH services*

Survivor Recommendations	Description
Mandatory training	<ul style="list-style-type: none"> • Training on domestic abuse could be integrated into professional training programmes, or MH services could receive specialist training from DVA services, particularly on coercive control and non-physical types of abuse. • MHPs to be more knowledgeable and understand the signs and dynamics of coercive control. • Increased MHP understanding about the intersections between domestic abuse, mental health, alcohol and substance use. • Increased MHP understanding about repeated interpersonal trauma and how this can impact mental health.
Development of a pathway	<ul style="list-style-type: none"> • It was suggested that a development of a pathway for DVA survivors in MH services would be helpful, so that women can receive timely support, given how quickly their circumstances may change and windows of opportunity can be missed. • More specialist support within MH services for DVA was recommended.
Integrated support	<ul style="list-style-type: none"> • Women asked for more integrated support between MH teams and DVA services (e.g., MH support being available when women enter refuge). • The development of links between MH and DVA services was recommended to improve knowledge and clinical practice.
Consistency of relationships	<ul style="list-style-type: none"> • Where possible, consistency with the same worker should be prioritised within MH services, to provide opportunity to build a relationship and trust over time, • Women highlighted the importance of having a plan in place (e.g., for MHP leave) and knowing a MH worker they could contact in their absence.
Awareness of support	<ul style="list-style-type: none"> • Many women described not knowing what support was available to them. They therefore suggested it may be helpful to know what support was available to them. This has been reported within literature reviews which suggested that information about coercive control and domestic abuse could be displayed within individual clinic rooms, waiting rooms and MHPs should have resources that can be shared with women, if it is safe to do so (Tarzia et al., 2020).
Listening and being taken seriously	<ul style="list-style-type: none"> • Most importantly, women recommended that MHPs reflect on their own assumptions, do not judge others, listen, and take their concerns seriously. • Women also emphasised the importance of their own expertise being respected within MH consultations.

Strengths and limitations

A study strength was its qualitative design and comprehensive analysis, which facilitated immersion into each woman's journey through services, and enabled theme identification both within and across narratives. Furthermore, the study adopted a trauma-informed approach, involving collaboration with DVA survivors and staff in project development and completion. This provided new insights and strove to make participation in the study as safe as possible, supported by participant feedback. Member checking and regular discussion within supervision shaped the analysis. A reflexive approach was also taken, which involved reflecting on my emotional responses, and what I was or was not attending to in theme development. I also kept a reflective diary and reflected on my beliefs (e.g., about how distress is conceptualised within a biomedical framework) throughout the project, within supervision, and a bracketing interview prior to study initiation. My positioning as a feminist researcher and adoption of a trauma-informed approach meant that I adopted a curious, non-expert stance, encouraging me to engage openly with the data and listen and learn from women's narratives rather than reporting what I 'already knew'. My research positioning and motivations are outlined, and readers are invited to consider this when drawing their conclusions.

Women were recruited from specialist DVA agencies and therefore, may, have compared their experiences of MH services with their experiences of specialist support, which may have shaped their narratives and the conclusions drawn. Given the significant demands and reductions in funding for specialist DVA provision, eighteen services were contacted and could not support recruitment. It, therefore, took 12 months to meet with seven participants (Ellard-Gray et al., 2015). Despite this, data richness was judged to be 'sufficient' for a major research project and was consistent with sample sizes of other narrative studies on DVA (Hancock, 2017; McGarry & Hinsliff-Smith, 2020; Vasileiou et al., 2018). Furthermore, all participants identified as cis-gender, White British, and heterosexual, and therefore, experiences of Black

and minoritized, and LGBTQ+ individuals may differ, especially given the structural inequality that is known to impact experiences of accessing and receiving MH support (Bornstein et al., 2006; Femi-Ajao et al., 2020).

Recommendations for future research

Whilst the current research is unique, it also echoes 25+ years of literature that women can experience healthcare services as unhelpful, re-traumatizing, and paralleling their experiences of abuse (Gerbert et al. 1997). Despite these repeated findings, there has been limited practical or cultural change within MH service provision (Lewis et al., 2023; Oram et al., 2022). Some researchers are therefore turning to methods such as participatory action research to directly impact women's experience and close the research-implementation gap (Cornish et al., 2023; Mantovani & Allen, 2017). This is recommended for future research. Future research should also explore the experiences of Black and minoritized survivors, including people who identify as LGBTQ+, to establish how their experiences may be similar or different to those presented (Thiara & Harrison, 2021).

Conclusions

The study's findings provide further evidence for previously expressed concerns about the ability of services as currently constituted to provide appropriate MH support to DVA survivors. Despite system constraints, the importance of caring and consistent relationships with professionals in which women were listened to and treated with compassion and humanity were consistently cited to make a difference.

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MEGAN WEBB, MSci (Hons)

EXPLORING DOMESTIC VIOLENCE AND MENTAL HEALTH

SECTION C:

APPENDICES OF SUPPORTING MATERIAL

SALOMONS INSTITUTE OF APPLIED PSYCHOLOGY
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A.

Section A: Sample of themes, subthemes and illustrative quotes

Theme	Subtheme	Illustrative quotes
Creating an environment of confusion	<i>"Only he had the key to reality"</i>	<p>"I didn't even realise just how bad things were actually getting because it was so gradual" (Participant, 20).</p> <p>"I knew it did not feel right...but I didn't know how abuse was supposed to feel. I knew something was repressive, but I did not know how things could be different" (Participant, 22).</p> <p>"It scared me much, much more than physical violence or sexual violence did. Because that had a beginning and an end, didn't it, but this didn't. No, this terrorizing was there all the time, the fear was there all the time, wasn't it?" (Participant, 9).</p> <p>"I didn't realize how severe the psychological violence had been or how badly it had affected my health until long after our separation. He had gaslighted me for such a long time, and I just agreed because I wanted to have peace in our home" (Participant, 2)</p>
	<i>"Dr Jekyll & Mr Hyde"</i>	<p>"I was going to the ... leaders in the church saying my husband's really abusive. He screams [at us] all the way to ... church and when he gets out of the car, he'll just run off and do his church activities... On the way home it would be the same stress. So he was like a Jekyll and Hyde." (Participant, 23)</p> <p>"There'd be grand gestures. Things that were very generous and very visible and that people would praise him, like, 'Oh...You're so lucky. He's such a great guy.'...he was really invested in this good guy [image]" (Participant, 28).</p> <p>"He kept calling me asking for forgiveness . . . brought me flowers, all these golden necklaces and earrings . . . During that month he did everything he hadn't done during our entire life together . . . I decided to give him a second chance " (Participant, 3)</p> <p>"I mean, it's not like you meet a violent man and say 'Yes, now everything'll be wonderful!'. You meet a wonderful man who turns out to be something entirely different later" (Participant, 9)</p>

