Domestic Abuse links to Suicide

Rapid Review, Fieldwork, and Quantitative Analysis Report

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west midlands police and crime commissioner

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Executive summary

Introduction

The UK police received, on average, over 100 domestic abuse-related calls an hour in 2014/15, which represents 10% of all recorded crime (HMIC, 2015). To date, very little systematic data have been gathered on the relationship between domestic abuse and victim suicide in the UK. In one of the first projects of its kind, the police and government in England and Wales established the Domestic Homicides Project to collect, review, and share quick-time learning from all police-recorded domestic homicides and suspected suicides of individuals with a history of domestic abuse victimisation nationally. During Covid-19 and attendant restrictions, the Project commissioned the Vulnerability Knowledge and Practice Programme, which published the report "Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021" (hereafter, the VKPP Report). Unexplained or suspicious deaths, and suspected suicides of individuals with a known history of domestic abuse, were included in the VKPP Report definition to allow for capturing as wide a range of deaths following domestic abuse as possible.

The VKPP Report revealed that there were 163 deaths in the 12 months from 1 April 2020 to 31 March 2021 reported by the police in England and Wales within 7 days of death. This is slightly higher than the previous year (152); but, this figure is in line with the 15-year average with regard to Home Office police-recorded homicide data. There were a total of 38 suspected suicides of domestic abuse victims in the 12 months 1 April 2020 to 31 March 2021. Across all of the individuals who died, the largest proportion of deaths were from intimate partner homicide (49%), followed by adult family homicide (18%), suspected victim suicide (18%), child death (12%), and a small proportion of the cases were from other causes (3%).

In cases where a victim of domestic abuse was suspected of taking their own life, the victim and suspect characteristics were like those in intimate partner homicide cases. However, female suspected suicide victims were even more likely than female IPH victims to be previously known as victims of high-risk domestic abuse involving coercive control. The previous domestic abuse in these suspected suicide cases was highly gendered. Nearly all suspects were male (91%, where known) and nearly all victims were female (90%). Suspected suicide victims were slightly younger than victims in other types, with mostly all of the victims being under 45 years old.

The most common cause of death in suspected victim suicides was hanging, with 46% of victims dying this way, followed by 28% dying from poison or drugs. This appears consistent with wider data relating to suicide, hanging, strangulation, and suffocation as the most common method of suicide in England and Wales for both men and women.

There were fewer BAME victims – possibly indicating under-identification of suspected victim suicides amongst minoritised ethnic groups. Previous non-fatal strangulation by the suspect of this or a previous victim was more present amongst this type of case As with intimate partner homicide, (attempted or actual) separation was also present in a sizeable number of cases.

Overall, 62% of suspects were aged between 16 and 44 years old; none were under the age of 16. Over half of suspects (52%) were aged between 25 and 44 years old, a pattern reflected both in intimate partner homicides (44%) and suspected victim suicides (51%).

Drawing on the VKPP report and other literature as a starting point, the present project aimed to further understand the relationships between:

a) domestic abuse and individuals dying by suicide;

b) sociodemographic characteristics and domestic abuse-related suicide;

c) different forms of domestic abuse and victims dying by suicide; and

d) Forced Marriage/Honour Based Violence (FM/HBV) and domestic abuse-related suicide.

Three strands of research were conducted to achieve the aims, including:

1) Rapid evidence review. The review examined the long- and short-term causes, drivers and aggravating factors of domestic abuse (e.g., physical, emotional, psychological, financial) related suicide, to deliver a strong evidence base for identifying risk factors.

2) Fieldwork. A qualitative study with domestic abuse victims was conducted to better understand the relationship between domestic abuse and risk factors for suicide.

3) Quantitative evaluation. A quantitative study of domestic abuse incidents and suicide to better understand how the incidence of suicide differs amongst the victims and perpetrators of domestic violence, and how this is correlated with its form.

Rapid Evidence Review

The literature search strategy was developed using the PICO framework designed to improve definition of the research question and to prompt for publication type and content. The framework is commonly used as guidance for conducting evidence reviews. Coercion and control is linked with suicide. It involves emotional and psychological manipulation and abuse and is experienced by between 88-91% of survivors (SafeLives, 2019; Aitken & Munro). Research suggests the life-threatening experience of nonfatal strangulation as a strong contributor to survivor suicidality. It may be that nonfatal strangulation is an effective facilitator of coercion and control. An abuse which appears to be highly correlated with survivor suicide is sexual assault/rape. Further, financial abuse, another form of coercion and control, was experienced by a third of survivors and to have contributed to their suicidality.

The review indicated that victim depression is linked to severity of the abuse and suicide. PTSD has also been reported in the literature as an independent predictor of attempted suicide by survivors. Attempted suicide is co-morbid with depression for 20% of the domestic abuse survivors. PTSD and depression are positively correlated with repetition of abuse, multiple concurrent forms of abuse, and the victim enduring multiple forms of abuse, including physical abuse, sexual abuse, and rape.

The four key contributors to suicidality are: physical and emotional/psychological pain (e.g., PTSD), hopelessness (including powerlessness/helplessness), lack of connectedness (disrupted relationships and isolation), and suicide capability (i.e., the means to take one's own life) Added to this has been 'burdensomeness', which is associated with self-hatred. There is a link between individuals having less self-compassion, feeling less belongingness, and experiencing a higher level of burdensomeness; these factors have been associated with increased depressive symptoms.

Drug and alcohol misuse are associated with suicidality. Self-harm is also a predictor of suicide and shares common risk factors with suicidality.

Fieldwork

The principal fieldwork data were collected from 34 survivors of domestic abuse and the secondary fieldwork data were collected from two families who had lost a family member to suicide where that family member had experienced domestic abuse.

All the survivors in our research who attempted suicide were subjected to sexual assault/rape. They also experienced an average of 17 different forms of abuse. The link between these abuses and suicidality is explained in the literature by the fact that they cause depression and PTSD, and are commonly experienced co-morbidly. Unfortunately, we were not in a position to administer diagnostic questionnaires to establish whether the survivors in our research had depression and/or PTSD. However, it is likely that they did have one or both because many of their descriptions include the risk factors for depression and PTSD. These were sexual assault/rape, life threatening abuse, repetition of abuse, multiple concurrent abuses, inclusion in the multiple abuses of physical and abuse and sexual assault/rape.

We were able to establish feelings states consciously experienced by survivors. According to the rapid evidence review, survivors are more likely to choose suicide if they experience hopelessness and despair. The survivors in our field research similarly described feeling hopeless, feeling trapped by the perpetrator, and feeling that life was unbearable, with no chance of changing what was happening to them/their family – which we interpret as despair. Notably, in the field research, the three survivors who did not have suicidal thoughts or attempt suicide did not feel that their life was unbearable.

The literature suggests that survivors are more likely to choose suicide if they experience feelings of panic, terror, and trauma, with the latter most often reported to stem from childhood experiences. All the survivors in our field research described feeling extreme fear, which we would equate with the terms ‘panic’ and ‘terror.’ Unfortunately, we did not ask interviewees about prior traumatic events, such as adverse experiences in childhood; nevertheless, several of the survivors in the field research did say that they experienced childhood trauma and/or that they had experienced domestic abuse in a previous relationship.

A last feeling state identified in the research literature as influencing survivors to choose suicide if they experienced it, is burdensomeness – specifically arising from disrupted relationships with self and others. All the survivors in our research who had suicidal thoughts or attempted suicide described feeling that they were a burden and several of the mothers who attempted suicide described thinking that their children would be better off without them. The survivors in our interview research who had suicidal thoughts or attempted suicide described feeling isolated and lonely, worthless, humiliated and that they were not as good as other people thought they were (e.g., feeling like a fraud). These feeling states are all functions of, and contributors to, disruption in a survivor’s relationship with others and with themselves – in conjunction with the shame and somatic distress which typically follows from abusive physical trauma.

Additionally, survivors who attempted suicide appear to have been influenced by the survivor’s family pressuring her to stay with the perpetrator or to take him back when they knew about the abuse. Also, the survivor having had one or more previous relationships in which she had experienced domestic abuse; and, critically, others not acting to help the survivor when the survivor knew that they had seen the signs of abuse and/or the survivor had disclosed the abuse. The importance of this lay in the fact that help from outside of the abusive relationship and wider family was perceived by the survivors as their last chance and when that help was not forthcoming, the survivor’s hope of escaping the abuse was extinguished. Many more of the survivors who attempted suicide were in contact with the police

than survivors who had suicide ideation or no suicidal thought/did not attempt suicide; and only just over a third of the survivors who attempted suicide said that the police helped them whilst they were in the relationship. Similarly, survivors' contact with health services seemed to have a significant influence on the survivors. Almost all the survivors who attempted suicide had contact with health services. Two-thirds were diagnosed with post-natal depression and were prescribed anti-depressants. Of the survivors who were diagnosed with mental ill health due to the perpetrator's behaviour and influence, just over two-thirds attempted suicide.

With respect to suicide attempts, almost half of White British survivors attempted suicide, compared to a third of the survivors with 'other' ethnicities and only one British Pakistani survivor. However, there are likely cross-cultural differences in survivor's willingness to disclose suicide ideation that could very well explain these ethnicity patterns.

In relation to whether being a mother precludes attempting suicide, this does not appear to be the case. In our research interviews, a third of survivors who attempted suicide were caring for children at the time and said that they reached a point where they felt their children would be better off without them.

Finally, from the rapid review we understand that survivors are more likely to choose suicide if they try to cope with the impact of the abuse through drugs and alcohol or self-harm. In our research a high proportion of the survivors who attempted suicide did use drugs and alcohol and/or self-harm as a way of coping. They also coped through eating in a disordered way. From the Rapid review we understand that eating in a disordered way is linked to burdensomeness via feelings of self-hatred. Whilst not long-term solutions, there were short-term coping strategies used by the survivors in our research which were positive in the sense that they were not correlated with suicide ideation/attempts. These included a strong reliance on religion, denial of the abuse and the survivor having an ability to distract herself from the abuse and abusive circumstances.

Quantitative Evaluation

Analyses of the data suggest that, tracking individuals across multiple incidents, that while it is common for both men and women to be sometimes classified as the victim or a suspect, the data make clear that men are much more often the suspect than they are the victim, and vice versa for women.

Conclusion

Based on our results, we recommend the creation and testing of an assessment tool that aims to identify the predictors of suicide by gathering information from the survivor. Administration of the tool should include gathering information from whether they have experienced life-threatening abuse; sexual assault/rape, coercion and control; multiple abuses and repetition of abuse, as well as information about their feeling states, including feelings of despair, hopelessness and burdensomeness/ isolation/self-hatred. The tool should also take into account the effects of the abuse on the survivor's self-identity, such as the number of relationships which have been disrupted or terminated. This should also elicit information about a survivor's perceptions of/relationship with the police (and health services) and may assist in building trust; and any previous or childhood experiences which were trauma or terror-inducing, such as, some form of abuse, disaster (e.g., house fire), accident or medical procedure. Further information should be gathered about the survivor's coping strategies, such as whether they are using self-harm and/or alcohol and drugs to cope.

We also recommend the development of guidelines for police forces and health services to introduce and maintain a domestic abuse survivor suicide prevention/welfare pathway, with local statutory and VCS partners. The framework should contain the information in this

report, and any other/up-dated information about how domestic abuse dismantles the survivor's identity and the link with suicide translated into operational understanding and practice.

Additionally, we recommend that a small amount of additional funding is made available to explore the information collected in this research about the contact survivors have had with services other than the police and health services (e.g. children's social care, schools, housing, immigration services, the Family courts and voluntary and community sector services). Moreover, more nuanced research needs to be undertaken to track the trajectory from abuse to suicidality and, in the process, to differentiate suicide ideation from suicidality. The research should incorporate evaluation of any of the above pilot activities.

Finally, given that the quantitative analysis highlights the high rate of suicide amongst male perpetrators of domestic violence, further research is necessary to better understand this relationship and how it is affected by socio-economic factors, mental health, and substance abuse.

Acknowledgements
The independent researcher and report authors would like to offer heartfelt thanks and admiration to the survivors who shared their experiences of domestic abuse to support this research. Thank you also to the families who lost a member to suicide following domestic abuse. The contributions from direct experience provide critical value and relevance to the recommendations in the report. Thank you to the practitioners for facilitating the research through their support for the survivors during the fieldwork.

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Rapid Review, Fieldwork, and
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1 Introduction

1.1 Research aim

The research reported here forms three components of University of Birmingham's tripartite study into domestic abuse and suicide. The first component is a rapid evidence review seeking to summarise current knowledge about domestic abuse and any links to suicide. The review aimed to inform fieldwork with domestic abuse survivors and families to understand their perspective on domestic abuse and whether/how it might in their experience have been linked to suicide. The fieldwork formed the second and primary component of the tripartite study, aiming to understand survivors' experiences in their own words. Direct quotes have been used in this report to strengthen their voices. The third element of the overall study is a quantitative evaluation. The evaluation compares domestic abuse-related suicide cases with a control group of domestic abuse cases over the past 15 years held by the West Midlands police that did not involve suicide, including repeat victimisation, victimisation type, and vulnerability, and engagement with support services, such as mental and physical health, and substance misuse.

The ultimate goal for research such as this would be to contribute to improved practice in preventing completed suicides. Suicide not only cuts short the victim's life, it also has a significant negative impact on suicide-exposed people (whether or not they were related to the victim) who are themselves at risk for psychopathology and suicide (Jordan, 2001; Jordan and McIntosh, 2010). Improved practice could take the form of improved risk assessments and case pathways, and/or better single or multi-agency activity, and/or better staff training. Accordingly, this tri-partite study has focused on trying to identify key factors which might exacerbate or mitigate suicidal ideation and/or suicide attempts, such as, forms of abuse, coping mechanisms or service responses. Continued efforts in this area are important because to date the ability to predict completed suicide with any accuracy has remained low. Large (2018) summed this up as follows:

'Despite the widespread adoption of suicide risk assessment there are no published randomized trials demonstrating that risk assessment can guide any suicide-reducing interventions to the point of reducing the overall prevalence of suicide in the assessed group, and it remains to be seen if this evidence threshold can be achieved by any new suicide-predicting method.' (p202)

1.2 Research context

1.2.1 UK VAWG legislation, policy and policing

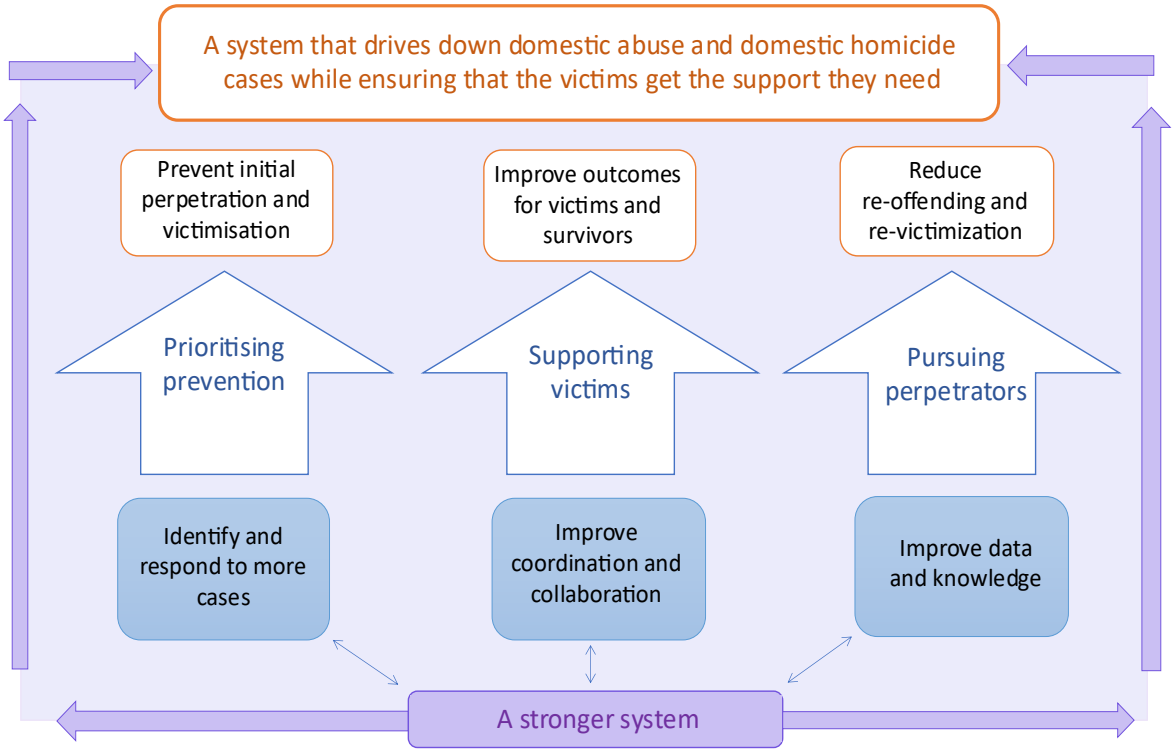
There has recently been increased government legislative and policy activity aimed at reducing the prevalence of crimes against women and girls. The Domestic Abuse Act[1] was passed in April 2021. Amongst other things, the Act introduced a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence, but can also be emotional, controlling or coercive, and economic abuse. A national Tackling Violence Against Women and Girls (VAWG) Strategy[2] was

[1] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted
[2] https://www.gov.uk/government/publications/tackling-violence-against-women-and-girls-strategy

launched in July 2021, and in March 2022 the government published the national Domestic Abuse Plan (England and Wales)[3].

The Domestic Abuse Plan takes forward the findings from the Inspectorate's report setting out four areas of focus for service delivery: prioritising prevention, supporting victims, pursuing perpetrators, and developing a stronger service delivery system. A simplified version of the Plan is illustrated in Diagram 1.