"I didn't choose him when he was bad, did I? No, I felt that I fell in love with him for his good sides. And in the beginning, the good sides outweighed the bad all the time but then the bad sides took over more and more and there was less good left . . . and then it was easier to get out, you know" (Participant, 9)

"He did things that made me feel like I was going mad"

"He would start acting as if nothing had ever happened and that nothing was wrong. I felt insane when this happened" (Participant, 4)

"The accusations, they nearly drove me insane, like to the point of where I nearly ended up in a psychiatric unit...because he used to accuse me of all this stuff...he would tell me I'm such a liar that I wouldn't know the truth if it slapped me in the face". (Participant, 28)

"It wasn't so much the physical, it was the mental abuse that was the worse. He manipulated my mind all the time and he'd twist everything and he did things that made me feel like I was going mad . . . I'd think well I'm sure I did that, no you haven't. But I had done it. But he'd . . . make me think that way . . . so he could control me" (Participant, 29)

Positioning women as crazy

"Look at your face, who is crazy here?"

"I asked him to seek psychological, psychiatric treatment, [...] he said he did not need it; he implied that I was the one who needed it, who was crazy" (Participant, 16).

"Any dealing with him was incredibly difficult and he would be quite abusive towards me... basically calling me crazy, mental health issues, insane, unreasonable, drama" (Participant, 23).

"I remember that once, he went got a mirror when I was crying and screaming and said 'look at you, look at your face'. He was very calm. He said, 'look at your face, who is crazy here?' And I had to look. I thought I was going crazy. I could not move and I used to think: 'My god! I am crazy, he abuses me, this is crazy, my life is crazy and, there is nothing I can do about it' (Participant, 22)

I mean a lot of the time he said to me, "You're the angry person, you need help, you're mental." (Participant, 31)

"I'll tell them you're mental again"

"[Name's] partner told her he would tell everyone that she was "mental and no one would believe her if she told them about [the abusive nature of their relationship]." Her greatest fear was that her baby would be taken away from her, and so she did not feel able to tell any of the professionals about the abuse. (Second-order, 18)

He's like: "I'm going to take these kids off you. I'm going to tell them you're a fucking bad mum," da-da-da-da (Participant, 23)

"In some cases, the men had even threatened to make a referral to social services, on the basis that their partners had been unable to protect and care for the children" (Second-order, 13)

"Paranoid, overreacting, neurotic woman"

"These were all established GPs and consultants, standing up in court and saying they believe he couldn't have done any of these things, how great he is and what a wonderful father he is." (Participant, 7)

"I don't feel safe. I don't feel that I can say what I want to say. I never feel I can say what I want to say because I am still frightened of him....And he's always got some kind of story that he's made up that makes it sound very, all very beautiful, and I'm just this paranoid, overreacting, neurotic woman" (Participant, 11)

"The collective identity of the "madwoman" was commonly used by abusers to undermine women, both before and after they had sought formal help" (Second order, 21)

Narratives of blame

"I always felt it was my fault, I guess because he told me it was"

"At first, I downplayed the violence and took the blame and responsibility of the situation. I did that to survive" (Participant, 2)

"Bruises heal in time but words last forever when you are told over and over how stupid ugly and insane you are, you really believe it, I am not financially or physically capable of going anywhere" (Participant, 15)

"It got to a point where I did not want to tell him if he was doing something that hurt me, because that would be one more of my flaws . . . I did not want him to know how awful I really was, continually needing him, and I was so lucky that he still loved me after I was so awful" (Participant, 12)

"I lost my self-confidence, [developed] high levels of anxiety and depression, which he threatened to leave me over if it would be an ongoing issue (Participant, 20)

"The issue isn't the chemicals in my brain, the issue is my life sucks"

"All GPs will do is just put you on anti-depressants which don't work. The issue isn't the chemicals in my brain. The issue is my life sucks." (Participant, 20)

"Women's stories are often seen as "symptoms" of the illness. As a result, either women's reports of violence are discounted or women are subjected to coercive treatment. For instance, providers often termed schizophrenia as the "doubting illness." So, when women reported abuse or infidelity by their husband as cause of their distress, providers perceived it as paranoia and participants' distress was unaddressed" (Second-order, 2)

“The health staff at my medical centre knew I was being beaten by my husband. I have been attending frequently over the years and we have discussed my fears and distress. However, I have never been given any information about women’s aid or where to go for help and support- on one occasion my GP suggested relaxation classes” (Participant, 15)

“I don’t feel like they care about these things at all...I was crying but, its normal, no one asked me about it. About anything” (Participant, 26)

"It feels like a witch hunt"

“When we ask for help, there’s no one to help us. They seem to take your children away instead of helping you” (Participant, 17)

“They didn’t seem to listen to me, until I went to find the facts and then they listened to me, which is even worse. It’s like you have to prove yourself not to be a liar before anyone listens to you” (Participant, 11)

“This is how a court report feels—it’s like standing on a beach, [starts to sob] holding your children’s hands and having a tsunami just coming towards you—and you try to run yourself but you’re also trying to protect your children because the tsunami is like your ex-husband plus all the officials plus everything.... But you’re just trying to stand still so that somehow you hope that the truth comes out” (Participant, 23)

"I needed clarification that I wasn't going mad"

Finally I figured out that when he did this [psychological abuse] it was like inflicting more abuse on me, a different kind of abuse, but I found out in therapy that it was still abuse” (Participant, 4)