Diagram 1 The national Tackling Domestic Abuse Plan (England and Wales)



Source: Adapted from the national Tackling Domestic Abuse Plan - Command paper 639 (accessible) (March 2022; updated 1 September 2022) [4]

Additionally, an inspection from Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)[5] in mid-September 2021, concluded that while great improvements have been made in the policing response to VAWG over the last decade, these were not enough. The HMICFRS inspection also reported that there were significant inconsistencies in the service that police forces provide to women and girls across England and Wales. The inspectorate recommended a fundamental change in the police approach to crimes against women and girls, prioritising the response, and aiming for greater consistency and higher standards of service delivery.

One of the HMICFRS report's recommendations was for the NPCC to put in place a framework for force-level action plans, and work with chief constables to produce plans which would improve and

[3] https://www.gov.uk/government/publications/tackling-domestic-abuse-plan
[4] https://www.gov.uk/government/publications/tackling-domestic-abuse-plan
[5] https://www.justiceinspectorates.gov.uk/hmicfrs/publications/police-response-to-violence-against-women-and-girls/

standardise their forces' response to violence against women and girls offences. The aim was to ensure policies, processes and practices are effective, actively monitored and managed, and meeting national standards. The NPCC published the framework in December 2021: the *Policing violence against women and girls National framework for delivery: Year 1*. It requires every police force to prioritise concentrated and determined action to achieve a common standard, culture and approach in preventing and responding to VAWG as part of any response to violent crime.

Included in this local response, and as part of the prevention part of the national Tackling Domestic Abuse Plan, should be a focus on preventing suicide linked to domestic abuse. In early 2020 the National Police Chiefs' Council and the College of Policing working with the Home-Office-funded National Policing Vulnerability Knowledge and Practice Programme (VKPP), produced a report: *Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021* (Bates et al., 2021).The report was designed to share real-time learning from the police-recorded domestic homicides *and suspected suicides of individuals with a history of domestic abuse victimisation* over the pandemic period. The report acknowledged that unexplained or suspicious deaths, and suspected suicides of individuals with a known history of domestic abuse victimisation are not homicides, nevertheless they were included to take into account as wide a range of post-domestic abuse as possible.

Findings from Bates et al. (2021) were that suspected suicides with a known history of domestic abuse victimisation (12 months to March 2021**):**

In cases where a victim of domestic abuse was suspected of taking their own life, the victim and suspect characteristics were similar to those in intimate partner homicide cases. However (female) suspected suicide victims were even more likely than female IPH victims to be previously known as victims of high-risk domestic abuse involving coercive control.

The previous domestic abuse in these suspected suicide cases was highly gendered. Nearly all suspects were male (91%, where known) and victims female (90%).

Suspected suicide victims were slightly younger than victims in other types, mostly under 45 years old

There were fewer BAME victims – possibly indicating under-identification of suspected victim suicides amongst minoritised ethnic groups

Previous non-fatal strangulation by the suspect of this or a previous victim was more present amongst this type of case

As with intimate partner homicide, (attempted or actual) separation was also present in a sizeable number of cases.

1.2.2 Report terminology and presentation

Terminology

Key terms and definitions as they have been used in this report are set out here (and in Appendix 3):

Domestic abuse: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- **psychological**
- **physical**
- **sexual**
- **financial**
- **emotional**

Controlling behaviour is: 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.

Coercive behaviour is: 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.

This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group[6].

Honour-based violence: an incident or crime involving violence, threats of violence, intimidation coercion or abuse (including psychological, physical, sexual, financial or emotional abuse) which has or may have been chose to protect or defend the honour of an individual, family and/ or community for alleged or perceived breaches of the family and/or community's code of behaviour[7].

Suicide ideation: there is no universally accepted consistent definition of suicide ideation. the magnitude and characteristics of suicide ideation fluctuate dramatically, it encompasses everything from fleeting wishes of falling asleep and never awakening to intensely disturbing preoccupations with self-annihilation fuelled by delusions. Following from this, although there are scales to measure depression, suicide ideation and risk for suicide exist, none produce a score that is sufficiently reliable or clinically useful in predicting the very small subgroup whose death by suicide is imminent. (The American Psychiatric Association Practice Guidelines for Psychiatric Evaluation of Adults, 2016; Harmer et al., 2022)

Suicide and suicide attempt: suicide is when people harm themselves with the goal of ending their life, and they die as a result. A suicide attempt is when people harm themselves with the goal of ending their life, but they do not die. (The National Institute for Mental Health)

In this report we have used the phrase 'choose suicide' and the term 'completed suicide' to support the avoidance of negative connotations with these actions.

We used the definitions set out here and in Appendix 3 for coding and analysis of our fieldwork findings (there is a full list of the forms of abuse in the Appendix). We acknowledge also, that there is a lack of internationally agreed definitions and systems for data collection on 'suicidality' and 'attempts' (Silverman & Diego, 2016).

Our use of the term 'domestic abuse survivor' in this report includes individuals who were experiencing domestic abuse at the time of reporting and/or who had very recently experienced

[6] https://www.gov.uk/government/news/new-definition-of-domestic-violence.
[7] https://www.gov.uk/government/statistics/statistics-on-so-called-honour-based-abuse-offences-england-and-wales-2020-to-2021.

domestic abuse. We recognise that both men and women experience domestic abuse. However, we have focussed on women only, because our fieldwork participants were all female. We feel that our approach is supported by the fact that women are likely to be at risk of more serious harm than men (over 90% of survivors discussed at MARAC are female (SafeLives, 2014)) and the results included in this report from other studies, are predominantly focused on women.

Finally, we have used the terms 'feelings' and 'emotional and psychological impacts' in this report. 'Feeling' or 'feeling states' refers to the emotions which survivors' are usually conscious of and can describe e.g., sadness. Whilst 'emotional and psychological impacts' refers to changes in mood and cognitive capability which can be outside of a survivor's consciousness e.g., depression.

Presentation

We raise four issues in relation to presentation:

We subscribe to the view that in exploring complex circumstances, such as the link between domestic abuse and suicide, simplification loses the detail needed to understand and respond well. We have therefore tried to find a balance between providing as much of the detail as possible, in particular, by using the 'survivors' voices' in quotes, and retaining 'readability' in this report.

To retain detail by including so many quotes has meant that we have needed to withhold the numbering of quotes to ensure participant confidentiality. For quality assurance purposes we have retained them in a securely stored version of this report.

We gathered a significant amount of information both about post-separation impacts on survivors from stalking and the role of the Family courts/CAFCASS in facilitating this; and their role in introducing, maintaining or escalating suicide ideation for the survivors. We have not included that information in this report; but would very much like to add an addendum with the information.

We also gathered valuable information about survivors' contact with services other than health and the police, children's social care, schools, housing, immigration services, the Family courts and voluntary and community sector services e.g., community and residential (Refuge) domestic abuse services and the Samaritans. We have not included that information in this report; but would like to add an addendum with the information.

Research logic

This research has been designed with the following logic:

Rapid review – to provide a context for the fieldwork, findings and discussion.
Conceptual framework – to investigate what the drivers of survivor suicide might be.
Fieldwork findings – answering the questions posed by the conceptual framework.
Theoretical framework – to explore why the drivers of survivor suicide might have the impact that they do.
Discussion – bringing together the findings from the conceptual framework and the theoretical framework with information from the rapid review (in particular Bates et al, 2021) and Aitken and Munro (2018).
Conclusion – taking a tentative position based on the discussion and making suggestions about potential next steps.

2 *Rapid evidence review*

As noted in the introduction, the review aimed to summarise current knowledge about domestic abuse and any links to suicide. The review findings were used to inform our engagement with domestic abuse survivors and families; and in the development of the fieldwork materials.

2.1 Rapid review: methodology

Search strategy

The literature search strategy was developed using the PICO framework designed to improve definition of the research question and to prompt for publication type and content. The framework is commonly used as guidance for conducting evidence reviews; as applied to this review it is shown in Table 1.

Table 1 PICO framework: domestic abuse and suicide

Population	Victims/survivors of domestic abuse. Domestic abuse or intimate partner abuse/violence who die by suicide; suicide; attempted suicide and suicide ideation.
Indicator	Dynamics and forms of domestic abuse e.g., physical, emotional, psychological, financial. Impact of domestic abuse on victims/survivors e.g., physical symptoms and cognitive distortions; emotional dysregulation, anxious depressive and other states/behaviours and post post-traumatic stress disorder.
Comparator (control population)	Factors likely to inhibit suicide in victims/survivors of domestic abuse/protective factors e.g., external factors and coping mechanisms.
Outcome (causation)	Factors likely to exacerbate suicide contemplation/attempts/risk factors. Compared to the impacts from domestic abuse on survivors.

The search strategy was established with a set of inclusion and exclusion criteria to narrow the focus because it was anticipated that a large number of studies with potential relevance would be identified in the initial stages. The primary search focused on published academic literature which was English and reporting on research undertaken in Western societies with profiles broadly similar to the UK e.g., USA. However, due to the scarcity of research into the specifics of domestic abuse and suicide, a wider secondary search was made and articles added from other societies. The searches covered the period from January 2000 – December 2020; although, a few papers on seminal work from before that were also examined. Also included were very recent UK government evidence-based policy reports. In recognition of the maturity of the UK voluntary and community sector response to VAWG, grey literature from reputable organisations such as Women's Aid, SafeLives and Refuge was also examined.

The PICO framework was used to develop a formal list of search terms. Searches were carried out in seven electronic databases. In relation to domestic abuse these were: EBSCO (Violence & Abuse), SAGE Journals (Violence Against Women) and Wiley Online Library; in relation to suicide: EMBASE: Excerpta Medica (OVID) and PsycINFO, EBSCO (Psychology and Behavioral Sciences Collection) and PubMed.

Rapid review limitations

All research has limitations and this is especially true of the available research on domestic abuse due largely to under and inconsistent reporting. Rowlands et al. (2020) highlighted this in their study of reporting of lifetime domestic abuse among 7,917 young women, The participants completed three surveys: at the first survey, 32% reported experiencing domestic abuse with a current or recent partner, of these one third did not report domestic abuse 12 months later. Additionally, Rowlands et al. (2020) found that the women who inconsistently reported a history of domestic abuse were also less likely to report suicidal ideation, self-harm, illicit drug use, and smoking at the 12-month follow-up. For the same reason, there is also a difficulty in obtaining sufficiently nuanced information, in our case, to understand the specific relationship between domestic abuse and suicide.

Findings from research into suicidality linked to domestic abuse, highlights variation between countries and between different racial groups, minority status and cultural beliefs on suicidality and suicide, in different countries (World Health Organisation, 2021). To limit such variation, this review focused on research undertaken in the UK or in Western societies with profiles broadly similar to the UK e.g., USA (with findings from a few other country studies where none was identified for the UK/similar societies).

A final crucial limitation was that within the time and resource constraints of this rapid evidence review, it was not possible to go beyond broad studies of 'domestic abuse' and 'suicide' and explore the discrete areas of research into the impacts of the different forms of abuse to understand their importance in the aetiology of victim suicide. Focusing on these areas in future research could bring to light the nuances which we anticipate could significantly progress understanding of the links between domestic abuse and victim suicide. The findings from the fieldwork in this project support this view.

2.2 Rapid review: findings

2.2.1 Introduction

The increased risk of suicidality and suicide among abused women has been documented in other countries (Stark and Flitcraft, 1995; Cavenaugh et al., 2011; Sansone e al., 2007). In their large-scale study of domestic abuse and suicide in Australia, MacIsaac et al. (2016) found 42% of women who died from suicide had experienced domestic abuse, with 23% having been a victim of physical violence, 18% experiencing emotional and psychological violence, and 16% having been subjected to sexual abuse. Cavanaugh et al. (2011), undertook a secondary analysis of data from the Risk Assessment Validation (RAVE) Study (Roehl et al., 2005)[8] in the USA and found that 20% of adult female survivors of domestic abuse had been suicidal/attempted suicide during their lifetime.

In 2018 the Refuge and the University of Warwick published research by Aitken and Munro on domestic abuse and suicide based on data from survivors using Refuge services. Findings were that 24% of survivors had experienced suicide ideation; 18% had planned how they would take their own

[8] The Risk Assessment Validation (RAVE) Study was funded by the National Institute for Justice and designed to assess the accuracy of four different methods for predicting risk of future harm and lethal assaults of women who had been abused by their intimate partners.

lives and 3.1%[9] had attempted suicide at least once. The findings indicated that survivor suicidality was influenced by many of the specific forms of abuse listed in this review.

Bolton et al. (2006) found that up to 43% of women in the USA who thought about suicide, had made an attempt. For the UK, Walby (2004) estimated that three women a week thought about escaping domestic abuse by taking their own lives and more than a third (33%) of all suicides were by women who had suffered domestic abuse.

According to Aitken and Munro (2018) the most common cause of death in suspected domestic abuse related suicides in the UK was by hanging, 46%, followed by 28% of victims dying from poison or drugs. This appears consistent with data relating to suicide in the general population. The Office for National Statistics (2020d) reported that for both men and women hanging, strangulation and suffocation (grouped into one 'type' of method) was the most common method of suicide in England and Wales.

Bates et al. (2021) noted that domestic abuse related suspected victim suicide and homicide in many ways have very similar risk profiles. In particular that cases of high-risk domestic abuse, often characterised by coercive control, might equally end in either a homicide or suspected victim suicide. The ideation highlights the loss of hope many women in abusive relationships experience. Taking a similar approach to Walby, Abraham (2005) positioned this type of suicide as the only form of resistance the woman is able to engage in – the choice of whether or not to take her own life, because her partner controls everything else. According to Abraham, in these circumstances suicide ideation by abused women reflects the extreme isolation and depression they experience. Ferraro (2006) also found that many women consider suicide as a way to stop the abuse because even separation will not necessarily stop the abuse; an alternative would be to murder the abusive partner.

See Appendix 1 for the social characteristics of victims/survivors of domestic abuse and suicidality.

2.2.2 Forms of abuse

Physical abuse

Aitken and Munro's (2018) findings were that 74% of domestic abuse survivors (women) had experienced physical abuse. They reported more than one form of abuse. The most common abuses were being pushed/pulled, punched, slapped, strangled and restrained. They were also kicked, injured with a weapon, suffocated, bitten, burned, stabbed and shot. For physical abuse the highest correlations with suicidality were in relation to physical abuse which was life threatening, including being strangled, kicked, or suffocated.

Non-fatal strangulation

Non-fatal strangulation is highlighted here because it is so prevalent, so dangerous and so gendered. Non-fatal strangulation usually leaves no external evidence, in this it differs from other forms of severe domestic abuse (except rape). With non-fatal strangulation, even where there is bruising and swelling, it often only becomes apparent days later; and the bruising may be difficult to detect on darker complexions (Baker & Sommers, 2008). There is evidence of survivors dying or becoming incapacitated weeks or months after being strangled as a result of heart attacks and strokes, caused by blood clots (Strack & Gwinn, 2011). In addition, Glass et a. (2008) found that survivors who are

[9] Percentages from Aitken and Munro (2018) have been rounded up throughout this report.

subjected to non-fatal strangulation were seven times more likely to be killed by their partners compared to survivors who had not experienced non-fatal strangulation.

Non-fatal strangulation is held to account for 17% of domestic abuse-related deaths in the UK (Long & Harvey, 2020). Non-fatal and fatal strangulation has been recognised as a gendered crime (Archer, 2000; Edwards, 2015; Bichard et al., 2021). Edwards (2015) reported that in England and Wales, over the previous three decades, this method of killing accounted for up to 37% of deaths of women by male partners. Bichard et al. reported that in 2018 that the second most common method of killing in female homicides was strangulation and asphyxiation, after stabbing (29% of women who died were killed by this method compared to only 3% of men). Glass et a. (2008) found that survivors who are subjected to non-fatal strangulation were seven times more likely to be killed by their partners compared to survivors who had not experienced non-fatal strangulation.

For the purposes of intimidation and control, there is other evidence of perpetrators selecting other body parts where injury doesn't show (Goodman, 2006; Allen et al., 2007). However, strangulation is used (sometimes just once) to immobilize and terrorize the survivor. It is painful and terrifying and renders the survivor completely powerless. Thomas et al. (2014) reported that survivors of non-fatal strangulation were clear that the assault was not a failed murder attempt, but a way for the perpetrator to exert power over them. However, despite other serious domestic abuse and intense fear, the survivors were severely shocked by the assault because they were aware of how vulnerable they were to being killed. The survivors reported largely failing in their efforts to extricate themselves from non-fatal strangulation and also, that their resistance resulted in an escalation of violence. Survivors reported the impact of the assault to be so frightening that the strangulation did not need to be repeated (although it usually is) in order for the survivor to be compliant and submissive. It is a powerful means of facilitating coercive control.

Several studies report that survivors of non-fatal strangulation are at increased risk of developing significant physical and psychological problems immediately following the assault and weeks later. Victims of non-fatal strangulation are also at heightened risk of being killed by the perpetrator of the assault (Strack and McClane, 1999; Strack et al., 2001; Wilbur et al., 2001; Glass, et al., 2008; Foley, 2015). Strangulation can result in the loss of consciousness within seconds and brain death within minutes, following from the fact that pressure applied to the neck can, within minutes, damage blood vessels or the windpipe (airway) and/or cause clots. In addition to risk of death, it can cause brain damage or a stroke. Bichard et al. (2021) reported the impacts of non-fatal strangulation as follows: loss of consciousness, mild acquired brain injury, seizures, motor and speech disorders, paralysis, memory loss, increased aggression, compliance, and lack of help-seeking. Psychological distress in the immediate aftermath of the strangulation, reflects survivors' fear that they were about to die (De Boos, 2019; Funk & Schuppel, 2003; Shields et al., 2010; Strack et al., 2001). Delayed psychological outcomes include: post-traumatic stress disorder, depression, anxiety, suicidality, nightmares and insomnia, generalised fear, powerlessness and vulnerability, shame, hypervigilance, dissociation, interpersonal difficulties, personality change, feelings of worthlessness (Bichard et al., 2021). Non-fatal strangulation is known to co-occur with sexual assault/rape (McQuown et al., 2016). See subsection 3.22 for a discussion on the impact of rape.