The GP was lovely, really, really nice and supportive ... She was a nice person, that was an empathetic person who wasn’t acting judgementally towards me, so I think that’s as good as it gets normally, isn’t it? (Participant, 7)

I was just a ball of fear. Fear and terror for a while, and so [the individual counselor] helped. I went every week. I still go every once in a while. You know, and she’s really helped me learn like what is a normal relationship, what is not (Participant, 14)

With the psychologist, I was able to see what was happening [...] (I3); [...] the support of all the staff here at the Center has been important because it helps me to see things that I not want to see, or hide (Participant, 19)

Abuses of power

"You need to tell me because I'm the only one who can help you" My husband (a GP) got his medical partner to prescribe Valium for me in the 1970s and I am still taking it. I know I am addicted to it" (Participant, 15)

"He [abuser] was very angry the first time I got hospitalized [for an eating disorder]. He did not want me to go (Participant, 27)

Families also limited or deterred women's access to mental health treatment, thereby worsening the illness symptoms (Second-order, 1)

"He'd take me, he'd take himself, take the kids" "When he was not trying to get me back, he was threatening me. He constantly called me, threatening to shoot himself, saying that he had no money because he had to pay me child support, that I had ripped him off, complaining about me having such a nice life" (Participant, 2)

'He would cry and say that he was going to kill himself if I left and it was my fault if he dies. He went into the garage one time with a rope and said he was going to do it and I would be worried and thinking poor him (Participant, 8)

"He gave me a wire and told me to strangle myself, he wanted me to suicide myself, he wanted me to die" (Participant, 17)

"I attempted to end the marriage; [he] had me drive while he held a gun saying he would kill himself." (Participant, 24)

"I knew what I needed to do. I couldn't do it yet, so I waited" It's like a mask, you wear it for so long that it sticks to your face and you can't take it off. Because it's what everybody knows. So you're never you. Even with people that you care about, you're never you. Because you can't be. Because if you take the mask off it means that you might slip up when you put it back on. . . . Because if the secret gets out you just know from this churning feeling inside you, something awful is going to happen. You just know. And it's going to hurt and you're going to be the fall guy" (Participant, 29)

Women employed several strategies to combat the abuse in their relationships. Some women tried to make things work and took a conciliatory approach to the abuser because he was a "king, in the bad mood." Others discussed getting out of the relationship and taking steps to become independent of the abuser (Second-order, 5)

Kyrgyz women are not merely passive victims—some do find the strength to escape and not return, usually with some type of external social support that empowers them to seek help (Second-order, 3)

"I knew what I needed to do. I couldn't do it yet, so I waited" (Participant, 14)

Gendered expectations

"Women are second class, they are lower than men" Men and women live in a different kind of system, men can do anything, they want...at home a man is the boss" (Participant, 22)

You think that's normal . . . in Mexico it is normal to have fights . . . that they (partners) can drink . . . is like there is still machismo in Mexico . . . like everything is part of marriage . . . I thought it (domestic violence) was part of marriage (Participant, 25)

He started to get angry at me for the house being messy . . . it'd be snide remarks, sort of, more like "What have you been doing all day?" "You've been home all day, what have you been doing, why isn't the house clean if you've been nothing all day?" (Participant, 20).

"Our society abandons a woman who speaks out about her circumstances, even when they are bad" 'It's the social status of the job. You can sometimes think that people will feel that you're not fit to look after patients when you can't, you know, you haven't been able to look after yourself or your family.' (Participant, 7)

"Yes, we are afraid of the society, we always give a chance that maybe things will change. Unfortunately, it is the opposite, it will carry on and on." (Participant, 26).

I was always afraid that people would see me differently, see me as a victim or think: "she can blame herself, what was she thinking? Should I feel sorry for her now?" (Participant, 2)

"I had this whole stigma in my head...that it was a sign of weakness" "Family, or society rather considers psychiatrists are only for crazy people. That's their negative views on psychological treatment" (Participant, 26).

I constantly feel like I'm still trying to move away from that whole [experience]—not that I let it happen, but I was one of those types of people; I'm in that category of something that they'll still never understand (Participant,21)

"I constantly feel like I'm still trying to move away from that whole [experience]—not that I let it happen but I was one of those types of people; I'm in that category of something that they'll still never understand" (Participant, 25)

Appendix B. Section A: Theme and subtheme matrix: theme development

Overview of the whole matrix:

Zoomed in matrix exemplars:

	Bhattacharya, A. A. (2022).	Bryngersdotter, H. S., & Haldorsdottir, S. (2022).	Childress, P., Panchanadekkar, S., & Joshi, M. (2021).	Copé, L. C. (2006).	Crandall, M., Senturia, K., Sullivan, M., & Shu Thornton, S. (2005).	Draw, J., Hallwell, G., Hay, S., & Jacob, S. (2022).	Donovan, E., Santer, M., Morgan, S., Daker White, G., & Wilson, M. (2021).	Doyle, J. L. (2020).	Enander, V. (2011).	Harris, B., & Woodcock, D. (2021).	Harrison, C. (2008).	Lammers, M., Ritchie, J., & Robertson, N. (2005).	Lapierre, S. (2010).	Larance, L., Y. Garrison, A., Devaney, S., & Seelye, J. L. (2018).	Larabatt, A., & Glida, A. (2013).	Labronci, L. (2012).	McCarthy, M., Hunt, S., & Milne-Skillman, K. (2017).	McGary, L., & Hinsiff-Smit, h, K. (2021).	Montminy, L. (2005).	Moulding, N., Franzway, S., Wendt, S., Zuffeney, C., & Chung, D. (2021).	O'Doherty, L. J., Tafel, A., McNair, R., & Hegarty, K. (2016).	Ploewy, J. E. (1993).	Rathus, Z., Jeffries, S., Menh, H., & Field, R. (2019).	Redding, E. M., Moracco, K. E., Barrington, C. L., & Corbo, A. M. (2022).	Reina, A. S., Lohman, B. J., & Maldonado, M. M. (2014).	Shah Afak Bacc Colo M., F G., & M. J.
Creating an environment of confusion		I was in free fall actually, I didn't know how to behave or know who I was. I had been living in some kind of drama theater, where everybody was supposed to play their role. And then one night it was over. The play had ended." (Survivor). "The was all so confusing"	"I didn't understand many things, I was somehow blind, like a hedgehog in the fog... I didn't like myself, I didn't respect myself... I thought I was supposed to be a victim and then I had to submit and sacrifice myself" (Survivor). "The omnipresent"	"The male partner is always right whether he is right or not" about the information. "You sit and know nothing. Looks like you have no way out. No information. Because of that you go crazy" (Survivor). "I was totally levelled with the ground, and I could not tell you"	"[What we need is] information, information. You sit and know nothing. Looks like you have no way out. No information. Because of that you go crazy" (Survivor). "I was totally levelled with the ground, and I could not tell you"	"It kept me in a constant state of anxious confusion" "Gaslighting left me completely confused. I felt like (and he told me) I was crazy as my reality was being persistently challenged and things I had seen and heard were"		"Every time he was that nice I could talk to him, he understood , he really got it. But when he was aggressive, you couldn't say a word. Even if you just said 'Hello', you could practically be thrown out of the house. So it was very strange for me since I"	"[Technology] exposed to him anywhere and at any time. "The notion of feeling safe from an abuser no longer has the same geographic and spatial boundaries it once did" (second order).	Three of the seven participants also reported having experienced confusion within the context of their abusive relationship and confidence appeared to be reported only by those women whose partners in the displayed caring as well as abusive	Maria, who was overtly dominated, was told that she was always 'wrong' no matter how she altered her behaviour, which lowered her confidence about her ability to succeed on her own. The other participant in the overtly dominated group who could 'never		"He felt I should support everything he thought, everything he did" (First order).	"All felt that non-physical emotional abuse was 'totally invisible' even though it was the prominent form of abuse in older age" (second order).			"I didn't even realise just how bad things were actually getting because it was so gradual" (first order).		"I knew it did not feel right, but I didn't know how abuse was supposed to feel. I knew something was different" (first order).	"he doesn't even allow you to even think for yourself" (Survivor). When he got angry, he didn't usually do something straight away. But you knew his jaw would go light. You could just see this kind of pulse thing. Sometimes		Some participants cited greater difficulties in identifying abuse because of the absence of physical abuse in their relationship s (it seems that they did not regard the abuse as such (second order). "I waited 5 years to seek help... you know				
"Dr Jekyll & Mr Hyde"		"He promised not to beat or abuse me, promised to be nice... to get me the "moon from the sky," pretending, "I will buy you new			When survivors considered the beginning of their relationship s, they frequently used words such as charming, charismatic, romantic.		"I mean, it's not like you meet a violent man and say "Yes, now everything's beautiful". You meet a wonderful man who turns out to be the	"[It was] little things that I kind of misook as, oh, he's very caring, [but it] was obviously the beginning of the grooming and the controlline			Confusion appeared to be reported only by those women whose partners displayed caring as well as abusive behaviours. For			"I always had a picture that this Prince Charming was going to come and take me away and give me a wonderful life because I had such a miserable			He's very withdrawn, he doesn't speak. Yet with strangers, he never shuts up." (first order).			"He swept me off my feet, by the way, in terms of spoiling me, my goodness. Anyway, he was writing this book with a friend of his and he said						

	Bhattacharya, A. A. (2022).	Bryngersdottir, H. S., & Halldorsdottir, S. (2022).	Childress, S., Panchanadeswaran, S., & Joshi, M. (2021).	Copel, L. C. (2006).	Crandall, M., Senturia, K., Sullivan, M., & Shiu, Thornton, S. (2005).	Daw, J., Halliwell, G., Hay, S., & Jacob, S. (2022).	Donovan, M., Morgan, S., Daker White, G., & Wilcox, M. (2021).	Doyle, J. L. (2020).	Enander, V. (2011).	Harris, B., & Woodlock, D. (2021).	Harrison, C. (2008).	Lammers, M., Ritchie, J., & Robertson, N. (2005).	Lapierre, S. (2010).	Larance, L., Garrison, Y., & Seelye, J. L. (2018).	Lazebnik, A., Deane, J., & Gildea, A. (2013).	Labronic, L. (2012).	McCarthy, M., Hunt, S., & Milne-Skillman, K. (2017).	McGarry, J., & Hinselwood, K. (2021).	Montminy, L. (2005).	Moulden, N., Franzway, S., Wendt, S., Zufferey, C., & Chung, D. (2021).	O'Doherty, L. J., Taft, A., McKelvey, R., & Hegarty, K. (2016).	Pilowsky, J. E. (1993).	Rathus, Z., Jeffries, S., Menikoff, H., & Field, R. (2019).	Redding, E. M., Moracco, K. J., & Maldonado, M. M. (2014).	Reina, A. S., Lohman, B. J., & Corbo, A. M. (2022).	Shah, A., Alka, B., & G. M. (2022).
Narratives of blame "I always felt it was my fault, I guess because he told me it was"	While women cited several external contributors such as dowry and husband's alcoholism, they also blamed themselves for the experienced violence. Some of them believed that it was their illness, hiding the illness from the marital family, and	"At first, I downplayed the violence and took the blame and responsibility of the situation. I did that to survive" (first order). They blamed themselves for being in a violent relationship and felt that they should have known better (second order). "I always	"It was weird, but we didn't talk about the fight, the problems, and the violence. I tried to ignore him. He ignored me until he wanted something and then he would pretend it didn't happen. If I tried to talk to him about it, I felt like I would make it worse."	"I was thinking to commit suicide, all kinds of thoughts. I was totally crazy" (first order). Survivors noted that whatever they did it was never good enough; any question was twisted to be interfering and everything was their fault.	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"You feel sorry, not for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"You feel sorry, not for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? 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How will he do the laundry, how will he cook, how will he...?" (first order).	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).	"I think it's really hard for yourself, you feel sorry for him the whole time. How'll he manage if I leave him? How will he do the laundry, how will he cook, how will he...?" (first order).