Bates et al's (2021) findings were that in the suspected victim suicide cases there was a history of non-fatal strangulation in approximately three-times more of the cases (28%) than in the cases where domestic abuse victim was killed by a partner (9%). Their findings included that coercive and controlling behaviour was much higher in the suspected victim suicide cases (56%) compared to the intimate partner homicide cases (30%) – and that non-fatal strangulation was present in two-fifths of the cases with coercive and controlling behaviour. Stalking has been recognised as a form of coercive control (Davis et al., 2000) and has also been found to be linked to non-fatal strangulation; 16.6% co-ocurrence with stalking in research by Bendlin and Sheridan (2019).

Coercive control

Coercive control includes control of behaviour in and outside of the home – through actual or threatened physical abuse and emotional and psychological manipulation, financial control, isolation from friends and family, honour-based violence/forced marriage and reproductive coercion and control. Aitken and Munro (2018) found that isolation from family and friends and experiencing threats of harm with a weapon, threats to kill a family member, were correlated with suicidality. Bates, et al. (2021) concluded that coercion and control (together with previous experience of domestic abuse) was the most common risk factor for suspected victim suicides. Their finding was that victims of suspected suicide were three times more likely to have experienced coercive and controlling behaviour than victims of intimate partner homicide. Sato-DiLorenzo and Sharps (2007) describe victim symptoms related to coercive control within dangerous relationships: difficulty concentrating, memory loss, suicidal attempts, and weight gain.

Emotional and psychological manipulation/abuse

SafeLives (2019) reported that 91% of survivors had experienced a form of emotional and psychological manipulation/abuse, involving a pattern of intermittent grooming (constant communication and compliments) and abuse. It included 'silent treatment' (65%); suggestions the survivor was mentally unstable (48%); shifting blame to the survivor; presenting insults as a joke, presenting different versions of events; and verbal insults, humiliations, criticisms or putdowns (45%). These tactics are all known to cause psychological confusion prompting survivors to doubt their own thinking and fear that they were 'losing their minds'. The SafeLives report also notes the perpetrators' grooming of family and friends, behaving differently in public to private and, using their status or social standing to 'recruit allies'.

Aitken and Munro (2018) reported 87.87% of domestic abuse survivors (women) having experienced emotional and psychological manipulation/abuse. A majority of survivors reported being subjected to control and intimidation, followed by being subjected to isolation and threats of harm. The latter included a significant level of threats to family members and pets.

Financial abuse

Financial abuse occurs when a survivor's current and future actions and their freedom of choice is curtailed and controlled by their partner using or misusing money. It can include using credit cards without permission, appropriating a survivor's benefits, preventing her from accessing her own bank account, building up debt in her name and gambling with family assets (Sharp, 2008).

Aitken and Munro (2018) found that approximately a third of the survivors experienced financial abuse, with just over a quarter reporting the perpetrator controlling the family finances. Furthermore, any report of financial abuse appeared to significantly increase the likelihood of suicidality. Economic abuse extends financial abuse to include restricting access to essential resources and denying a survivor the means to improve her economic status e.g., through employment, education or training (Women's Aid, undated).

So called honour-based violence (HBV)

Aitken and Munro (2018) reported a correlation with suicidality amongst domestic abuse survivors who described so-called 'honour' based violence. The proportion of survivors who experienced honour-based violence was 4.1% and more than half of these clients (56.5%) were from South Asian backgrounds, representing 22.7% of all South Asian survivors in the sample. These percentages are low, however, Annually, around 1,800 incidents are reported to the police in England and Wales HMIC, 2015). Bates (2017) divided honour-based violence cases into three typologies: in *Type I* the

sole perpetrator was a current or ex-intimate partner (as in other domestic abuse cases); in *Type II* the perpetrator was one or more of the victim's birth-family members, generally their birth family; and in *Type III* in a current or ex-intimate partner perpetrator, and in addition one or more of the victim's family members – most commonly their in-laws. Bates found that in types I and II the survivor was at higher risk of harm – respectively 66% and 47%, compared to Type II which was 52% (as measured by SafeLives Insights data)[10].

Reproductive coercion and abuse

Tarzia and Hegarty (2021) define reproductive coercion and abuse includes any deliberate attempt to influence or control a woman's reproductive autonomy, for the purpose of either preventing or promoting pregnancy. They argue that lack of a clear definition has prevented the establishment of a robust evidence base and that there is poor understanding of the way in which it interacts with domestic abuse and sexual violence. It is typically perpetrated against women by a male intimate partner (Grace et al., 2018), although other family members can also be participants or instigators (Silverman, 2019).

Reproductive coercion and control are currently recognised in three main forms: pregnancy coercion (where a woman is forced to become pregnant against her will); contraceptive sabotage; and controlling the outcome of a pregnancy (forcing a woman to terminate or continue a pregnancy against her will) (Grace et al., 2018). Aitken and Munro (2018) reported a small number of enforced terminations. A growing body of current research suggests associations between other forms of domestic abuse coercion and control and reproductive coercion and abuse (Silverman, 2019; Clark et al., 2014; Northridge et al., 2017; Samankasikorn et al., 2018), unwanted pregnancies (Grace et al., 2018), poor mental health (McCauley et al., 2014), decreased contraceptive self-efficacy (Gee et al., 2009; Katz et al.,2017) and increased risk of sexually transmitted infections (Kazmerski et al., 2015).

Sexual abuse

Aitken and Munro (2018) found that 30% of women said that they had been sexually abused. The most common form of abuse reported was forced vaginal intercourse i.e., rape. The survivors said that it was one element of several ongoing forms of abuse they were subjected to. Women who experience sexual abuse are at risk for suicidal ideation or completed suicide (Coker, et al., 2002; Cavanaugh et al., 2011).

2.2.3 Emotional and psychological impacts

Psychological distress and injury

Forbes et al. (2014) found that the emotional and psychological distress of domestic abuse survivors was almost four times higher than women in the general population (using a range of mental health measures[11]). Aitken and Munro (2018) found strong evidence for psychological distress or injury across all of the 3,500 survivor case records they sampled. Of these 86% met or surpassed the threshold for clinical concern on the Refuge's measure of psychological distress (CORE-10[12]; see Appendix 2) and 83% of survivors confirmed feeling despairing and hopeless. Within the suicidal group 49% scored in the severe range of psychological distress. Aitken and Munro's conclusion was that

[10] The SafeLives Insights system is both a case management and outcomes measurement/reporting IT system for domestic abuse services in the UK. It provides the largest dataset on domestic abuse in the UK.

[11] Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM), Patient Health Questionnaire, Generalised Anxiety Disorder Assessment, and the Post-traumatic Diagnostic Scale to measure post-traumatic stress disorder.

[12] CORE-10 (Clinical Outcomes in Routine Evaluation- 10 item) is a short, 10 item version of the CORE-OM (a common self-report measure of global distress).

survivors' feelings of despair or hopelessness; and experiencing panic, terror or past trauma were the most highly correlated with suicidality. Support for the contribution of the latter experiences comes from Pilowsky et al. (2006), who found that individuals with panic disorder were twice as likely to present with suicidal ideation, as those without panic disorder.

Depression

Pilowsky et al. (2006) found that individuals with depression were seven times more likely to experience suicidal ideation, as those without depression. For domestic abuse survivors (women), Ferrari et al. (2016) reported that the proportion with symptoms of depression in their sample was double that of women in UK general practice; for symptoms of anxiety, this proportion is three times as large. Furthermore, they noted that these findings were consistent with those for women who were domestic abuse survivors in the USA (Bell & Goodman, 2001; Becker et al., 2010) and Hong Kong (Sullivan et al., 1992). Chandan et al. (2019) found that female domestic abuse survivors had double the risk of developing anxiety, and three times the risk of developing depression than women who had not experienced domestic abuse.

Aitken and Munro (2018) found that 86% of the survivors in their research who were suicidal group reported feeling depressed. Sato-DiLorenzo and Sharps (2007) surveying women in domestic abuse shelters in the USA reported that anxiety and depression were linked to the level of seriousness of the abuse the survivors had experienced. Devries et al. (2013) reviewing pre-2013 longitudinal studies also reported that experience of domestic abuse increases the likelihood of depressive symptoms and of suicide attempts among women.

Post-traumatic stress disorder/Complex post-traumatic stress disorder

Trevillion et al's (2012) systematic review of epidemiological studies of diagnosed mental illness found that post-traumatic stress disorder (PTSD) was higher for domestic abuse survivor women than any other mental health condition. They noted conclusions from Forbes et al. (2014) that health service staff fail to identify the symptoms of PTSD in the context of domestic violence; and also, the need for health services to put in place specific domestic abuse trauma interventions for survivors (Duxbury, 2006).

Aitken and Munro (2018) extend the concept of PTSD, describing complex PTSD as an independent condition within the International Statistical Classification of Diseases and Related Health Problems (ICD-11). This was also noted by Bates et al. (2021) on the basis that complex post-traumatic stress disorder (C-PTSD) is likely to include many of the adverse psychological impacts experienced by abused women (and should be recognised as a form of 'bodily injury' for the purposes of criminal liability).

Klonsky and May (2014) note that risk factors for suicide such as, psychiatric disorders, depression, hopelessness, and even impulsivity, are poor predictors of completed suicides, however, that PTSD is an independent predictor of attempted suicide. In a later research paper, they propose that suicide ideation and attempts are explained in terms of just four factors: physical and emotional and psychological pain (PTSD), hopelessness (including powerlessness/helplessness), lack of connectedness (disrupted relationships and isolation), and suicide capability (the means to take one's own life) (Klonsky & May, 2015).

Co-morbid depression and PTSD

O'Campo et al. (2006) reviewed civilian and military groups domestic abuse survivors (women). They found that 34% of the abused civilian women and 25% of abused military women had symptoms that met criteria for at least one of the diagnostic categories compared to 18% and 15% of non-abused

women in the two groups. Comorbidity of PTSD and depression affected 19.7% of the civilian abused women versus 4.5% of non-abused civilian women, whereas for active-duty military women, the prevalence was 4.6% and 4.2% for abused and non-abused women, respectively. This has implications for health service staff needing to recognise PTSD and/or depression in women who are domestic abuse survivors.

Hedtke et al. (2008) studied a sample of 4,008 women over a two-year period and found that a) women with histories of sexual assault were three times more likely to have PTSD and twice as likely to have depression than those without; and b) that survivors who had been subjected to multiple and/or repeated abuses were most likely to experience PTSD, depression; and also, substance use problems. Furthermore, that the severity of these co-morbidities increased incrementally with the increase in concurrent abuses and/or repetition of abuses over time. Furthermore, Hedtke et al. concluded that the strongest and most consistent risk factors for PTSD and depression was experiencing both physical and sexual assault in the multiple forms of violence.

Feeling states

Aitken and Munro (2018) reported that 96% of the survivors in their research who reported suicidal thoughts or acts, said they felt despairing or hopeless. Linehan and Nielsen (1981) surveyed shoppers and found that those who had previously felt suicidal reported feelings of hopelessness and that hopelessness was strongly associated with the individuals' perception of themselves as lacking social desirability. This suggests disruption in their relationships, distance (or complete isolation) from supportive others, and a lack of belongingness – a finding reflected throughout a wide range of the literature on the antecedents of suicide.

Zeppegno et al. (2021) found that feeling burdensome is also significantly correlated with suicidality, including in eating disordered patients, especially those with anorexia (in relation to which symptoms might represent anger and hatred towards the self). In support of the latter perspective, Yen and Siegler (2003) and Chang et al. (2014) found that forgiveness of self/ alleviating feelings of self-blame and promoting the motivation to change reduced or eliminated the positive link between domestic abuse and suicidality.

Øverup et al., (2017) investigated the relationship between burdensomeness, which can be interpreted as having a negative relationship with self) and attachment anxiety (i.e., disruption in their relationships with others). They reported that there is a link between individuals having less self-compassion, feeling less belonging, and experiencing a higher level of burdensomeness. Importantly, Øverup et al. found that these factors were associated with increased depressive symptoms. This replicates predictions from Attachment Theory[13] (Bowlby, 1973). Joiner (2007), who identified the same two 'feeling states' (thwarted belongingness and perceived burdensomeness) as key predictors of suicidal behaviour. Together with two other elements: a desire for suicide (not wanting to be in the world), and capacity (the means) for suicide. This was supported by Van Heeringen (2018).

Van Heeringen (2018), Van Orden et al. (2010) and Hagan et al. (2016) agreed that thwarted belongingness (which they described as 'feeling alone') and feeling of like a burden were contributors to suicide. The latter two research teams added a sense of hopelessness (being helpless/powerless and with no prospect of this changing in the future). Extending the idea of belongingness, Fedina et al. (2021)) looked at gentrification and found lower levels of neighbourhood cohesion were associated with higher levels of domestic abuse. Furthermore, neighbourhood disconnectedness worsened

[13] Attachment Theory explains individuals' emotional and psychological wellbeing in terms of the depth of the emotional bonds they are able to form with other people (their capacity to achieve this being dependent on the quality of their early years relationships with their own caregiver).

psychological distress symptoms and suicide risk most strongly among individuals exposed to domestic abuse.

Meadows et al. (2005) found that in their small sample of low income, African American domestic abuse survivors (women) those who strongly espoused hope, spiritual well-being, self-efficacy, coping, social support from family members, social support from friends and effectiveness of obtaining resources were least likely to be suicidal. However, in line with the findings from the other studies, only hope and support from family differentiated those who made serious/multiple suicide attempts from those who did not.

2.2.4 Coping strategies

Drug and alcohol use

In a Canadian study, Espinet et al. (2019) found that the lifetime suicide risk for individuals with substance use disorder was 5 – 10 times higher than the 3 – 5% risk in the general population; for individuals with alcohol abuse problems, it was is 10 times higher; for those using opiates it was 14 times higher and for those with mixed-drug use it was 17 times higher. In addition, Espinet et al. reported that these individuals made multiple suicide attempts. Bolton et al. (2006) focused on domestic abuse survivors and similarly concluded that self-medication through drug and alcohol use increases the risk of suicidality. Aitken and Munro (2018) found problematic alcohol and drug use were significantly associated with suicidality.

Ragin et al. (2002) interviewed 122 mostly African American and Latina women, and found that the 45 who attempted suicide, were more likely to report substance abuse among both first-degree (specifically fathers) and second-degree relatives, than were women without such suicide attempt histories. They were also more likely to report witnessing the physical abuse of their mothers (see subsection 5.2 for information about the impact of childhood trauma, (including witnessing domestic abuse, on lifetime suicidality).

Self-harm

Self-harm is a key risk factor for suicide (Hawton et al., 2014; Whitlock et al., 2015; Chan et al., 2016). In a relatively large, ten-year study in England, Hawton et al. (2015) found the risk of suicide in the first year following self-harm to be 49 times greater than the general population risk of suicide in England and Wales. While the absolute risk of suicide was greater in males, the risk relative to that in the general population was higher in females. Whitlock et al. (2015) note that self-harm and suicidality have common risk factors, such as, experience of trauma, abuse, or chronic stress, few effective mechanisms for dealing with emotional stress, poor relationships or isolation, depression or anxiety and feelings of worthlessness.

Duration of abuse and multiple abusers/abuses

Aitken and Munro (2018) found a link between the duration of domestic abuse and suicidality. This relationship appeared to be strongest for physical or financial abuse. In their research sample, the mean duration of physical abuse for those in the suicidal group was just over four years compared with just under three years for those in the non-suicidal group. In addition, survivors who had been abused by more than one person were more likely than those who had been abused by a single perpetrator to express suicidality (approximately 16% of survivors in the suicidal group had been abused by more than one person compared with 8% of the non-suicidal group).

Reporting on the WHO's data on the health effects of domestic abuse, Potter et al. (2021) noted that all forms of domestic abuse were associated with poorer health outcomes, however, two categories of

combined abuse were the most damaging. The most common category was any abuse combined with sexual assault, which was associated with the poorest health, including memory loss, suicide ideation and attempted suicide (see subsection 5.2 for an exploration of the traumatic impact of rape). This was similar to the finding by Hedtke et al. (2008) that physical and sexual assault together were the strongest risk factors for PTSD and depression. Potter et al. reported that the second most common category, with the next poorest outcomes (again including memory loss, suicide ideation and attempted suicide) was the combination of physical and emotional and psychological abuse. See subsection 5.1 for an exploration of the dismantling of identity.

Being subjected to life-threatening abuse

Sato-DiLorenzo and Sharps (2007) found that women who experience life-threatening domestic abuse assaults are significantly more likely to attempt suicide than victims of less dangerous behaviour to attempt suicide during their lifetime. Their finding was that domestic abuse survivors who fear for their lives could choose suicide in an attempt to reclaim control over an unpredictable and uncontrollable situation. Hedtke et al. (2008) concluded that there is a link between the seriousness of the threat to life and the degree of mental ill health experienced by a survivor – in the form of PTSD, anxiety and depression. This impact from severe (and chronic domestic violence), are in turn risk factors for suicidal ideation (Johnson et al, 2008).

Aitken and Munro (2018) found that the strongest correlations with suicidality were for physical abuse, being strangled, kicked, or suffocated – together with any report of sexual abuse. Also, for psychological abuse, isolation from family and friends and experiencing threats of harm with a weapon, threats to kill a family member; and any report of financial abuse. In terms of mental health/psychological symptoms, problematic alcohol and drug use were significant. Isolation was also associated with suicidality.

Kuehn et al. (2020) highlight the finding from a significant number of studies that one of the most robust predictors of future suicide is a previous suicide attempt, regardless of the cause. They add that some research has identified the average time period between a suicide attempt and a completed suicide as one year. Kuehn et al. concluded that thoughts of suicide and suicide attempts should never be dismissed as 'merely a cry for help', because doing so risks ignoring those whose psychological pain had reached the point that they are likely to take their own lives in the future (Kuehn et al., 2020).

2.3 Rapid review summary

From this rapid review of the literature on potential links between domestic abuse and suicide, it appears possible to draw the following summary conclusion:

In terms of the abuses, studies into non-fatal strangulation have identified the life-threatening experience as a strong contributor to survivor suicidality (Aitken & Munro). It may be that as an effective facilitator of coercion and control, non-fatal strangulation may influence the fact that coercion and control was found by Bates et al (2021) to be three times more likely to have been experienced by survivors in domestic abuse suicides than in domestic abuse homicides. Financial abuse forms part of coercion and control, Aitken and Munro found it to have been experienced by a third of survivors and to have contributed to their suicidality. Coercion and control involves emotional and psychological manipulation and abuse, and is experienced by between 88-91% of survivors (SafeLives, 2019; Aitken & Munro). An abuse which appears to be highly correlated with survivor suicide is sexual assault/rape (Coke et al., 2002; Cavanaugh, 2011).

In terms of emotional and psychological impact, depression is linked to severity of the abuse (Sato-DiLorenzo & Sharps, 2007) and suicide (Devries, 2013). Chandan et al., (2019) found that domestic abuse survivors were three times more likely to have depression than non-abused women. PTSD has

been found to be an independent predictor of attempted suicide by survivors (Klonsky & May, 2014). It has been found to be co-morbid with depression for 20% of the domestic abuse survivors (O'Campo, 2006; Hedtke et al, 2008). Hedtke et al. found a correlation between PTSD and depression and repetition of abuse, multiple concurrent forms of abuse, and inclusion in the multiple abuses of physical and sexual abuse/rape.

In relation to feeling states, those most likely to predict suicide have been identified as despair and hopelessness; although this often includes panic, terror and/or past traumas (e.g., in childhood) (Pilowsky et al., 2006; Aitken & Munro, 2018). Hopelessness has been strongly linked to a lack of 'belongingness' (i.e., disrupted relationships/isolation) (Lineham & Nielsen, 1981). These conclusions fit relatively well with Klonsky and May's (2015) framework of four key contributors to suicidality: physical and emotional/psychological pain (PTSD), hopelessness (including powerlessness/helplessness), lack of connectedness (disrupted relationships and isolation), and suicide capability (the means to take one's own life) Added to this has been 'burdensomeness' (Zeppegno, 2021), which is associated with self-hatred (Van Ziegler, 2003; Chang et al., 2014). There is a link between individuals having less self-compassion, feeling less belongingness, and experiencing a higher level of burdensomeness; and these factors were associated with increased depressive symptoms (Øverup et al., 2017). This replicates predictions from Attachment Theory[14] (Bowlby, 1973) and prompts consideration of the importance of relationships in the maintenance of individual's health and wellbeing, particularly in terms of self-identity.

In relation to coping strategies, drug and alcohol misuse appear to be significantly associated with suicidality (Espinet et al., 2019; Aitken & Munro, 2018). Self-harm is also a predictor of suicide (Hawton et al., 2015; Whitlock et al., 2015; Chan et al., 2016) and shares common risk factors with suicidality.

See Appendix 4 for a profile of the Rapid evidence review findings in bullet points.

3 Fieldwork

3.1 Fieldwork: approach

The focus of the fieldwork included whether domestic abuse increases the risk of survivors dying by suicide; whether survivors with particular demographics are more likely to choose suicide, whether certain forms of domestic abuse are more likely to result in the survivor dying by suicide and whether forced marriage/honour-based violence increases domestic abuse-related suicide.

We adopted the qualitative approach of gathering insights directly from survivors into their experience of domestic abuse. We hoped to find patterns within the survivors' narratives which might suggest links between forms of abuse, the impact of abuse on survivors and thoughts of suicide or suicide attempts. Accordingly, we asked about the impact the domestic abuse had on the survivors, what coping strategies they were able to deploy, whether and who they received help from, and then whether they had suicidal thoughts or had attempted suicide. Clearly, gathering data via interviews meant that cases of completed suicides were outside the scope of this research. See subsection 3.2.4 for research limitations.

[14] Attachment theory has identified the importance of approach and avoidance in determining the quality of relationships between humans. Individual tendencies reflect the quality of their attachment with at least one primary caregiver childhood but can be enhanced or damaged by later life experiences.

Our approach in the interviews was unusually unstructured for two reasons. The first reason was that we were keen to avoid missing potentially valuable information exchanges by putting limits to the discussion. We approached the survivors with the perspective that they are true experts by experience. The second reason was that we were conscious of the extremely sensitive nature of the subject matter and were aware that for some of the survivors the time period between leaving the abusive relationship and talking to us was only a few months. Accordingly, we were careful to allow participants to choose when and how to offer personal information and to avoid controlling the interview. See subsection 3.2.4 for research ethics and safety.

3.2 Fieldwork: methodology

This section sets out our fieldwork preparations and how we engaged the research participants. The section begins by describing the conceptual framework we developed to guide creation of the fieldwork materials and initial interpretation of the findings.

3.2.1 Conceptual framework

We commenced the fieldwork by developing a conceptual framework for exploring and illustrating the relationships between factors that could constitute or contribute to, a link between a survivor experiencing domestic abuse and the survivor choosing suicide. The fieldwork methodology was qualitative, with data gathering taking the form of interviews principally with domestic abuse survivors. The study also gathered some information from families who had lost a family member to suicide where that family member had experienced/was experiencing domestic abuse.

A conceptual framework was constructed to support planning for the research. Conceptual frameworks are a form of theory of change in so far as they articulate assumptions about causal relationships between initial contributing factors or inputs, the interim impacts or outputs, and final outcomes. These assumptions can then be tested in the research. In summary, our conceptual framework theorised that a survivor's experience of abuse was likely to result in trauma-induced low mood which could, in certain circumstances, precipitate suicide.

Initial inputs: the initiating inputs were taken to be the abusive behaviours of the perpetrators. The impact of these may be exacerbated by gender norms such as, a patriarchal culture (including forced marriage); the survivor having special needs (a disability or learning difficulties); the survivor having caring responsibilities (e.g., children, elderly parents); and/or the survivor having experienced early childhood violence/trauma not mitigated by protective factors (adverse childhood experiences), in particular child sexual abuse; and also, that the survivor's mother was abused.

The abusive behaviours of the perpetrators which we used as a prompt for the participants were initially derived from the forms of abuse identified in Bates et al. (2021). Additional forms of abuse emerged from the survivors' narratives and these are included in italics. The abuses were:

Physical abuse:

physical violence

non-fatal strangulation

attempt to kill (other than non-fatal strangulation and use of a weapon)

use of a weapon

threat to maim, rape or kill

domestic servitude/unrealistic expectations

several abusers (e.g., family members)

Emotional abuse:

humiliation

criticism

mind games (gaslighting)

threats to abuse family members/pets

threats relating to forced marriage/honour-based violence

manipulation of/via children

abuse of the children

disrupted sleep/exhaustion

Coercion and control

isolation from friends and family

financial control

control of behaviour in the home

control of behaviour outside of the home

forced marriage

reproductive coercion & abuse

Sexual assault

physical

ICT/online

Stalking/surveillance

Physical

ICT/online

Interim impacts: the interim impacts or outputs were identified as the survivors' emotional and psychological impacts from the abuse – which were assumed to be negative. A further assumption was that the negativity could be mitigated if survivors were able to support themselves with effective coping strategies such as, maintaining hope through religious faith, rather than substance use or self-harming. Also, if survivors had social and other support e.g., support from family and friends; if a survivor had been able to develop or maintain financial independence; if they had been able to retain

or develop outside/online activities and relationships; and/or if a survivor had prior experience of living independently (providing a vision for a post-separation future and confidence that it was achievable).

The emotional and psychological impacts which we used as a prompt for the participants were adapted from Lester (2021). Lester's research focused on the role of irrational thinking in the suicidal process. We included contributors to suicide ideation and potentially completed suicide, identified in other research. These were: cognitive constriction (Neimeyer, 1984; Shneidman, 1996), emotional dysregulation (intense, often quick, changes in mood/feelings) (Al-Dajani et al., 2019); fear (anxiety and panic attacks) (Weissman et al., 1989; Khan et al., 2002); and unbearableness (unable to live with the pain or circumstances) (Corriera et al., 2014). Our list of impacts was thus:

Hopelessness (inability to view imagine appositive future).

Fear (anxiety and panic attacks).

Unbearableness (unable to live with the pain or circumstances).

Cognitive constriction (negative event/circumstance colours perception of all event/circumstance).

Helplessness (repeated failure resulting in anticipated failure to change the circumstances).

Entrapment (subordinated in relation to a more powerful other).

Burdensomeness (lack of belonging resulting in no entitlement and/having to be grateful for help [which is not reciprocal]).

Emotional dysregulation (intense, often quick, changes in mood/feelings).

Low self-esteem (not valued for who they are).

Shame (recipient of disgust for who they are).

Imposter syndrome/perfectionism (imbalance in assessment of achievement in the face of unrealistic expectation [driven by persistent criticism from a more powerful other]).

We discuss the relationship between the abuse and impacts such as these in section 5, where we suggest that suicide ideation, and potentially completed suicide, can be prompted by perpetrators' attacks on survivors' identities, including via abusive events which create trauma-responses.

There is large number of potential coping mechanisms available to survivors. This has led to long-standing debate within research surrounding the best way to characterize coping styles (Brown and Bond, 2019). Coping may reflect either situational (unique to a stressor) or dispositional (habitual methods) ways of trying to manage stress (Ayers et al., 1996; Bouchard et al., 2004; Livneh and Martz, 2007). For this research we chose situational coping and listed coping strategies likely to be specific to domestic abuse. Our rationale was that focusing on what the survivors did, rather than aspects of who they are, may have more potential for the development of tools to assess risk. Accordingly, the coping mechanisms which we used as a prompt for the participants were:

Avoidance [requiring hypervigilance] (planning ways to prevent confrontation, including leaving home).

Religion.

Finding someone or a service to confide in for emotional support.

Finding someone or a service to help in practical ways.

Self-distraction (watching television, exercising, cleaning, cooking or a hobby).

Denial (in self-talk and telling others that everything is/will be okay).

Venting negative emotion (angry outbursts or bursting into tears to friends, neighbours/strangers, children, pets).

Substance use (drinking alcohol, taking over-the-counter drugs or illegal drugs).

Behavioural disengagement, withdrawing into self (including reduced self-care).

Self-blame.

Self-harm (e.g., cutting or picking at skin to the point of drawing blood).

Eating disorder (eating too much or too little).

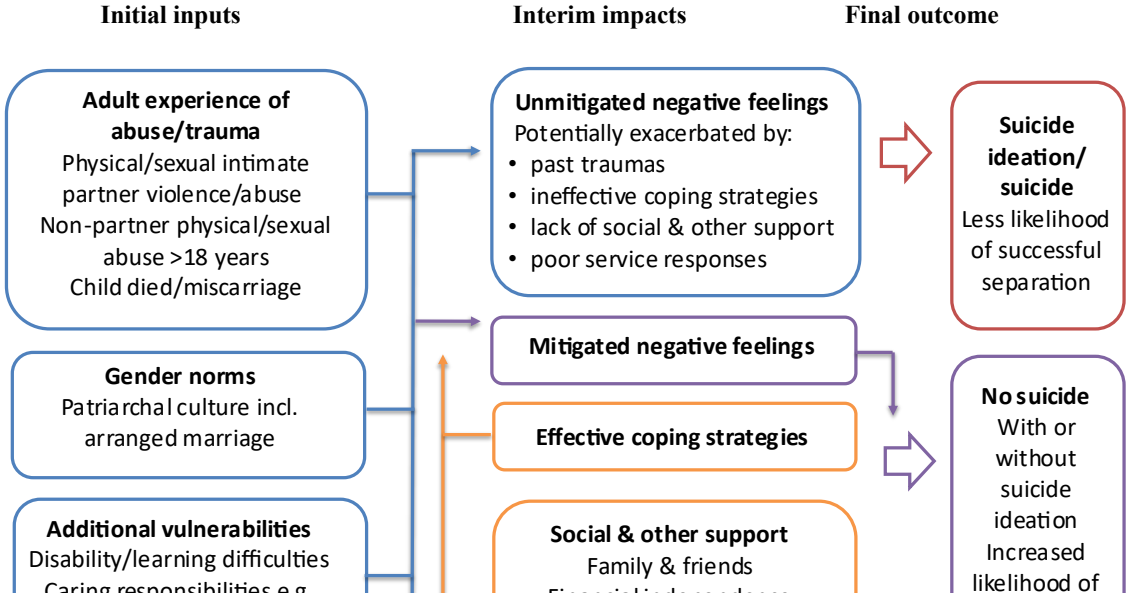
Fearing that you are going crazy (not sure what to believe/what is real. Not trusting your own judgement).

Whilst limiting this list to a manageable number of coping strategies we tried to include ways of coping which were emotion focused, problem-focused, adaptive and maladaptive. It should be noted that these coping mechanisms are not solutions and can therefore only ever be helpful/positive in the short-term. Some of the maladaptive ways are potentially seriously dangerous depending on the intensity of their use e.g., Hawton et al's (2015) finding that the risk of suicide for individuals who self-harm in the subsequent 12 months was 49 times greater than for the general population in England and Wales.

Final outcomes: the interim impacts were assumed to influence the final outcomes. As noted above, the final outcomes were anticipated to be one of the following: a survivor having experienced no suicide ideation; the survivor having experienced suicide ideation but not having attempted suicide; or the survivor having attempted suicide. In the context of data gathering via interviews, examining cases of completed suicides was outside the scope of this research (see subsection 3.2.4 on research limitations). An additional assumption was made that depending on the degree to which the interim impacts were or could be mitigated, a final outcome may be expected to be influenced by/include, an increased likelihood of successful separation.

The conceptual framework is illustrated in Diagram 2.

Diagram 2 Conceptual framework



This conceptual framework was used to develop the fieldwork interview questions (see the semi-structured interview guide in Appendix 7). An exception to this is the fact that adverse childhood experiences were not identified as potentially impactful in the original conceptual framework and in consequence did not generate questions in the semi-structured interview guide. See subsection 3.2.4 on research limitations.

3.2.2 Data collection

The principal fieldwork data were collected from 34 survivors of domestic abuse and the secondary fieldwork data were collected from two families who had lost a family member to suicide where that family member had experienced domestic abuse.

Survivors

The survivors were all volunteers who received information about the research and an invitation to participate via a domestic abuse the organisation which was supporting them in the Birmingham area. We hoped to have participants who reflected the spectrum of characteristics noted in Bates et al. (2021) i.e., ethnicity, ages, pregnancy and maternity, special needs, sexual orientation and gender. However, the fact that we were relying on voluntary participation meant that this was not within our control.

The profile of our fieldwork participant group was as follows:

Ethnicity: In addition to engaging survivors from the range of ethnic and cultural backgrounds who were likely to access generic domestic abuse support services, we were particularly keen to talk to survivors from South Asian communities. This was because we wanted to understand the extent to which so called honour-based violence and abuse might influence a survivor to choose suicide. The voluntary nature of the participation meant that scope for purposive sampling was limited but we were able to address this by approaching domestic abuse organisations specialising in support for South Asian domestic abuse survivors. In terms of ethnicity 12 (35%) survivors' experience was within a Pakistani or Indian cultural context and 14 (41%) survivors were White British. Other ethnicities included: Sudanese/Egyptian, Iranian, French Algerian, White/Black Caribbean, 'Mixed', and White/American Iraqi (see Table 1).

Table 1 Participating survivors' self-reported ethnicity

Survivor self-reported ethnicity	Number of survivors	Proportion of total
British Pakistani	9	27%
White British	15	44%
Other	10	29%
Total	34	100%
Other: British Indian Pakistani/Yemeni Sudanese/Egyptian Black Caribbean Iranian French Algerian White/Black Caribbean Mixed White/American Iraqi	 2 1 1 1 1 1 1 2 1	

Domestic abuse survivors' ethnic and cultural background can be important because the cultural meaning and degree to which suicidal behaviour may be acceptable differs between communities, and suicidality can be highly stigmatized (Bertolote et al., 2005; Alem et al., 2007a; Devries, 2011). In addition, ethnicity and cultural background can indicate a potential for a survivor to have experienced honour-based violence and abuse (HBV). In our research 15 / 44% of the survivors described circumstances which reflected our understanding of HBV. This amounted to the survivor describing feeling pressure from their birth family, the abuser's family and the wider family and community, to maintain family honour. The pressure not exhaustively included the survivor accepting an arranged marriage, undertaking the gendered role assigned to them within the relationship (in particular embracing a caring role for the abuser and his family), and the survivor maintaining the marriage at any cost. Other reasons for wanting to talk to survivors of so-called honour-based violence included the fact that more victims of honour-based violence and abuse are considered to be at risk of serious harm and homicide (68%) than are victims of generic domestic abuse (55%). And victims of honour-based violence are seven times more likely to experience abuse from multiple abusers than survivors of generic domestic abuse (SafeLives, 2017). Nineteen (56%) of the survivors experienced generic domestic abuse.

Table 2 Forms of abuse experienced by participating survivors

Honour-based violence and abuse	Domestic abuse
15 (44%)	19 (56%)

Special needs, sexual orientation and gender: only one of the survivors described having disabilities or learning difficulties when they met the abuser. She suffered from bipolar (BPD)15 and Emotionally Unstable Disorder (EUPD)16 (and the perpetrator withheld her medication, so that she "struggled more and more with feelings going from one extreme to the other". Several survivors said that the abuse and the chronic stress they experienced in the abusive relationship had left all of them with emotional and psychological difficulties and some of them with physical disabilities e.g., severe arthritis. The lack of disabled participants is perhaps not surprising as studies have shown that whilst disabled women are twice as likely to experience domestic abuse compared to non-disabled women, they are much less likely to be referred into domestic abuse services (SafeLives, 2017) – and we accessed participants through domestic abuse organisations.

In terms of sexual orientation all the survivors described themselves as heterosexual.

In terms of gender, they were all female. This was also not surprising in view of the fact twice as many women as men are victims of domestic abuse (1.6 v 0.8 million in 2019) according to the Office for National Statistics – Crime Survey for England and Wales (2019). The participating survivors referred to as 'she/her' in the rest of this report.