Extract of the 'Creating an environment of confusion' theme, to provide examples of in-vivo codes per paper included in the review:

	Bhattacharya, A. A. (2022).	Bryngersdottir, H. S., & Halldorsdottir, S. (2022).	Childress, S., Panchanadeswaran, S., & Joshi, M. (2021).	Copel, L. C. (2006).	Crandall, M., Senturia, K., Sullivan, M., & Shiu, Thornton, S. (2005).	Daw, J., Halliwell, G., Hay, S., & Jacob, S. (2022).
Creating an environment of confusion "Only he had the key to reality"		I was in free fall actually; I didn't know how to behave or know who I was. I had been living in some kind of drama theater, where everybody was supposed to play their role. And then one night it was over. The play had ended". "It was all so confusing"	"I didn't understand many things, I was somehow blind, like a hedgehog in the fog . . . I didn't like myself, I didn't respect myself . . . I thought I was supposed to be a victim and had to sacrifice myself" (Survivor). "The omnipresen	"The male partner is always right whether he is right or not" about the situation. The women's perspective or opinion did not matter. "I didn't know that I was to accept what he said in reality. Only he had the key to reality" (Survivor). "Could not	"[What we need is] information, information. We do not have any information. You sit and know nothing. Looks like you have no way out. No information. Because of that you go crazy" (Survivor). I was totally leveled with the ground, I could not believe in my	"It kept me in a constant state of anxious confusion" "Gaslighting left me unable to make decisions and left me completely confused. I felt like (and he told me) I was crazy as my reality was being persistently challenged and things I had seen and heard

Appendix C. Participant Information Sheet



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Information about the research

Exploring Domestic Violence Survivors' Narratives of Navigating Secondary Care Mental Health Services

Hello, my name is Megan Webb. I am a Trainee Clinical Psychologist at Canterbury Christ Church University, and I am studying for a doctorate in clinical psychology.

I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

Please do talk and discuss with others about the research if you wish. Please take time to read the following information and decide whether or not you want to take part.

Please do contact me if you would like more information or if anything is unclear by emailing Megan Webb on [REDACTED]

This project is being supervised by Anne Cooke, clinical director of Salomons Institute of Applied Psychology [REDACTED] and Dr Angela Sweeney, Senior Lecturer in User Led Research at Kings College London.

Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study.

Part 1

My research will look at women's experiences of accessing and navigating secondary care mental health services during or following domestic violence. Secondary care mental health services include general community and hospital mental healthcare in the UK. Examples of secondary care mental health services include adult mental health teams, community mental health teams, crisis teams, early intervention teams, assertive outreach teams and inpatient wards.

What is the purpose of the study?

It is very common for survivors of domestic violence to access mental health services at some point. People's experiences of them are very varied, but there is not much actual research about this. I am particularly interested to hear from individuals who have experienced coercive control. This interest has been shaped by my experiences of working within domestic violence and abuse services and now training to be a clinical psychologist.

My hope is to highlight what is helpful and unhelpful about current mental healthcare provision, and how things might need to change to better serve the needs of domestic violence survivors who have experienced coercive control. I hope the end result of this study will be improvements to services.

Why have I been invited?

You have been invited to take part in this study because you are currently accessing a domestic violence and abuse specialist service and you may have also accessed secondary care mental health services.

Do I have to take part?

No. Your involvement is entirely voluntary and therefore it is up to you to decide whether to join the study. If you would like more information before you make your decision, then please do get in touch. If you think you would be willing to take part, please do speak to your DVA worker or contact myself directly. If you agree to take part, I will go through the information with you and then ask you to sign a consent form to show that you have agreed to take part in the study. You are free to withdraw from the study at any time, without giving a reason, up to 48 hours after interview completion. In this case your interview recording will be deleted and not used for research purposes. I am not employed by any of the services concerned and, therefore participating/declining or withdrawing participation will not affect your care in any way.

What does the study involve?

I hope to interview 8 to 11 people about their experiences. To take part you must:

- Identify as a woman.
- Be aged 18 years and above.
- Have experienced domestic violence (including physical, financial, emotional/psychological, and sexual abuse) and coercive control.
- Have accessed secondary care mental health services (e.g., adult mental health teams, community mental health teams, assessment and treatment services, crisis teams, early intervention teams, assertive outreach teams, inpatient services) in the United Kingdom.

Unfortunately, once 8-11 people have been recruited, I will be unable to interview more people. However, I am happy to share the final paper with anyone who would like a copy.

What will happen to me if I take part?

You will be given the opportunity to ask any questions you might have and discuss with me anything you are unsure about. I will then arrange to meet you at a time that is convenient to you. We will need to meet somewhere safe that we can talk with privacy, this will preferably be within your DVA service, however you can choose the place if this is not possible. This may be for instance, online via a teleconferencing platform or at a university building. I will ask you to talk about your story of accessing and navigating mental health services. I am keen to hear your experiences so there will be no right or wrong answers. It is difficult to say exactly how long this will take, but it is likely to take between 60-90 minutes, depending on how much you would like to say.

I would like to record our discussion via audio tape. Your information will be completely anonymised. I would like your permission to quote the words you have used in the reports of my research and if you are concerned about being recognised you may prefer not to allow me to do this. I will read and re-read the typed-up interviews and then summarise how I understand your experiences and the links I see between different people's experiences. I will then invite you (if you would like to) to have a look at what I have written and give feedback about how well you think my understanding of your experience fits with your understanding. I can then change my interpretations based on your feedback and then type up what I hope will be our shared understanding into a research paper. I will also produce a summary of the results which I can then share with you.

What are possible disadvantages and risks in taking part?

In the interview, although you will not be asked specific details about the abuse or trauma you have experienced, you will be asked to reflect on these experiences in relation to your experiences of mental healthcare. It's possible that this could be upsetting. You do not have to talk about anything that you don't feel comfortable sharing, or that makes you feel upset. If you become distressed during the interview, please do let me know. You can take a break or stop the interview at any time.

Prior to the interview, I will ask you who, if anyone, you would like to be contacted if you became distressed and we can put a plan in place. If I feel that the interview is distressing for you, I will ask you whether you would like to stop or take a break. We can talk at the end of the interview, and I will ask you about your experience of the interview, how you are feeling, how safe or at risk you feel, and the level of support that is available if you feel you need it. If needed I can stay with you while we sort out support. If it would help to talk to me again later, we can arrange that. I will also give you details of sources of support you can access if you do feel this would be helpful following our meeting.