Age *(and relationship status):* the ages of the participating survivors ranged between 23 and 54 years, with an average of 37. See Table 3. The youngest survivor and the oldest survivor were in a relationship with the abuser, but not married, all the others were married.

Table 3 Participating survivors' ages

Average age of survivors	Age range of survivors
37	23-54

Bereaved families

The bereaved family members were volunteers who received information about the research and an invitation to participate via a policing or domestic abuse the organisation in the Birmingham area. We hoped to have participants who reflected at a minimum, different ethnicities. Despite us relying on voluntary participation, we did achieve this and also one of the two families lost a male, rather than female, family member.

3.2.3 Data analysis

In terms of data collection, we undertook the fieldwork interviews by telephone to preserve survivor anonymity and recorded with handwritten notes to provide a measure of participant anonymity and

[15] People with bipolar disorder tend to experience mania and depression.
[16] Emotionally unstable personality disorder (EUPD) is also known as borderline personality disorder (BPD). People experience intense and fluctuating emotional pain and feelings of emptiness, desperation, anger, hopelessness, and loneliness.

confidence. The data were manually coded using categories which closely reflected the prompts for the initial inputs, interim impacts and final outcomes listed in subsection 3.2.1 on the conceptual framework. Additional themes were identified as they emerged from the survivors' narratives. Notwithstanding the small sample size in the fieldwork for this research, we quantified the survivors' responses and present the data in this report together with percentages. Our thinking is that subject to the reminder of the small sample size, the percentages facilitate comparison between the different sub-groups of respondents: survivors without suicide ideation or attempts, survivors with suicide ideation but no attempts and survivors who attempted suicide.

Our analytical approach combined a phenomenological focus on the individual cases to understand the underlying structure or essence of the survivor's experience and constant comparative analysis, finding patterns and commonalities within their experience. In order to promote interpretive accuracy when lifting data from the interview responses, a holistic case study was constructed for each survivor. This process preserves a sense of the survivor as a whole person in a social context and mitigates possible fragmentation of meaning when analysing deconstructed responses under the coding categories.

3.2.4 Fieldwork ethics and limitations

Fieldwork ethics

Ethical approval for this research was provided by the University of Birmingham STEM ethics committee. The participating survivors and families were approached via the organisations supporting them; they had access to information about the research and the semi-structured interview questions. Prior to acceptance into the study the participants were risk assessed to be sure that they were in a position to benefit from, rather than being harmed through participation in the research. The participants were supported by their support workers immediately pre- and post- interview, as well as receiving a follow-up call the next day. It was extremely important to the research team that the survivors would experience their participation as beneficial to themselves. Feedback from survivors was that they felt 'happy and strong' after sharing their story; that they felt that 'someone was finally listening to them'; that they were 'so grateful' to be part of the research; that they felt 'some closure' after the interview and that they were 'excited to have been involved' with the research and felt 'lighter' after the interview.

Fieldwork limitations

A key limitation for this research was the voluntary nature of fieldwork participation. This meant that we were not, within the time constraints of the project, able to engage participants who reflected the spectrum of characteristics noted in Bates et al. (2021) i.e., ethnicity, ages, pregnancy and maternity, special needs, sexual orientation and gender. We also wanted to talk to equal numbers of survivors who had experienced no suicidal ideation, those who had experienced suicidal ideation and those who had attempted suicide; or equal numbers of survivors who had experienced forced marriage/honour-based violence. The proportion of survivors who did experience so-called honour-based violence and abuse was 44% (see Table 2, above), however no males volunteered to participate in the fieldwork and their experience is only represented by one of the two bereaved families who described the experience of their male family member. Clearly more research is needed into the experience of males who have had thoughts of suicide or have attempted suicide which was linked to them being victims of domestic abuse.

Important for planning future research was the fact that many of the survivor's experience of suicide ideation only emerged as part of the survivor's narrative in the process of reflecting on the abusive relationship and her feelings and thoughts at the time.

In relation to bereaved families, we were also constrained by the local and national lack of support organisations for families bereaved as a result of suicide linked to domestic abuse. As we did with the individual survivors, we wanted to invite bereaved family members to volunteer via an organisation which we could rely on to support them to participate in our fieldwork. This was not possible.

Finally, we note, with sadness, that in seeking an understanding of what ultimately drives a domestic abuse survivor to choose suicide the closest we can get to the experience is to engage with domestic abuse survivors who have contemplated and attempted suicide – not those who have completed it.

4 Findings in relation to abuse, cognitive/emotional impact, coping and outcomes

The fieldwork findings are presented using the conceptual framework. The tables in this section provide the data spilt into four categories for each abuse: all the survivors (34); the survivors who did not have suicidal thoughts or attempt suicide (4 / 12%); the survivors who thought about suicide but did not attempt it (19 / 56%); and the survivors who thought about and attempted suicide (11 / 32%). See subsection 1.2.4 for the definitions we used for these categories.

Importantly for the generalisability of our findings, we note that the experiences described by the survivors are typical rather than unusual for survivors of domestic abuse.

Survivors

4.1 Findings: the abuse

The initial inputs comprise the abuses experienced by the survivors; sourced from the those identified in Bates et al. (2021) (see subsection 3.2.1). The prevalence of these, and the most common forms of abuse which emerged from the survivors' narratives, are set out in this section in Tables 4 to 8 together (the abuses emerging from the survivors' narratives are italicised in the tables). The definitions of the forms of abuse are set out in Table 18, Appendix 3.

4.1.1 Physical abuse experienced by survivors

The survivors were asked what forms of physical abuse they had experienced. Analysis of their responses is set out in Tables 4a to 4g. The difference between the survivors who did not experience suicidal thoughts or attempt suicide and those who attempted suicide appears to have been influenced by the perpetrator attempting to kill them (other than through non-fatal strangulation and use of a weapon). The proportion of these survivors who attempted suicide was 82% compared to 50% of survivors without suicidal ideation/attempt (a 32-percentage point difference).

Table 4a Physical violence experienced by survivors

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
32	94%	4	100%	18	95%	10	91%

The survivors described these scenarios in the following ways:

"The abuse got worse till he was hitting, kicking and beating me. It got even worse when I had my daughter. I remember him beating me up in the car for about 40 minutes. I was completely bruised up. He would say: 'I'm going to kill you.' when he was hitting me."
"He pinned my head down and strangled me from behind. Another time he used his fist to try to bash my head in. I thought he was going to kill me."
"He hit me full in the face with a head butt. He pushed me down the stairs, he smashed up the sides of my face, he hit me with coat hangers and he threw bottles at me."
"The physical violence was very, very bad. He spilt my head open and I would see the blood spattering. Now I live with scars on my forehead and face from the different times he smashed my face and head up."

Table 4b Non-fatal strangulation experienced by survivors

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
17	50%	3	75%	6	32%	5	45%

The survivors described these scenarios in the following ways:

"Strangulation, he applied the same pressure each time and just extended the length of time he held on. If it was a small annoyance, he would do it for a couple of seconds. But there were times when I would be thinking 'he's not going to let go'. He may kill me intentionally, but he may also just get it wrong and kill me."
"He took drugs. That is against my religion. The first time I asked him to stop, he strangled me. After that he hit me and strangled me all the time."
"He strangled me often and punched me in the head because the bruises don't show through your hair. The strangling doesn't show and neither did the rapes. But he did also break my fingers and toes."
"He strangled me all the time so I always had bruises round my neck. I used to wear polo necks and scarves all the time. I had to use a really expensive foundation (£40) to cover it."

Table 4c Attempts to kill (other than non-fatal strangulation and use of a weapon) experienced by survivors

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
22	65%	2	50%	11	58%	9	82%

The survivors described these scenarios in the following ways:

"He tried to kill me in different ways, he forced pills down my throat, he strangled/ hung me, and he tried to drown me in the bath."
"He would punch and kick me. He stood on me and cracked my head."
"He beat me, punching and kicking and he also choked me (non-fatal strangulation). He threw cups at me and smashed plates over my head. One day he tried to suffocate me with a pillow."

Table 4d Abuse with a weapon experienced by survivors

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
16	47%	3	75%	6	32%	4	36%

The survivors described these scenarios in the following ways:

"He got sexual gratification from transsexuals, so he planned to give me testosterone therapy injections to change me into a male."
"He stabbed me six times with a bread knife."
"He threw furniture at me e.g., a wooden stool, a solid wooden box, bottles, glasses of wine. Sometimes he did this during the night while I was asleep."
"My life was constantly in danger. Beatings. Being forcibly held down. Threatened with an axe which he kept by the bed. He made very violent threats to my life. He held me against the doorframe naked. He tried to drown me in the shower."

Table 4e *Threat to maim, rape or kill experienced by survivors*

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
19	56%	2	50%	10	53%	7	64%

The survivors described these scenarios in the following ways:

"He would get the iron out and put it on to warm up. He would hold it to my face. I would do whatever he wanted before he actually burned me…"
"He said 'I will get someone to do an acid attack on you. No-one, not even your friends will want to look at you, let alone go out with you'. He knew how much fear that would create for me. For years

I have been trying to avoid people in public for fear of the attack. I did not tell the boys and I think they have found some of my behaviour strange."
"I didn't leave because he used to say: 'If you leave me, I will burn the house down and kill the children.' Then when I decided to leave anyway, there was no Refuge that would take my 14 year old son and I couldn't leave him."

Table 4f Domestic servitude/unrealistic expectations experienced by survivors

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
11	32%	2	50%	6	32%	4	36%

The survivors described these scenarios in the following ways:

"I had a really difficult pregnancy due to stress and exhaustion, which led to high blood pressure and pre-enclampsia. That was because of the criticism and because I was still doing everything in the house. When I was 24 weeks pregnant, he attacked me and I fell. He dragged me across the room by my hair. My daughters were crying."
"I was doing the cooking and cleaning, looking after all his needs and the baby's, and doing my university work. He was home every weekend so I asked him to help look after the baby. He said: 'you are my slave, I own you' and he beat me."
"With all the rapes he got me pregnant four times in six years. It was very hard on my body. He didn't want to know about raising the children and he made me do all the housework. He would say, 'all you're good for is cooking and cleaning.' Breastfeeding was impossible because of the stress."

Table 4g Abuse by several perpetrators (e.g., family members) experienced by survivors

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
15	44%	1	25%	10	53%	4	36%

The survivors described these scenarios in the following ways:

"If I confronted him about anything, like when I caught him with his girlfriend, he would strangle me. His mother always supported him."
"He raped me. Every time I resisted, he called his father saying how useless and worthless I was and getting advice about how to control me. I was hurting all the time. I stayed away from everyone because of the shame and humiliation."
"As soon as I became pregnant, I lost all privacy from his mother in particular. Mother and son 'ganged up' on me. She came to all my maternity appoints and texted professionals beforehand to get

time with them without me in the room. After I had the baby, they told the midwife that I was a bad mother and they needed to be there to supervise."
"In this marriage we lived with his parents and his brother. They all treated me as if I was nobody. The father and brother hit me but my mother-in-law was the main abuser. When the police came to stop him beating me the night I left, his extended family all came to the house to stop the police protecting me. The police had to call for backup to disperse the crowd."
"He and his brother kidnapped me and kept me in a locked in a room and raped me. He was very abusive. His mother was also very abusive."

4.1.2 Emotional abuse experienced by survivors

The survivors were asked what forms of emotional abuse they had experienced. Analysis of their responses is set out in Tables 5a to 5e. The difference between the survivors who did not experience suicidal thoughts or attempt suicide and those who attempted suicide appears to have been influenced by:

The perpetrator telling everyone in the survivor's social network and the services, that the survivor 'was crazy'. The proportion of these survivors who attempted suicide was 82% compared to 50% of survivors without suicidal ideation/attempt (a 32-percentage point difference).

The perpetrator manipulating the survivor's children and/or using the children to manipulate the survivor. The proportion of these survivors who attempted suicide was 82% compared to 57% of survivors without suicidal ideation/attempt (a 32-percentage point difference).

The perpetrator abusing the children. The proportion of these survivors who attempted suicide was 82% compared to 50% of survivors without suicidal ideation/attempt (a 32-percentage point difference).

Table 5a Humiliation and criticism

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"I would be in public with him, and he would start shaking and stomping his foot. I would be so scared I would wet myself. People would be staring. Then he would say: 'Look what you've done. You're disgusting, look at you, you're a fucking mess!' and everyone would stand there looking at me…humiliated."
"He 'put me down' alone and in front of others all the time. It was humiliation. He criticised my makeup, my looks; calling me names like 'slut' and 'whore'. It was embarrassment all the time. I felt 'less than' everyone else I knew."
"He would tell other people that I was a sex maniac. He would give false descriptions of me sexually and my 'performance' in bed to everyone we knew."

"He criticised me for 'never cooking proper food for the children'. I was careful how I fed the children because my mother traumatised me by forcing food into me. When he was left alone with the boys he forced them to eat. When he could, the older one ate the younger one's food, to help him cope."
"Nothing about me was good enough. So, I spent all my money on skin treatments and cosmetic surgery. He humiliated me in front of everyone about my face and body."
"The criticism was relentless. I could not take the mind games anymore. When I said I needed a break, he and his family said: 'You're the one who needs their mind seen to'. I became seriously suicidal."

Table 5b *Mind games and the perpetrator telling everyone the survivor 'was crazy'*

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
*Mind games (gaslighting)**	33	97%	4	100%	19	100%	10	91%
Abuser told everyone the survivor 'was crazy'	24	71%	2	50%	**15**	75%	9	82%

* Perpetrators exert control by manipulating the survivor into questioning their own reality; some survivors described feeling as if they were 'going mad'. This is referred to in some literature as 'gaslighting' (Tracy, 2016).

The survivors described these scenarios in the following ways:

"He re-wrote history, recalling our conversations and convincing me that my memory of what was said was wrong."
"The physical abuse is bad, but the mental abuse is far worse. He started moving things around the house and when I said something about it he would say I was imagining it, I was crazy, nothing had moved. I didn't realise it was abuse, I didn't even realise it was happening to me."
"The mind games included moving things in the house and when I noticed something had been moved, he would say it hadn't moved, that I was imagining things. Also, lying, so that I never knew what was true and what wasn't – about him (e.g., his history), what he had done or was going to do, who he had seen, what he thought or said about anything. When he is the only person, you see and talk to, you end up not knowing what to believe, what the truth is."
"He manipulated me, confusing me. He lied all the time; and he was always telling me what I saw wasn't real e.g., if I caught him doing drugs, he would say it was just 'in my head' and tell everyone that I was making up stories that weren't true. I started screen-shotting messages to try to remember what was true and what was lies."
"If we were around other people, he would whisper things like 'you slag' under his breath so only I could hear him. I would get angry, and he would say 'See I told you she was crazy'."
"My parents and all the family believed him when he told them I was crazy. He told them that he was always having to advise me how to behave."

Table 5c Threats to abuse family members/pets

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
15	44%	1	25%	8	42%	6	55%

The survivors described these scenarios in the following ways:

"If I resisted in any way he would say 'your child will suffer'. He kept threatening death on my child (our child) and my parents, as well as me. He also threatened curses through witchcraft."
"I stayed because he threatened to get social services to take my children taken away from me by telling them about my mental health problems. I left when he got worse and started threatening to kill my daughter."
"He made threats to kill my brothers and parents to stop me doing or saying things; and he would say: 'If you ever leave or I see you with another man, I'll kill you'."

Table 5d Threats relating to honour-based violence

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Threats relating to honour-based violence	6	18%	1	25%	3	16%	2	18%

The survivors described these scenarios in the following ways:

"My family and community said that a successful woman is a married woman (we are raised to know that you must not get divorced). So, I thought: "This is marriage, and the abuse is going to go on forever". There was no way out, I couldn't go back the only escape was ending my life."
"However, he treated me, I had to take it for the sake of family honour. He would say: 'don't speak in front of me, you're already divorced and you don't want to break down this marriage.'

Table 5e *Manipulation of/via children and abuse of the children*

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Manipulation of/via children (n=31)*	24	71%	1	25%	14	74%	9	82%
Abuse of the children (n=31)*	25	81%	2	50%	14	74%	9	82%

* For the purposes of data collection in this research we have separated behaviours which could be described as manipulation of/via the children and abuse of the children. However, we recognise that manipulation of a child is a form of abuse.

The survivors described these scenarios in the following ways:

"Then he gave my nine-year-old son a phone and told him to record me in my mum's house. I didn't know. My son took the film to his father. When my husband used the film to attack me, my son was confused and upset. He wanted to please his dad, but he didn't want to be the cause of his father attacking me."
"My daughter told the school: 'I hate my life because of my stepdad; he slapped my bottom; I'm scared of him etc and each time the school called him, and he allayed their fears. She was presenting textbook child sexual abuse symptoms and disclosures and he just persuaded them it was me, because I 'had mental health problems'."
"He would hold me down and go to strangle me and he would say: 'See the children are watching!'.
"He raped me a lot and filmed it and sent it to the children."
"He raped me all the time – sometimes 4/5 times a night., he would pour vodka down my throat and then rape me. He invited my child into our bed and then started to sexually assault me in front of the child."

In most cases the survivors did not tell services about the perpetrator's abuse of the children. The reasons for this include that the survivors feared that they would be accused of not protecting the children or of neglecting them, with a potential consequence of the children being removed by social services. A survivor who was in contact with services during the relationship said: "I could not be honest with them because I was too scared that they would take the children." This fear was fuelled by the perpetrators as a means of coercion and in order to avoid the household being scrutinised by children's social care. The perpetrator also benefits in the longer term because the police then do not have a record of abuse directed by him at the children if/when he seeks post separation contact and/or custody in the Family Courts.