What are possible benefits of taking part?

I can't promise that the study will help you, but I hope that the findings of this study could improve understanding of what domestic violence survivors need from mental health services. I also hope that this could lead to improved services and support in the future. Some people also find that talking about their experience and sharing their experiences can be useful.

Will my participation be kept confidential?

Yes. Ethical and legal practice will be followed at all times and all information about you will be handled in confidence. There are some rare situations in which information will have to be shared with others for example if I believe that you or another person is at risk of serious harm. You can find more information about this in Part 2 of this information sheet.

What happens after our meeting?

I will contact you after our meeting to thank you for your participation in the study. You may also wish to have a copy of the transcript of your interview to check its accuracy (you may change your mind about this at any time) or wish to take part in checking findings from the research and offering comments on the work. I will discuss this with you before the interview starts.

What if there is a problem?

Any complaint about the way the study has been run will be addressed. The details are included in Part 2 of this information sheet.

Thank you for taking the time to read this information sheet.

This completes Part 1 of the information sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2 of the Information Sheet

What will happen if I don't want to carry on with the study?

This research is not associated with the provision of any services, and therefore withdrawing participation will not affect any care that you may currently be receiving in any way. Participation is voluntary and you are therefore free to stop the interview at any point or choose to withdraw your information after the interview, without having to give a reason why. This will be possible up to 48 hours after interview completion. Your interview recording will be deleted and not used for research purposes.

Will information from or about me from taking part in the study be kept confidential?

All information which is collected from or about you during the course of the research will be kept strictly confidential. The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something you have told me, I were to become concerned about your safety or the safety of someone else. Your real name or personal details will not be used in the research write-up, and I will ask if there is a particular name (pseudonym) that you would like me to use for you in the write-up. This pseudonym will never be stored with your real name or personal details. All interviews will be audio-recorded, and I will personally type up and analyse the interview data. To assure the quality of my work, my research advisors will look at parts of the anonymised typed-up interviews and will supervise my work. Interview recordings and transcripts will not include your real name. All information will be kept securely and confidentially on password-encrypted memory sticks or computers. Information that could identify you, like your name will be locked separately from interview data. I will be responsible for keeping this data secure until the study is

finished. When the study is finished, records of all your personal details will be destroyed. In line with the University regulations, the anonymous transcripts will be put on a password protected and encrypted file and stored within the University for 10 years in a locked filing cabinet in a building with 24-hour security. After the 10 years, they will be destroyed. All data use is strictly within the Data Protection Act (2018). If you are willing to participate, I will need you to give written consent to these arrangements.

What will happen to the results of the research?

I will write a report to be submitted to the exam board of my training course. I hope to publish the results of this study in a scientific journal and in the media for domestic violence survivors, mental health service users and health care professionals. Please be assured that only anonymised quotes will be used, disguised if necessary, and that individual participants will not be identifiable in the write-up. I will send you a transcript of your interview and the final write-up to ensure that you are happy with quotes included. I will be more than happy to send a short summary report of the findings to you at the end of the project if you would like to have them.

How is the research funded?

The research is partially funded through my training programme at Canterbury Christchurch University. Your travel expenses can be reimbursed up to a maximum of £10 and if you would like to you will receive a £10 gift voucher for your participation in the study.

Who has reviewed the study?

All research [redacted] is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The Salomons Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University.

What is there is a problem?

If you have a concern about any aspect of this study, please do get in contact with me and I will do my best to address your concerns. You can contact me by emailing me at [redacted]. Alternatively, you can leave a message on the 24-hour voicemail phone number [redacted]. Please leave a contact number and say that the message is for me [Megan Webb], please specify whether it is safe to leave a voicemail and I will get back to you as soon as possible. You may also wish to speak to the lead supervisor of the project, Anne Cooke [redacted]. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology – [redacted].

What next?

You may wish to have a think about this project and have a discussion with family, friends, your DVA worker, or other significant people in your life before confirming your participation.

If you would like to speak to me and find out more about the study, or have questions, you can contact me by email on [redacted].

You can also speak to a member of staff at your DVA service and give consent for them to pass your details on to me so that I can get in contact with you. Please confirm the contact details that are safe to contact you on and confirm that it is safe to leave a voicemail. I will then contact you by email, telephone or text (whichever you prefer), to answer any further questions you might have and arrange meeting for an interview.

Alternatively, you can also leave a message for me on a 24-hour voicemail phone line [redacted]. Please say that the message is for me [Megan Webb] and leave a contact number so that I can get back to you, please specify if it is safe to leave a voicemail.

Further information and contact details:

Please feel free to contact me should you have any more questions about this study:

Megan Webb
Salomons Centre for Applied Psychology

Appendix D. Participant Consent Form



Salomons Institute for Applied Psychology
1 Meadow Road, Tunbridge Wells,
Kent TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Exploring Domestic Violence Survivors' Narratives of Navigating Secondary Care Mental Health Services

Consent Form

	After having read the participant information sheet, please read the following:	Please initial in the box
1	I have read and understood the participant information sheet for the above study, and I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, and without it affecting my rights or access to care in any way.	
3	I understand that the content of the interview is confidential as long as the researcher is not concerned about my safety or the safety of others.	
4	<p>I confirm that I meet the criteria (below) to participate and agree to take part in the above research study:</p> <ul style="list-style-type: none"> • I identify as a woman aged 18 years and above • I have experienced domestic violence (including physical, emotional/psychological, financial, and sexual abuse) and coercive control. • I have accessed secondary care mental health services (e.g., adult mental health teams, community mental health teams, crisis teams, early intervention teams, assertive outreach teams and inpatient wards) in the United Kingdom. 	
5	I understand that if I wish for my data to be withdrawn, I will need to contact Megan or her supervisor, Anne Cooke. I understand that this will be possible up to 48 hours after interview completion.	
6	I understand that the interview will be audio recorded for the purpose of the research. This recording will be managed in accordance with the General Data Protection Regulations 2016 and the Data Protection Act 2018. I hereby give permission for the interview to be recorded.	
7	I understand that the interview will be transcribed and that any information that might identify me will be removed from the transcript.	