Table 5f *Exhaustion including through disrupted sleep*

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
25	74%	3	75%	16	84%	6	55%

The survivors described these scenarios in the following ways:

"I was very, very tired from cooking, cleaning, begging for money for the children, worrying about debts; and always, the abuse. It was constant pressure. I had no time to play with my children or read to them or talk with them. He isolated me from them."
"He raped me. It was relentless – I was so tired, I couldn't sleep knowing that he was going to do it to me."; and "He would also rape me when I was sleeping. I couldn't sleep. I was exhausted."; and "He raped me when I was asleep; so, I was too scared to go to sleep. I became completely exhausted – and id didn't stop because you fall asleep when you are so tired."
"He used sleep deprivation to wear me down. I was working long hours as a full-time academic, I was also doing all the household chores. He would wake me – the good dad who had heard his son – and tell me I was a bad mum for not responding to my child when he needed me in the night. My mum stayed over several times and noticed that he was waking the child and then coming in to wake me…"

4.1.3 Coercion and control experienced by survivors

The survivors were asked what forms of coercion and control they had experienced. Analysis of their responses is set out in Tables 6a to 6f. The difference between the survivors who did not experience suicidal thoughts or attempt suicide and those who attempted suicide appears to have been influenced by the perpetrator subjecting the survivor to reproductive coercion and abuse. The proportion of these survivors who attempted suicide was 64% compared to 25% of survivors without suicidal ideation/attempt (a 59-percentage point difference).

However, the anomaly here is the survivors who experienced suicide ideation but who did not attempt suicide despite experiencing reproductive coercion and control. The proportion of these survivors was 84% compared to the 25% of survivors without suicidal ideation/attempt (a 39-percentage point difference).

Table 6a Isolation from friends and family

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"It was the control, with everything going through his mother. They bought all my clothes, she dressed me, they went through all my laundry and threw away things they didn't like. She chaperoned me if we went out. I wasn't allowed any friends or to see my family."
"All my friends and family turned against me because he told them lies, like: 'she's jealous of you'. I stopped trusting them because I didn't know what he had told them and so I couldn't trust that they were on my side."
"He told everyone my children's school: 'You don't want to talk to her, she's got serious mental health problems'. The result was that none of the other mothers would talk to me, and they wouldn't let their children play with my children."

Table 6a Financial control

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"He used my cards, so the spending was all in my name. He left me with £20k of debt. I have that debt now – I have lost any chance of financial freedom."
"He was working but I had no money, I was too scared to ask him why he had sent all the money back to Sudan. I got food from my mother and sister and money from my brother. I had two children with 11 months between them."
"He took all my money. He called me a 'money dupe'". *
* (a term popularised by the online game: 'Roblox Lumber Tycoon 2', referring to people who are easily deceived into handing over money).
"He took all the money. He took the children's money – saying he was 'just borrowing it', but he never paid it back. He sold my car and kept the money. He transferred the house into is name (on the deeds) so that he owned it."
"I have Disability Living Allowance and a bank account. He took over all the money. I had to beg for money to feed the children."

Table 6c Control of behaviour in the home

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"I was locked in a room or in other rooms. I was not allowed a bed, had to sleep on the floor. He had a sexual fetish for very fat people, so he forced me to drink weight gain shakes. He wanted me to be very fat. I had no control over my own body."
"He controlled my behaviour in the house e.g. I could only shower/bath when he said I could. He controlled how much water in the bath and how long I could stay in for. Also, when and how long I could brush my teeth. I was not allowed to put Tampax in and had to ask to buy sanitary towels."
"He counted the used teabags to ensure that I only drank one cup of tea per day."
"Inside the house I had to ask to do anything. I wasn't allowed to disturb anything e.g., the toothpaste tube or wherever anything had been put down."
"It was little things – being forced to focus on the minutest detail of everything all the time – reprogrammes your brain. I started worrying and being anxious about every little thing. I was reduced to survival mode. I lost who I was."

Table 6d Control of behaviour outside of the home

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"Our lifestyle was soon a routine of abuse. Him hitting me and controlling my shopping and looking after the household, my clothes, what I ate, when I slept and when I got up, who I visited, where I went. He cut my contact with anyone I liked. I went straight from my parent's home to him. I had a strict upbringing; I didn't know any other ways of being."
"I went across the road to a party. He texted: ''come home. I'm going to kill you; you're going with other men and taking drugs.' From what he'd done to me before, I thought: 'I can't do this anymore.' I was terrified."
"Outside the house, he controlled who I saw. I wasn't allowed to talk to men or look at them, I had to look down all the time. I was only allowed to go out with him or with people he chose. He isolated me from my friends and my family."
"He allowed me no space at all e.g., he 'liked' the music I liked, and he joined the clubs I joined and came with me. He latched onto everything I was and did and sucked the energy out of it and me."

Table 6e Forced marriage

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
4	12%	0	0%	1	5%	3	27%

The survivors described these scenarios in the following ways:

"I told my parents I did not want to go through with the wedding. They dragged me into it – what I thought, what I wanted didn't matter."
"He was my family's choice. We didn't know each other at all. He never talked to me. He just swore at me and called me 'bad' names (in his language). I told my parents I can't live here with him. But they said I had to."
"As the wedding got closer, I started getting more and more anxious, scared and depressed. I realised I couldn't live with this guy. No-one would listen to me. I chose suicide with an overdose of paracetamol. When I didn't die, I just went through with it."

Table 6f *Reproductive coercion and abuse*

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
24	71%	1	25%	16	84%	7	64%

The survivors described these scenarios in the following ways:

"Close to term the family wanted the baby out of me. They started making me walk up and down the stairs and gave me 'Asian remedies' to drink to bring on birth. The pressure was unbearable, I had stress and heartburn."
"When I announced the second pregnancy, he said: 'I will kill this baby' and he beat me for two hours. Then he threw me down the stairs."
"The abuse started when I became pregnant. He said he didn't want a girl. He tried to force me to have an abortion. I said 'No', so, he beat me up."
"I am allergic to hormonal contraception, so I had the coil put in. He made me have it removed. But when I did get pregnant, he punched me in the stomach saying: 'I hope you miscarry'."
"He tried to make me have another baby by withholding my contraception and raping me, because he wanted a boy. So, I got myself sterilised. I got a really, really terrible beating for that."

Many of the survivors talked about the attitude the perpetrators had towards women e.g. "He said all women must be controlled and that I would wish that I had behaved." and "Even now, after we have separated, he says he still 'owns' me.".

4.1.4 Sexual assault experienced by survivors

The survivors were asked whether they had experienced sexual assault and/or any ICT/online sexual abuse. Analysis of their responses is set out in Tables 7a and 7b. There was no significant difference between the groups of survivors in relation to sexual assault because only one survivor said that she was not raped by the perpetrator (in most cases this abuse was regular).

The survivors did not disclose the rape to the police (or health services). It appears that the role of rape is similar to that of non-fatal strangulation in the sense that the impact on the victim is devastating, but there is no visible evidence of the abuse.

Table 7a Sexual assault/rape

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Physical (rape)	33	97%	3	75%	19	100%	11	100%
ICT/online	2	6%	0	0%	1	5%	1	9%

The survivors described these scenarios in the following ways:

"When he started with the 'angry voice' and body movements and slamming doors. If someone scares you this much, you just want to disappear. My hands would go cold like they had been in a freezer and my spine would start to shiver. I know he was going to hold me down (strangle or rape). And afterwards he would laugh. He left no evidence [of the physical/sexual abuse] – it was like it was another thing that was in my head".
"I would wake up in the morning tied to the bed. I couldn't go to the loo. He would laugh at me. He was a 'sexual controller'. It was sexual torture. He was very sexually violent. He would rape me. I would wake up in the night and he had a hand over my mouth and rape me. Then he would cuddle up and make me a cup of tea."
"I was never allowed to say 'no' to sex – or even asked. It was like a 'wank'. He would pull down my pyjama bottoms while I was asleep (2-3am in the night) and rape me; or grab my hair and push his penis down my throat. I would be vomiting and crying, and I would wet myself. He would be shouting 'shut up, if you don't do it, I'll knock your teeth out. Afterwards I would run to the bathroom, to the toilet, he would follow me and force himself on me while I was on the toilet. It went on for years and years. In the end I learnt to be silent and motionless. Then he would call me a 'cold bitch'."
"All he did was rape me. When I was really ill he went further – anal sex. I was disgusted and the shame was unbearable."

Table 7b Online/videoed sexual assault/rape

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Physical (rape)	33	97%	3	75%	19	100%	11	100%
ICT/online	2	6%	0	0%	1	5%	1	9%

The survivors described these scenarios in the following ways:

"He humiliated me by filming himself raping me and then sharing the video with his friends and them all laughing at me."
"He would drug me and then film intimate videos of me and send them to the children. Afterwards I would find his handprints on my thighs."

4.1.5 Stalking/surveillance experienced by survivors)

The survivors were asked whether they had experienced stalking in person and/or ICT/online. Analysis of their responses is set out in Table 8. There was no significant difference between the groups of survivors in relation to stalking because almost all of the survivors described being stalked by the perpetrator in person and online.

Table 8 Stalking/surveillance

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Physical	31	91%	4	100%	17	89%	10	91%
ICT/online	33	97%	4	100%	19	100%	10	91%

The survivors described these scenarios in the following ways:

"He installed CCTV inside the house to monitor me."
"He stalked my son. He joined my son's online Pokemon Club and he also hacked into my son's school IT account and sent him messages."
"That started a two-year cycle of him stalking me and sucking me back in. I would close my Instagram account and open a new one but he always found me and was the first one trying to contact me."
"I found videos taken by him of me from 18 months before I met him, filmed from the house next door to mine. He bought the house next door and got a puppy. He used the puppy to ingratiate himself with my child and he hooked me in by inviting my child to help him walk the puppy. I wouldn't let my child go off with a 'strange' man, so I went along. He also befriended my brothers. That's how the relationship started."

4.2 Findings: additional issues emerging from survivors' narratives

Additional information emerged from the survivors' narratives which appeared likely to have influenced the survivors' thinking with respect to suicide. This was information about support the survivor might have received from her parents and/or siblings and about her contact with the external world when she was experiencing domestic abuse. Also, information about her previous relationship experience.

4.2.1 Survivors' family relationships and relationship history

This information emerged from the survivor's narratives rather than being a response to a specific question. Analysis of their responses is set out in Tables 9a to 9e. The difference between the survivors who did not experience suicidal thoughts or attempt suicide and those who attempted suicide appears to have been influenced by:

The survivor's family pressuring her to stay with the perpetrator or to take him back when they knew about the abuse. The proportion of these survivors who attempted suicide was 55% compared to 0% of the survivors without suicidal ideation/attempt (a 55-percentage point difference).

The survivor having had one or more previous relationships in which she had experienced domestic abuse. The proportion of these survivors who attempted suicide was 36% compared to 0% of the survivors without suicidal ideation/attempt (a 36-percentage point difference).

Four of the survivors described discovering that they had been groomed into the relationship as a means for the perpetrator to acquire leave to remain in the UK. In all four cases the survivor was pressured into pregnancy to create a 'right to family life' for the perpetrator.

Four of the survivors described serious difficulties in getting professionals to believe them because the perpetrator held a position of trust e.g., a witness protection social worker supporting the survivor who had left a previously abusive relationship; a GP lead for safeguarding, a youth worker in a Mosque, and a nursey worker/teaching assistant.

Table 9a Survivor's family pressured her to stay/take him back

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
14	41%	0	0%	8	42%	6	55%

The survivors described these scenarios in the following ways:

After one of the incidents when he left me unconscious … I told my mother but she wouldn't listen. Our mothers were badly treated, so abuse is regarded as 'normal'. Our mothers just say to us: 'He'll change'. But how? Abusers don't change! If you are lucky, they get tired when they get old."
"When I went crying to my family, they said it was my fault."
"He said: 'I will kill you if you leave'. I spoke to my mother. She said 'NEVER' leave him – you will be killed."

Table 9b Survivor had to cope with the perpetrator having other sexual relationships

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
14	41%	1	25%	9	45%	4	36%

The survivors described these scenarios in the following ways:

"He would take me with him when he went to see friends and family, but he would be there with her and he was intimate with her in front of everyone and in front of me. He would also make me sit next to his cousin who wanted to do sexual things and accept it – I felt disgusted."

"He fell out with his girlfriend and she phoned me and told me everything about the relationship. It was so horrible I started throwing up."
"He raped me whenever he wanted to. Meanwhile he was having an affair."

Table 9c Survivor had a previous abusive relationship

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
8	24%	0	0%	4	21%	4	36%

The survivors described these scenarios in the following ways:

"My previous partner would come home drunk and be very violent and abusive. He battered me, he strangled me, he bit my face; and he smashed the house up. He called me names. I used to hide in the bedroom with the door bolted."
"My first husband was convicted of ten counts of rape and beating – me; and the other abuses – emotional abuse and coercion/control."
"In my first relationship he was very physically abusive – beatings; stomping on my face. He pushed me to the ground and he raped me in front of our three year old daughter. When I heard from his friends that he was boasting he had 'fucked me', I knew I couldn't be more shamed and humiliated than I already was, so I went to the police, and he was convicted of rape."

Table 9d Relationship was being used by the perpetrator to get leave to remain

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
4	12%	0	0%	4	20%	0	0%

The survivors described these scenarios in the following ways:

"Our family only knew him for three months before the wedding. He was in England as a student. We did not know that he was here illegally. His plan was to come as a student, then marry to get a VISA to live in England. Everything he told me/us was lies."
"I thought he married me because he loved me; he told me he loved me. But it was all lies. It was all just to get permanent residency in the UK. His plan was to make himself look like a settled kind of guy, with a wife and kids here in the UK. It was my first relationship; but it turned out that he had left two little boys and a wife back in Pakistan."
"While I was needed to sign his VISA application extensions, he 'put up with me', but as soon as he got the VISA everything changed. He started forcing big arguments on me, to get me to leave. I couldn't leave because I had the children and wouldn't be able to work, to support myself and them."
"He had been really nice till I had the baby and he made sure it had his last name – then it became all about his VISA. He said he never loved me, he just wanted his papers."

"Every time he bought the child something. He would want a photo of him and her. She would start crying and he would start cursing her. I realised that he was building up a record of a 'happy family' for his VISA application."

Table 9e The perpetrator was a 'trusted professional'

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
4	12%	1	25%	0	0%	3	27%

The survivors described these scenarios in the following ways:

"He had a part-time job at the local youth centre teaching Islamic Studies. He used my religion against me; that's what men do in Islam. Not allowing me to talk to any man in or outside of the family, even the GP and optician."
"He was known to everyone as a kind community GP and he was the local safeguarding lead for the NHS. Shortly after we got together, he got me diagnosed as having bipolar disorder and classified as 'vulnerable adult' with mental health problems. After that I was not allowed to speak on my own behalf in medical appointments."
"No-one listened to me. I called social services saying: 'Help me'. But they would not believe me. They saw that he was a nursery nurse and later a teaching assistant and they regarded him as a trusted professional."
"Telling someone was not possible, I was isolated from family and friends and all the professionals knew and liked him."

4.2.2 Survivors' contact with the external world

This information emerged from the survivor's narratives rather than being a response to a question. Analysis of their responses is set out in Tables 10a and 10b. The difference between the survivors who did not experience suicidal thoughts or attempt suicide and those who attempted suicide appears to have been influenced by the degree to which others who knew about the abuse acted to help the survivor. Three quarters of the group who attempted suicide told someone about the abuse compared to half of the survivors without suicidal ideation/attempt. Survivors described knowing that others had seen the signs of abuse (e.g., bruises on her face, neck and arms) and/or the survivor had disclosed the abuse, yet no-one acted on the information. This circumstance applied to 91% of survivors who attempted suicide compared to 50% of survivors who did not have suicidal thoughts or attempt suicide (a 41-percentage point difference).

Table 10a The survivor told someone about the abuse

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
19	56%	2	50%	**10**	50%	8	73%

The survivors described these scenarios in the following ways:

"I talked to my mother and my sister about how he was controlling me. But my mother said that he I just being overprotective."
"These people are really good. They wear a mask in front of other people. He was always happy and bubbly and respectful to everyone. I told my brother what was going on and he said: 'No – he's such a nice, kind guy…' ."
"At the support group I attended (for mothers whose children have a learning disability) the group leader saw the open wound on my arm and asked me what had happened. I told her the truth and she said: 'Shush, shush'. I was left thinking nobody cares – what's the point in going on."

Table 10b There were signs for others/survivor disclosed, but no-one acted on the information

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
20	59%	2	50%	**9**	45%	10	91%

The survivors described these scenarios in the following ways:

"Physical abuse included regular non-fatal strangulation. People noticed the marks on my neck, but no-one took the trouble to ask about them. My work colleagues admitted afterwards that they had noticed but they were 'minding their own business'."
"He beat me up in front of friends and family for dinner. He was shouting abuse at me, hitting and kicking me, I was bleeding. Later his nephew went out and bought me a McDonalds because I didn't get any food."
"When he beat me, and I had black eyes and bruises. But I had to take the children to school. So, he told everyone there that I injured myself as part of my mental health problems. No-one asked me what happened."

4.3 Findings: the emotional and psychological impact

4.3.1 Feelings experienced by the survivors

The interim impacts were identified as the survivors' feelings as a result of the abuse (the survivors' descriptions of the emotional and psychological impact – as this requires conscious awareness, it may not have captured the full actual impact. The survivors were asked what feelings they had experienced during the relationship as a result of the abuse. Analysis of their responses is set out in Tables 11a to 11f.

There was no significant difference between the groups of survivors in relation to their feelings as a result of the abuse they experienced. However, the feelings not experienced by the three survivors who did not have suicidal thoughts or attempt suicide, were burdensomeness, shame or that their life was unbearable. It might have been useful to ask survivors about grief as research indicates that it has a powerful impact on individuals[17] (Mughal et al., 2020) and a number of survivors talked about how much they had lost. Some of the women had lost their children:

"Two years ago, when we had the first lockdown, my daughter was with him and he refused to give her back. So, I've lost my daughter. None of the abuse was documented so my description of what happened is meaningless. To negotiate contact I would have to go to contact mediation, but I can't. I'm just struggling to cope. I feel like I can't breathe most of the time."

Other survivors described losses such as:

"I had ten miscarriages from the abuse. He killed my babies – I didn't grieve. Now I am still crying." and "It came on top – realising: 'Oh my God, 15 years of my life. What has happened to me? I was really, really sobbing."

Table 11a Feeling scared; including anxiety and panic attacks

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"The fear was massive. It was what he would do in the relationship and what he would do if I tried to get rid of him. Those 'acid attack' threats were always there; they have never left me."
"He came up and gripped my neck from behind to strangle me. That was the first time – I had a panic attack. The panic attacks became constant. I became very anxious and depressed and stressed. Soon I started losing my hair in clumps."
"The feeling of real fear, terror, will live with me for the rest of my life."
"I was so shocked that someone would do the sexual abuse [rape] he did to me. I was really scared. I became so submissive, it was abject, crawling humiliation. He's still in my head all the time. "

Table 11b Feeling isolated, lonely and trapped

[17] An individual who experiences loss may have a range of feelings, including numbness, sadness, denial, anger, guilt, helplessness, depression, and yearning and sudden bouts of tears. Also, disbelief, confusion, difficulty concentrating and preoccupation, guilt, anger, restlessness and a lack of capacity to initiate and maintain an organized pattern of activities. They may have difficulty sleeping, loss of interest in daily activities, experience nausea or stomach upset, dizziness, headaches, tension and/or fatigue and be vulnerable to illness.

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	Total (n=34)	%	Total (n=4)
34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"He wouldn't allow me to see anyone. I had no friends. The only time I went out it was if he took me out. I was really, really lonely. I would sit and watch the clock tick, waiting for hours for him to come home."
"The abuse was constant, before the wound has healed it is opened up again. I wasn't able to heal to protect myself. And the damage goes deeper each time I felt trapped and suffocated, I locked myself in the bathroom to get away – and had panic attacks when I did. It was just a matter of time before I got to suicide – no hope, no point and no way out."
"You are trapped – if I had known I wouldn't have given him the time of day. Before you know it you re in over your head. In my case, with four children and no means of independent survival. And in any case, having left him, my daily life is still a living hell."

Table 11c *Fearing going crazy (not sure what to believe/what is real/not trusting own judgement)*

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"He convinced me that I had mental health problems and that if you did, then you are 'possessed by the Devil'. I was therefore a 'bad person' and 'not acceptable'.
"I ended up doubting my own thought process, my memory and my faith. He used my religion. He unpicked my identity. Even now, I doubt about who I am and what I enjoy."
"I was lost, depressed, crying all the time. I felt as if I was losing my mind."

Table 11d Catastrophizing and emotional dysregulation

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
34	100%	4	100%	19	100%	11	100%

Catastrophizing is a cognitive distortion in which a negative event is experienced as a disaster (Sam, 2013). This was described to the survivors in this research as: feeling that everything is going wrong when even quite a small negative thing happens (you drop something, someone fails to return your greeting or you mislay your keys or miss the bus). Catastrophising is clearly associated with fear of pain and a range of negative feelings including rumination, anxiety, depression, self-criticism/negative self-view (Keogh & Asmundson, 2004). Catastrophizing appears to have a bi-directional relationship with PTSD (Tull, 2021; Seligman et al., 2019).

Emotional dysregulation is an emotional response which is disproportionate to the stimulus. This occurs when an individual is overwhelmed by anxiety associated with a particular emotion. We described it to the survivors in this research as: having to manage your feelings because they can go (often quickly) from one extreme to another. Individuals experiencing emotional dysregulation are often not aware of the emotion covered by the anxiety. (Fredrickson et al., 2018). The degree of emotional dysregulation experienced by the survivors in our research is likely to have been a function of overwhelming by fear rather than 'just' anxiety.

Emotion dysregulation is recognised to be a core component of PTSD (Frewen et al., 2006; Etkin et al., 2007; Seligoswski et al., 2015). Frewen et al., 2006 also note that emotional dysregulation drives hypervigilance and attentional biases, enhanced startle response, hyper-arousal, numbing, irritability, heightened trauma memories, generalization of fear, and avoidance of emotional material or trauma reminders.

The symptoms of catastrophizing and emotional dysregulation, together with other circumstantial evidence, could be useful indicators to family, friends and professionals that a survivor may be experiencing more abuse than she is able to disclose. However, prescribed anti-depressants mask these symptoms. A survivor described this as follows:

"I have coped by being on anti-depressants for the past four years. I have been off them for one month now. The anti-depressants stop you having extreme swings in your emotions. These have come back with no medication in my system to moderate them… but I can't be on medication all my life."

Another significant challenge posed by PTSD in general and emotional dysregulation in particular is that individuals who experience them have difficulty with accurately assessing risk i.e., they have an impaired ability to discriminate between danger and safety. This is critical for survivors trying to keep themselves and their children safe (and, again, anti-depressants are likely to exacerbate the situation).

The survivors described their experience of catastrophizing and emotional dysregulation in the following ways:

"My mood was all over the place with angry outbursts and sudden bouts of crying. Colleagues were really supportive when I would suddenly start crying at work."
"The littlest thing could send me off the rails. I would be very angry and suicidal and then very calm – I never knew when I was going to be up and down. "
"I was depressed and crying all the time, but I was also arguing and aggressive or irritable with everyone."
"I was swinging between blowing up, having meltdowns and crying. Always feeling worthless and shamed."
"At first my feelings yo-yo-ed all over the place, but then I became just a shell, really empty, nothing. I had no energy for anger. I just felt pathetic and worthless, not worth the time or effort to help."

Table 11e Feeling shame

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
33	97%	3	75%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"The other emotion was shame. He coerced me into doing a lot of sexual things I am ashamed of – I am a slag." The coercion and abuse was how I ended up doing shameful things: "You feel like you can't say no." I couldn't seek help because no-one would understand the coercion and control and abuse that led up to that. There are still some things that I can only write down, I can't say it."
"I felt horrible shame from being raped. I can't be cuddled now because as soon as someone tries to put their arms around me, I get triggered into panicking and freaking out."
"The shame was awful; shame and hopelessness – me pleading with him not to rape or beat me."

Table 11f Feeling like a fraud

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"I felt like a total fraud because I had started believing that what I was getting from him was all I deserved; that I was not as good as other people and that I was not worth proper love and affection."
"Fraud – one of my sons said I was an 'impersonator'. Well, none of it was me – in the home being abused wasn't me and nor was the mask I put on to my children and outside the home. I have had two-years of therapy and my personality is just starting to come out. It has not been easy because the people closest to you have got used to manipulating you like he did."
"I was wearing a mask that everything's fine and perfect when everything was falling apart. I was falling apart."

Table 11g Feeling that life is unbearable; feeling that there is no hope of changing what is happening; feeling worthless and burdensome; and feeling hopeless

Survivors' feelings	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Life is unbearable	33	97%	3	75%	19	100%	11	100%
No hope of changing what is happening	34	100%	4	100%	19	100%	11	100%
Worthless	34	100%	4	100%	19	100%	11	100%
Burdensome	33	97%	3	75%	19	100%	11	100%
Hopeless	34	100%	4	100%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"He was just using me for sex and money; but I had become completely reliant on him. I felt so worthless and such a 'shit' mum that I believed him when he said I wouldn't be able to live without him. He said he was too good for me and that I wasn't worthy to be with him; that I was 'unbearable', 'clingy' and a burden."
"I felt worthless – he gave me the silent treatment; I felt helpless and hopeless – no future – where shall I go, what shall I do? I thought about giving up."
"I felt worthless, ashamed, very scared all the time. They (him and his parents) had manipulated me into thinking that I was a burden to everyone. I really felt like I was a burden. I felt so bad I couldn't ask anyone for help."
"He wanted me to rely on him all the time. When I did I had to be grateful. But then he would hurt me again."
"You give up because any moves you make to minimise the abuse are futile – resistance from the victim just changes how he controls and abuses. Every day I had a safety plan based on what I thought he would do. None of it stopped the beating and the rape and the psychological abuse."

4.3.2 Survivors before the abuse

We asked the survivors to describe themselves before they met the abuser and 25 (74%) of them did so. Some of them also compared themselves before, meeting the abuser with the person they now experience themselves to be after the abuse.

Examples of the descriptions of the survivors' personalities:

"Before I met him, I loved life. I was a happy person. I used to do good things, study, love my family and children. I wanted a future with a nice house and a supportive relationship."

"I used to be happy and confident. I was active and laughing and I had a good circle of friends who I had fun with. I was free to do anything. I had loving parents who I also could have fun with; and I had no financial worries."
"I was a fun and happy person. Before I was married, I was socialising, happy, confident, I looked after myself and I had my hair nice and wore makeup."
"I was exuberant, extrovert, the life and soul of the party. I was very honest and caring and loving. I was always wanting to help people. I was inquisitive, enthusiastic and curious – wanting to learn more and do more. I am a problem-solving person. I was ambitious."
And these descriptions of the survivors' accomplishments:
"I had been working before we got married and I had been learning to drive before the wedding. I was a 'normal' young woman."
"I had a psychology Undergraduate degree and a psychology Masters degree. I was commencing a conversion course turning the Masers into a PhD."
"I owned my own city-centre flat."
"When I met him, I was doing a degree in psychology to educate myself about autism (because my three children are all on the spectrum). I wanted to be a clinical psychologist."
"I was an entrepreneur; I had set up and was running a social enterprise and I was doing community work."
"I was happy. I was a qualified psychiatric nurse earning £25k pa. I also completed a university degree."
"I got my A-levels and a job and I was applying to go to university."
"I owned my own house, had a performing and teaching career, and a wide social and professional network."
"I was much more financially successful than he was. When we met, I owned my own house, I had my own business, I had money in the bank. I was a competent and confident single mum with a child."

Examples of the survivors' descriptions of how they had changed as a result of the abuse include:

"I remember being happy and carefree, a girl who didn't think twice about security (like whether a door is locked) and who's approaching me (like walking behind me in the street). Now it just takes a certain phrase, someone's appearance or expression, a location or a smell to trigger bad feelings."
"You can't go back. All I want is to feel happy again. Even with medication, I am not 'happy' like I was before all this happened."
"Before I met him, I was confident, I cared about people, I always tried to do the right thing. I was too naïve, too kind. I trusted people. I was a happy person before I met him. Now, after the physical abuse and the mental torture - I'm not the same person. I don't trust anyone anymore. I am too scared. The mental torture he put me through has scarred me for life."
"I will never be that girl I used to be – loving and free and innocent."
"I had no mental health problems, and I was able to talk without any difficulties. I used to be a first-class university student and now I am someone who can't string two words together. Now I have no job, no prospects and the conversion course has had to be postponed."
"I did not have depression until the beatings, and it got worse with the beatings when I had the baby. Now because of the beatings, I have fibromyalgia, severe asthma, arthritis and daily medication for depression. I am registered disabled and have a disabled parking badge because I can't walk far. My eldest son has depression (He is 12 years old now and always scared. He still checks to see if he is doing things right – in case he gets a beating. And my second child has autism because of the beatings while I was pregnant."
"I had lots of drive and ambition. I wanted to do things in life. I was positive. I invested in what I looked like. He got me to a point where I had no identity. Now I am having to relearn how to live again. How to care for myself and do normal things."

"I used to be such a positive person. When I did have contact with them, they said I was 'hollow' and 'empty' and 'tired'. That was from being a cheerful, positive person."
"As a result of the beatings, I am left with arthritis and serious mobility difficulties. I have had to have a walk-in shower fitted because I can't get in and out of a bath."

4.4 Findings: survivors' coping strategies

The interim impacts included the survivors' ability to introduce coping strategies which may have been effective at mitigating the negative impact of the domestic abuse in the short term. Although, some of the survivors' coping strategies were maladaptive and potentially harmful, depending on the intensity of their use. The survivors were asked about how they managed their feelings (what were their ways of coping/ how they managed their feelings. Analysis of their responses is set out in Tables 12a to 12l. The difference between the survivors who did not experience suicidal thoughts or attempt suicide and those who attempted suicide appears to have been influenced by:

Being able to benefit from particularly effective coping mechanisms, such as:

Religion – the proportion of survivors without suicidal ideation/attempt was 50% compared to those who attempted suicide 9% (a 41-percentage point difference). Additionally helpful was the fact that survivors said their religion forbade them to use alcohol and/or drugs, which research indicates are strongly predictive of suicidality.

Denial – the proportion of survivors without suicidal ideation/attempt was 75% compared to those who attempted suicide 36% (a 39-percentage point difference).

Self-distraction – the proportion of survivors without suicidal ideation/attempt was 75% compared to those who attempted suicide 36% (a 39-percentage point difference).

And not relying on harmful coping mechanisms, such as:

Self-harm – the proportion of survivors who attempted suicide who used self-harm such as cutting to cope was 55% compared to 25% for those without suicidal ideation/attempt (a 30-percentage point difference).

Substance use – the proportion of survivors who attempted suicide who used alcohol and/or drugs to cope was 50% compared to 27% for those without suicidal ideation/attempt 27% (a 23-percentage point difference).

Eating in a disordered way – the proportion of survivors who attempted suicide who ate in a disordered way was 45% compared to 25% for those without suicidal ideation/attempt (a 20-percentage point difference).

Table 12a Survivors avoidance/hypervigilance

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Hypervigilance/ avoidance	33	97%	3	75%	19	100%	11	100%

The survivors described these scenarios in the following ways:

"Hypervigilance – it was exhausting, treading on eggshells, always watching his behaviour and aware of trying not to say the wrong thing. I would be judging he body posture and his footsteps, his expression and tenseness. Even in bed, I couldn't sleep because he would wake in the night and attack me while I was asleep."
"I coped at first by 'avoiding' – drinking and going on online dating apps to make myself feel better. Then I started 'avoiding' by gambling and got into a lot of debt."
"I would sneak an online order e.g., a parcel of food; then I would have to hide the packaging in the neighbour's bin, so that he didn't find it and turn his anger on me. "
It took me a while to discover that the gas for heating and hot water wasn't broken, he was just turning it off before he went out for the day. So, I would turn it on, and then turn it off again (and let the house cool down) before he got back."

Table 12b Survivors' using religion to cope

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Religion	12	35%	2	50%	9	47%	1	9%

The survivors described these scenarios in the following ways:

"Prayer really, really helped me. Whenever I felt alone, I used to pray to comfort myself."
"Religion helped me cope. It stopped me turning to alcohol or drugs, like anti-depressants or self-harming. They are not allowed in my religion. I still pray five times a day. I work as hard as I can to be a good person."

Table 12c Survivors' finding a confidante or a service for emotional and/or practical support

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Finding a confidante for emotional support	20	59%	2	50%	13	68%	5	45%
Finding practical help	5	15%	0	0%	4	21%	1	9%

The survivors described these scenarios in the following ways:

I called the Samaritans and talked to them. When they understood what was happening, they told me to leave. With their support, I packed my bags and with help from my family and the police I left."
"I survived because I was making secret calls to a domestic abuse service for support."
"I turned to social media to have online friends."
"There was a teacher who I could talk to, she was really understanding and one day when it had been really bad, the school called the police and they took the children to a family friend (the only person I knew who didn't believe him). The school saved me."
"One of things that really helped was talking to a friend who I managed to keep up a sneaky relationship with. In the end she rescued me – calling the police and coming to fetch me in her car."

Table 12d Survivors using self-distraction and/or denial to cope

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Self-distraction	19	56%	3	75%	12	63%	4	36%
Denial	18	53%	3	75%	11	58%	4	36%

The survivors described these scenarios in the following ways:

"I used self-distraction – don't let your mind be unoccupied and have space to think about what was really happening. I did it with knitting. I typed at work and then I would come home and knit all evening till I went to bed. Knitting stops your mind thinking. It was so bad that I was diagnosed with repetitive strain injury."

"I love makeup. He didn't like me doing it, so I started doing it in secret. I would plan and start taking it off my face an hour before he was due home."
"I coped by being in denial – blanking feelings about not wanting to be here (in the world). It is a toxic coping strategy, I came very, very close to suicide. I stood in the kitchen with a knife deciding to cut my throat."

Table 12e Survivors venting negative emotion in their efforts to cope

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Venting negative emotion	10	29%	0	0%	7	37%	3	27%

The survivors described these scenarios in the following ways:

"I kept having angry outbursts. I went to his work and in the carpark, I told him that I was going to tell everyone that he was a drug addict. He pushed me across the car and started strangling me, but some men came and stopped him."
"My feelings were all over the place. I was swinging between blowing up, having meltdowns and crying."

Table 12f Survivors using drugs and/or alcohol to cope

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Substance use	8	24%	2	50%*	3	16%	3	27%

* Although this is a high percentage which could suggest substance use is effective in avoiding suicidal thoughts - relying on this coping strategy is harmful in other ways.

The survivors described these scenarios in the following ways:

"I was drinking a lot. I used alcohol to cope, to numb it all. Now that I don't drink, I get flash backs and tiggers and every day I fight with my mind."

"Alcohol. I drank too much. I have since stopped wanting to drink more than the occasional glass of wine."

Table 12g Survivors coping through behavioural disengagement (including from themselves)

All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
28	82%	3	75%	17	89%	8	73%

The survivors described these scenarios in the following ways:

"In the end I could not think straight. I could not function. I was just sitting, with a blank face, not eating, just sitting. He had got me to a point where I didn't trust anyone, so I couldn't get help."
"At first, I was shocked and then I became an emotional wreck. Then I just had 'no feelings' about it all, the abuse and about him and my life. It goes from bottling it up, then all the feelings, then just a monotone…."
"I was not caring for myself and had been reduced to almost no mental capacity by him and the hospital released me back into the house to be abused. I was suicidal."
"I was so scared of him that I 'disappeared as a person'. Me as a person no longer existed. The real me? I didn't know her; who I was, what I wanted."

Table 12h Survivors coping by blaming themselves

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Self-blame	26	76%	2	50%	17	89%	7	64%

The survivors described these scenarios in the following ways:

"Self-blame – at first, I thought if I could just be a better wife and mother it would be alright. Then I realised there was nothing I could do. Then I blamed myself for getting involved with him but by then it was too late, I had four children and no money, I couldn't get out."