8	I understand that Megan's research supervisors may see a sample of my anonymised transcript.	
9	I understand that anonymised verbatim quotes from my interview may be included in publications.	
10	I understand that a research analyst panel may be used to reflect on a summary of key findings and themes identified.	
11	I wish to have a copy of the transcript of my interview to check its accuracy (you may change your mind about this at any time).	Yes/No
12	I wish to take part in checking findings from the research and offering my comments on the work (you may change your mind about this at any time).	Yes/No
13	I wish to receive a summary of the results at the completion of the study (you may change your mind about this at any time).	Yes/No
14	I wish to be informed by email (or alternative safe contact method) if the research is published (you may change your mind about this at any time).	Yes/No

Name of participant: _____

Signature: _____ Date: _____

Name of person taking consent: _____

Signature: _____ Date: _____

Appendix E. Interview Schedule.

Interview Schedule

Introduction: "The main focus of the interview is to hear your experiences of navigating mental health services during or following experiencing domestic violence. That's what we will be spending most of our time talking about together today.

The aim of the research is to find out what is helpful and unhelpful about current mental health services, and how things might need to change to better meet the needs of domestic violence survivors.

I am really keen to hear your views, about your experiences of mental health services, and how you made sense of this. There are no right or wrong answers. I won't be asking about your experiences of abuse directly, and throughout the interview you do not have to share anything about your experience that you do not wish to. However, there might be some questions that you might find difficult, and if this is the case you can stop the interview or take the break at any time, and we can stop straight away.

Do you have any questions before we begin?

Main Section: Starting at the beginning, what led to you accessing mental health services for the first time? [and how do you feel that your experiences of domestic violence may have impacted your experiences of care if at all?].

Prompts

1. What was your experience of navigating mental health services? What was most helpful about your experiences of mental health services? What was the most unhelpful about your experiences of mental health services?
2. Can you tell me how you experienced relationships and interactions with staff?
3. Did you receive a mental health diagnosis? Did this affect or change how you understood yourself and your experiences'?
4. Did you receive support from any other agencies at the time? What was this similar to your experiences of mental health services? What was different to your experiences of mental health services?
5. I understand that many people who experience coercive control often have their mental health used as part of the abuse, for example being called crazy or feeling like they're going crazy, and I wonder how this fits with your experience of mental health services, if at all?
6. Is there anything we haven't spoken about today in relation to mental health services that you think would be important to share?

Closing questions

7. What are the most important messages I should take away with me?
8. What advice or recommendations would you give to mental health services on working with people who have experienced domestic violence?

Appendix F.

Participant demographics Form

I would like to ask you some questions about yourself, collection of this information will help to me to understand who has taken part in this research project. Please only share information that you feel comfortable with, you do not need to answer any questions you do not wish to. The answers to these questions will be presented as ranges across participants to protect your anonymity. If you have any questions please do not hesitate to ask me [REDACTED]

- How do you define your gender?

- How do you define your age?

- How do you define your ethnicity?

- How do you define your religious faith (if any)?

- How do you define your sexuality?

- How do you define your socio-economic status?

- What would you describe as the main reason for accessing mental health services?

- How long (approximately) was your contact with mental health services (what has been your journey?)

**Appendix G.
Standard Operating Procedure.**

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Appendix H.
Ethical Approval Letter

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Appendix I.
Study recruitment poster

Have You Used Adult Mental Health Services?

If so, I would like to hear about your experience.

Experiences of mental health services are varied, but there has been very little research into the experiences of domestic violence survivors.

I will be interviewing domestic violence survivors about their experiences of mental health services.

My aim is to find out what is helpful and unhelpful about current mental health services, and how things might need to change to better meet the needs of domestic violence survivors.

I hope the end result of this study will be improvements to services.

**TO FIND OUT MORE, OR TO TAKE PART,
PLEASE DO EMAIL ME, MEGAN WEBB,**

Or speak to a member of the team for more information.



This research has gained ethical approval from the Salomons Institute of Applied Psychology, Canterbury Christ Church University. Exploring domestic violence survivors' narratives of navigating secondary care mental health services. 18/11/2021 Version 1.

Appendix J. Participant Summary Report



Exploring Domestic Violence Survivors' Narratives of Navigating Secondary Care Mental Health Services

STUDY SUMMARY REPORT

Dear participant,

Thank you so much for taking part in the study in the above research project. I am incredibly grateful to you for sharing your experiences with me. The research is now complete, and I have therefore included a summary of the research below, to let you know what was found and the next steps for the project.

Background and aims

Survivors of domestic abuse regularly access mental health services. However, existing evidence suggested that these experiences are often unhelpful and in some cases re-traumatising. The current project therefore looked to explore survivors' experiences of secondary-care mental health services as there was limited research in this area. The study aimed to understand what survivors found helpful and unhelpful about current mental healthcare provision, and how things might need to change to better serve the needs of survivors.

The study

Seven women who had experienced domestic abuse and accessed secondary-care mental health services took part in the study. The research was conducted between June 2022-2023. Participation involved attending a one-to-one interview and participants were asked to describe their experiences of navigating secondary-care mental health services either during or following experiencing domestic violence.

The interviews were transcribed and analysed using narrative methodology and thematic analysis. The final findings represented points of connection and difference across narratives, their capacity to speak to aspects of experience that had not been captured in the literature before, and what participants described as most important in their journeys through services. The final findings were shaped by participant feedback on emergent themes.

Findings

The findings were organised into three main themes 'Missing the connection(s)', 'Missing windows of opportunity', and 'Finding a safe haven'. A figure outlining the themes and subthemes are presented below:



Theme 1: Missing the connection(s)

This theme intended to capture the experience of disconnection that was reported within participants experiences of navigating secondary-care mental health services. Women described the experience of being '**diagnosed and discharged**' and having to fight to re-access mental health support, often in the context of long waiting times and gatekeeping by services. This resulted in fragmentation to their journeys within and across multiple services.

Short appointments and time-limited support reduced the opportunity to build trusting meaningful relationships with mental health professionals, which resulted in a **lack of connection**. Interactions with staff often felt superficial and like a 'tick-box' exercise in which there was a lack of exploration or curiosity about the reasons or context for accessing mental health services.

Mental health professionals often **missed the connection** between the experience of abuse and people's reason for accessing mental health services. Mental health professionals often focused on the 'presenting problem' in terms of diagnosis, which meant that the cause of distress was left unaddressed. Women were often strategic in navigating mental health services in the context of significant abuse, fear, and risk. Rather than being expected to bring it up themselves, participants reported wanting professionals to ask them about the abuse explicitly or ask if 'they were okay'. They could then make an informed decision about whether it was the right time/place to disclose.

A common reason for accessing mental health services was **searching for an explanation** for the experience of distress. Many women reported missing the connection between abuse and their distress when accessing mental health services. For many, this was due to the ambiguity, isolation, and confusion created

by coercive control tactics and accusations of 'madness' from the perpetrator. Many women, therefore, initially welcomed a mental health diagnosis from professionals as it explained how they felt and countered the perpetrator's narrative that they were going mad. Other participants described having to 'fit into a box' and being seen by professionals as their diagnostic labels. Mental health services typically rejected any complexity, instead categorising women's difficulties into boxes rather than considering how their difficulties might intersect (e.g., lack of understanding from professionals that substance use was often a coping strategy to 'numb the pain' and frequently intersected with the experience of domestic abuse and mental health).

Theme 2: Missing windows of opportunity

Missing the connection(s) had several consequences: Participants reported that professionals often ignored the abuse, held unhelpful assumptions about domestic abuse that impacted their care, and offered interventions that were inconsistent with their needs. Windows of opportunity for meaningful support whilst interacting with mental health services were, therefore, consistently missed. There was reflection in women's accounts of 'what could have been' if appropriate support had been provided when it was needed. For participants, this resulted in a loss of faith, trust and disengagement with the mental health system.

Professionals often **ignored or discounted** overt disclosures of abuse or actively avoided acknowledgment of historical documentation of abuse on women's care records. Some experienced this as a lack of care in which staff could not be bothered or did not wish to learn more about their circumstances. Women repeatedly spoke of the experience of reaching out for help and being met with silence from services, which was experienced by some as abandoning.

Professionals' lack of understanding about domestic abuse and focus on the 'presenting diagnostic problem', meant that participants felt the 'problem' became "all about them" rather than the perpetrators' abuse. This perpetuated the **invisibility of abuse** and projected blame onto women. The invisibility of abuse meant that professionals often colluded with the abuse, in some instances, increasing risk towards women, as distress was often only seen through a diagnostic lens rather than exploring the context.

Lack of understanding often meant professionals made **unhelpful assumptions** about domestic abuse that were experienced as blaming and judging. Professionals showed a lack of knowledge of the complexities and risks involved in leaving an abusive relationship and accessing mental health support whilst experiencing abuse. Women reported not being taken seriously due to professionals' assumptions about domestic abuse, substance use, and mental health which has a significant impact on their experiences of care.

There was a lack of availability of appropriate support and therefore, **inappropriate support** was often offered as a 'tick-box' to women despite not meeting their needs. Psychiatric medication was routinely offered as the initial intervention, with long waiting lists for therapeutic support. Women described a 'mismatch' between the

severity of their distress and the support offered by services and how developing trust with professionals was vital to trusting that support may be helpful.

Theme 3: Finding a safe haven

This theme intended to capture the experience of accessing support in which women were listened to, understood, and supported. For some people, this was within NHS mental health services. For others, this was within specialist domestic violence services and private practice.

Participants described the importance of '**connection and security**' in their safe haven. The opportunity to build consistent relationships was highly valued and crucial to a sense of safety. For all women, being seen and treated with compassion, respect, and humanity increased their sense of connection. For many women, one professional relationship had been pivotal in shaping their journey. Awareness that appropriate, meaningful support 'was out there' was crucial to a sense of hope. Women described the importance of professionals investing and being alongside them rather than telling them what to do. Professionals that advocated on women's behalf, particularly in interactions with mental health services, were perceived as helpful, especially in times of isolation. Peer support was also recognised as alleviating the sense of 'just being me' and providing connectedness with others who understood.

Professionals that understood the dynamics of abuse and provided resources and information allowed women to put their distress in context, name the abuse, and alleviate feelings of self-blame and isolation. Women expressed relief at professionals '**just getting it**' and not having to explain themselves repeatedly. Domestic abuse staff's intuition, understanding, and expertise allowed women to feel safe in non-blaming, non-judgemental environments. Having a professional that went at their own pace and allowed women to make sense of their experiences was powerful in supporting women to recognise the abuse was not their fault and in holding hope for the future.

What happens next?

This report represents a brief overview of the research undertaken. The full research paper has been submitted in partial fulfilment of the requirements for a doctoral degree. Once assessed and approved, the research team will refine the paper before submitting it for publication. It is hoped that the full research paper will be available in its published form in late 2023 / early 2024. I will be very happy to notify you when the research is published if you would like this.

Based on the study findings, I hope to develop a short guidance document for distribution to both domestic violence and mental health services, detailing the findings of the study and recommendations suggested by you in terms of what needs to change to improve mental health services for survivors.

I would once again like to thank you for your time and commitment to the project. It has been a privilege to work with you and hear your experiences. I hope that the

study findings will help to inform and makes change to current mental health provision and wish you all the very best for the future.

Best wishes,

[Name]

Trainee Clinical Psychologist

Salomons Institute of Applied Psychology

Appendix K
Part B: Sample of themes, subthemes, and exemplar quotes.

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Appendix L.
Annotated transcript extracts.

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Appendix M.
Extract of VCRM readings.

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Appendix N.
VCRM Participant Summary

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Appendix O.
Extract of VCRM reader-response

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Appendix P.
Examples of I poems

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Appendix Q.
Examples of Nvivo codes

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Appendix R.
Reflective diary extract

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Appendix S.
Author guidelines for chosen journal.

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