"I told people, I told his parents; no-one did anything. You start questioning yourself when everyone turns their back on you. You think it must be you. So, yes, I blamed myself."
"I blamed myself and he and his friends blamed me, saying that I led him on. They called me 'psycho'. It was all my fault, I'm bad."

Table 12i Survivors coping through self-harm and/or eating in a disordered way

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34)	%	Total (n=4)	%	Total (n=19)	%	Total (n=11)	%
Self-harm	10	29%	1	25%	3	16%	6	55%
Eating in a disordered way	11	32%	1	25%	5	26%	5	45%

The survivors described these scenarios in the following ways:

"I also began over-eating. I used to be overweight years before, and started putting that weight back on again. I remember the same thing happening when I was a child and was trying to cope with my parents' domestic abuse."
"He would stand over me (for everything and) when I was cooking, criticising me and telling me I was useless. I got so stressed cooking that I couldn't eat in front of people. So, he said I had an eating disorder."
"I self-harmed after being abused as a child, but I had stopped for ten years before I met him. Then, when he started abusing me, I started again – cutting."

4.5 Findings: additional impacts related to services

The survivors were asked about the contact they had with services during the time that they were in the abusive relationship. They provided information about their contact with health services, the police, children's social care, schools, housing, immigration services, the Family courts and voluntary and community sector services e.g., community and residential (Refuge) domestic abuse services and the Samaritans. They also described the support or lack of support, they received from their colleagues, employers, peers at university and other groups. Several survivors described how services saved them, e.g:

"The paramedic examined me and then he said he couldn't feel the baby and I would have to go to hospital for a scan to check if it was okay. When I was in the ambulance (and he was following in his

car), the paramedic told me the baby was fine, they just wanted to talk to me without him there. When we got to the hospital, they took me into a room alone and they gave me toast and tea and let me call my parents."

And also, where services exacerbated the situation:

"The friend called an ambulance and the police, and they got me to hospital. The mental health team and a hospital social worker were there, and she said: 'you're not going to have your children now.' I was in a bad mental state, so I went back to my hospital room and tried to hang myself."

In this report we have focused on the feedback about contact with health services and the police.

4.5.1 Survivors' contact with the police

In twenty-two cases the police aware of domestic abuse during the relationship. Information about police involvement emerged through the survivors' narratives and is explored in the discussion below Table 13. In addition to exploring why there was no police contact, the table captures three of the emerging themes as key data-points. The fist was whether the survivor felt that the police helped her whilst she was in the abusive relationship. The second was whether the police believed the perpetrator and acted against the survivor (distinct from not acting to support the survivor). The third key data-point was whether the police helped the survivor to leave the relationship.

Table 13 Survivor contact with the police

Survivors' experience		All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
		Total (n=34) for row (a) (n=22 for rows (b) - (f)	%	Total (n=4) (n=1 for rows (b) - (f)	%	Total (n=19) (n=13 for rows (b) - (f)	%	Total (n=11) (n=8 for rows (b) - (f)	%
	Survivor was in contact with police during the relationship	22	65%	1	25%	13	68%	8	73%
	No because survivor didn't realise it was abuse	2	6%	1	25%	1	5%	0	0%
	No because survivor did not think police would help	11	32%	3	75%	5	26%	3	27%
	Police helped (in the cases they knew about)	**10**	45%	1	100%	6	46%	3	38%
	Police believed the abuser and acted against the survivor (in	**4**	18%	0	0%	2	13%	2	25%

Survivors' experience		All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
		Total (n=34) for row (a) (n=22 for rows (b) - (f)	%	Total (n=4) (n=1 for rows (b) - (f)	%	Total (n=19) (n=13 for rows (b) - (f)	%	Total (n=11) (n=8 for rows (b) - (f)	%
	the cases they knew about)								
	Police helped the survivor leave (in the cases they knew about)	**8**	36%	1	100%	4	31 %	3	38%

Almost three quarters (73%) of the survivors who were in contact with the police attempted suicide, compared with just over two-thirds (68%) of the survivors with suicide ideation. Only a quarter (25%) of the survivors who did not have suicidal thoughts or attempt suicide were in contact with the police. The main reason given for not contacting the police was the survivors' belief that the police would not help. Less than half (46%) of the survivors with suicide ideation and fewer than that (38%) of the survivors who attempted suicide said that the police helped them whilst they were in the relationship. Included in these two groups were the approximately one third of survivors [who were in contact with the police] who said that the police had helped them leave the relationship.

Of the 22 survivors who received help to leave the abusive relationship, the police were involved in eight cases. In three of the eight cases the police acted on their own and in the other five cases the police acted in conjunction with others: the survivor's parents, teenage daughter, sister and children's social care. In the other 14 of the 22 cases the survivors received help from: one (usually their mother) or both of their parents, their teenage daughters, their sisters, friends and colleagues (work and fellow mature students), Women's Aid/Refuge, health professionals such as, a midwife, the domestic abuse midwives and a health visitor; the Samaritans.

Fourteen of the survivors did not mention receiving help to leave in their description of separating from the perpetrator of the abuse.

Survivor contact with the police: discussion

Seven themes or issues emerged from the survivors' narratives in relation to the contact they could have had or did have with the police. Six of the themes highlight concerns or learning opportunities in police practice and one of the themes recognizes good practice. These were:

The survivor never being in a position to call the police. The survivors described this scenario in the following ways:

"I was alone in the house and isolated from anyone outside the house. At times I thought about suicide. I thought no-one cares, I can't get help from anyone. I would not have been able to call the police because I was never allowed to talk on the phone without being listened to."

The survivor not believing that the police would help if she did contact them. The survivors described this scenario in the following ways:

"I didn't call the police because I didn't want to make a scene. What would they do anyway? It was always my word against his."
"The police are the last resort. He started beating me and I ran from our flat to my friend's house, but he followed and punched and kicked me till I was unconscious. My son was screaming 'Stop it! Leave her alone!'. He was distraught. It is what prompted me to finally call the police."

The police lacking domestic abuse knowledge (including knowledge about how domestic abuse manifests in different cultural contexts), lacking empathy or being overtly hostile to survivor. The survivors described this scenario in the following ways:

"I dialled 999 but he made me hang up. Three days later two policewomen visited. I couldn't tell them what was going on – too scared. They referred the incident to the Health Visitor. She also didn't see what was going on. None of the professionals understand how helpless the victim is. They are the only ones who can act – but they haven't got a clue!"
"The police ask what's going on but I would never have spoken out, I would have denied it, because of his threats to kill me if I did. In any case the services ask questions too late when the control is already established."

The police 'not doing anything' to help the survivor. The survivors described this scenario in the following ways:

"I went to the police repeatedly about the stalking but they didn't do anything. Examples include:
He would drive past our house and sit outside in the driveway in someone else's car at night
He would drive past me on my way to work
He was contacting me on social media, so I blocked him; he created an Instagram account just to get contact with me.
Even now, because you can't block people on Gmail, his emails come into my Junk folder and I have to delete them
He contacted people who know me to get them to contact me for him
I discovered that there were some people amongst my Facebook contacts who were keeping him informed, so I had to delete all my Facebook friends
He had florists deliver flowers to me at work
He put Post-it notes on lampposts where I would see them on my way to work – this was scary because he would have to be there in person at the same time as me in order to get the Post-its to stick to the posts."
I went to the police each time, but they did nothing. I feared for my life, I was sure that I was going to end up dead, kidnapped or acid attacked. I had been told that he would get 'three strikes and then out' i.e., he would get two warnings and then the police would arrest him. So after several reports my mother attended the police station with me. The police didn't take me seriously until she came to the police station with me. On that occasion the police officer left the room to look at what they had on record about him stalking me. It turned out no-one had spoken to him when I had reported the stalking incidents, so he had not had any warnings. "Nothing – I had a horrible sinking feeling – we were back to the start. I felt hopeless."
"I called the police after a bad assault, but all they did was a risk assessment. They asked if he tried to kill me and when I said no, they said I was not 'at risk'. I wanted them to put a Non-molestation Order on him without me because I was too scared."

"When I did call the police they said it was out of the time limit. I didn't know there was a time limit. Women should be told to register the case. At the time we are just thinking about keeping ourselves safe. Afterwards I had been recovering, to feel strong enough to call the police. It all takes energy."
"He took the blind cord and strangled/hung me but my daughter came in and I ended up in Intensive Care. Afterwards I learned that the police came and left because I was unconscious – but they never came back for a statement and didn't ask my daughter for a statement."
"I called the police when he lost his temper and assaulted my son. It was witnessed by the other children. I wanted to press charges. The police NFA'd it. That was the last time I called the police."
"There was a teacher who I could talk to, she was really understanding and one day I told her everything. The school advised me to install hidden wi-fi cameras in the house. I put them in the three places where he usually abused me -the bedroom, the living room and the kitchen. The police believed him. It was only when the school helped me and called the police and they saw the evidence on the videos that they believed me."
"I didn't report the rapes till after we separated (because I was too scared). The police would not act on it saying it was 'revenge reporting' because he took my child."
"Telling the police doesn't make you safe. They do very little. Since we separated, he has breached Protective Orders 33 times. My case has been to MARAC[18] twice and I have been supported by a police cyberteam; but nothing has stopped him."

The police believing the perpetrator rather than the survivor. The survivors described this scenario in the following ways:

"The day I left him, he gave me a really bad beating and then he put a kitchen knife to my throat. I managed to dial 999 and he let go when he realised the police were coming. These men are cold and calculating. One minute he was raging and 'out of control' beating me and threatening to kill me with the knife at my throat, then when he realised the police were on their way, he stopped immediately. He said to me: 'You watch what's going to happen to you now!'. Then he went and put the knife back in the kitchen drawer, went upstairs and tidied himself up; then he went outside for a cigarette. When the police arrived, he was cool and in control and saying that I was hysterical and crazy. He was a drug addict and a control freak, but all the police saw was a smart, polite accountant."
"He beat me up and raped me; he left after the birth of our baby. Then, seven months later, he came back and started controlling me. He made threats about taking the baby, saying: 'I don't want you, I just want the baby.' We had a blazing row and I lost it and threatened him with physical violence. He called the police and they charged me with 'malicious communication'. I had to pay the Court costs and I was given 18 months' probation."

Poor management of intelligence by the police (not letting the survivor know how dangerous the perpetrator was/not recording the incidents – necessary in the Family Court). The survivors described this scenario in the following ways:

As the police had not kept records of when he was stalking me, I couldn't get a restraining order. I didn't have the energy to try to build up another case to get one."
"It's not until you are in court (because he takes you to court in a fight to control you through the children) that you learn that children's social care rely on the police to provide the evidence of domestic abuse reports and call outs needed to evidence risk of harm to the children. In my case the police had not recorded the reports, so no evidence is taken to mean no risk of harm."

[18] A Multi-agency Risk Assessment Conference is a regular local meeting to discuss how to help victim/survivors of domestic abuse who have been assessed as being in the top 10% at highest risk of homicide or serious harm.

Instances where the police helped the survivors – for which the survivors were extremely grateful. The survivors described this scenario in the following ways:

"My parents and family said that I should go back to him. I went back. He came into the room and said: 'Watch what I do to you.' Then he grabbed me by my hair and started hitting me. I rang the police. They came in 10 minutes and I told them everything. The police got me into a hotel for the night."
"The police were very good. They were very nice when I made a statement and they kept calling afterwards to see if he had contacted me."
"My body and face were bruised and people at university noticed and called the police. The police contacted me, but I said if he finds out that I am talking to you he will kill me. So, the police came in plain clothes and when he was away from the house. They said that they would wait for me to decide what to do, meanwhile they would record everything so that when I did want to leave him, it would ensure that I would get the baby."
"I called my father for help to leave. Then his mother called all his extended family to the house. They all had a go at me. They locked me in the house and took the baby. My father called the police who came. They locked the police in the house too, but the police made them give my son back to me. Five days later his family came to kidnap my son. They attacked my father and injured him. The police came and got rid of them."
"When he got me arrested, the desk sergeant talked to me and I told him everything. He said tell the whole story. But the solicitor said to go 'no comment' so that's what I did. I wish I had told the whole story. I didn't really understand that the controlling was abuse. I cried with relief when I discovered it was abuse. I had been feeling so worthless, hopeless and a failure."

4.5.2 Survivors' contact with health services

Twenty-eight of the survivors gave birth during the relationship and accordingly, were in contact with maternity services. Information about health service involvement emerged through the survivors' narratives and is explored in the discussion below Table 14. The table captures two of the emerging themes as key data-points. The first was the diagnosis of post-natal depression and prescription of antidepressants and the second was mental ill health diagnoses of the survivors due to the perpetrators' behaviour and influence on the health service.

Table 14 Survivor contact with health services

Survivors' experience	All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
	Total (n=34) (n=28 for rows (b) - (d)	%	Total (n=4) (n=1for rows (b) - (d)	%	Total (n=19) (n=17 for rows (b) - (d)	%	Total (n=11) (n=10 for rows (b) - (d)	%
All health services								

Survivors' experience		All survivors		Survivors without suicide ideation/attempted suicide		Survivors with suicide ideation only		Survivors with suicide ideation who attempted suicide	
		Total (n=34) (n=28 for rows (b) - (d)	%	Total (n=4) (n=1for rows (b) - (d)	%	Total (n=19) (n=17 for rows (b) - (d)	%	Total (n=11) (n=10 for rows (b) - (d)	%
	Survivor was in contact with health services during the relationship?	28	79%	1	25%	17	89%	10	91%
Mental health diagnoses									
	Survivor was diagnosed with post-natal depression	10	29%	0	0%	3	16%	7	70%
	Was the survivor prescribed anti-depressants?	14	41%	1	25%	7	37%	7	70%
	Survivor was diagnosed with mental ill health due to the perpetrator's behaviour and influence	7	21%	0	0%	3	16%	4	40%

The difference in health service contact between the survivors who did not experience suicidal thoughts or attempt suicide and those who attempted suicide was surprising:

Of the survivors who attempted suicide, 91% of them had contact with health services, compared to 1% of the survivors without suicidal ideation/attempt (a 90-percentage point difference).

Of the survivors who attempted suicide, two-thirds (64%) were diagnosed with post-natal depression compared to 0% of the survivors without suicidal ideation/attempt (a 64-percentage point difference).

Of the survivors who attempted suicide, two-thirds (64%) were prescribed anti-depressants? compared to 25% of the survivors without suicidal ideation/attempt (a 39-percentage point difference).

Survivor was diagnosed with mental ill health due to the perpetrator's behaviour and influence. The proportion of these survivors who attempted suicide was 36% compared to 0% of the survivors without suicidal ideation/attempt (a 36-percentage point difference).

Survivor contact with health service: discussion

Seven themes emerged from the survivor's narratives in relation to the contact they had with health services. The services they described having had contact with were: their GPs, community mental health services, maternity services and a dentist. Six of the themes highlight concerns or learning

opportunities in health service practice and one of the themes recognizes good practice. The themes were:

GPs not ensuring that survivors were able to see the GP alone. The survivors described this scenario in the following ways:

"I didn't go to the GP because my husband never let me go in alone."
"He accompanied me everywhere attending the GP with me. He was so intrusive and suffocating that once, at a hospital by the end of the appointment I was crying; and one of the nurses slipped a domestic abuse helpline leaflet into my pocket as we were leaving."

The survivor being too scared to disclose the abuse to the health professional. The survivors described this scenario in the following ways:

"I could not ask for help from the GP because the whole family would come with me; and they told the GP that I was a problem. My husband said: *'You're a problem. You've got a problem'.* He got the GP to record that I was a problem. Even if the GP heard my story, the backlash from the family would have been too much. So, I pretended I was fine."
"When they asked about the drink and drugs I said: 'I don't think he is drinking and taking drugs'. I told them I had a cocaine and drink problem. He would kill me if I told them it was him. I hadn't got a problem but I did want to get help. They decided I was the unprotective one."
"After I had my daughter, the CPN was visiting me every day and she could tell something wasn't right. She asked but I was saying everything was fine because I was too scared of him."

The health professionals not having sufficient knowledge of domestic abuse (including knowledge about how domestic abuse manifests in different cultural contexts). The survivors described this scenario in the following ways:

"I went to the GP but he didn't recognise what was going on (I couldn't be explicit). He just diagnosed post-natal depression and prescribed anti-depressants. I thought: 'I am living with a beast and I'm asking for help and all you can do is say: 'oh you need anti-depressants!'"

The health professionals (GP and mental health) accepting/not questioning the perpetrator's negative presentation of the survivor. The survivors described this scenario in the following ways:

"He admitted to controlling me, he said he had to do it because I had bipolar. A District nurse saw him screaming and shouting at me and pushing me in the street. The children were really traumatised by it. She reported it to the Council. They called him and he explained it all away. No-one from NHS followed it up."
"He got me diagnosed with: OCD[19], PTSD, emotionally unstable personality disorder and depression. OCD comes from everything being controlled e.g., you have/can only buy three things at the shop, which just the right money; you have to clean exactly how he tells you to; you always have a specific amount of time to do anything. You're always counting – minutes and pence and things. That's not OCD that's survival."

[19] Obsessive compulsive disorder (OCD) is a common mental health condition where an individual has obsessive thoughts and compulsive behaviours.

The health professionals not responding supportively to the survivor's 'cry for help' or disclosure of abuse. The survivors described this scenario in the following ways:

"No-one listened to me. I called the GP and social services saying: 'Help me'. But they would not believe me. They saw that he worked with children, and they regarded him as a 'trusted professional'."
"I went to see the GP who listened to my story but didn't do anything."
"I tried to raise the issue of him withholding my son's inhaler when he needed it with the GP. No success."

GPs failing to identify depression due to abuse-related trauma and prescribing antidepressants for post-natal depression instead. The survivors described this scenario in the following ways:

"Within a few months I was pregnant. That was when he started becoming controlling. He was very, very controlling around the birth. When I had my daughter, he said he didn't like girls. I was confused and exhausted. I had a baby and three autistic children all of whom had problems at school. The GP gave me anti-depressants."
"When you have a baby, they start controlling you." Health visitors see the depression, they 'diagnose' 'post-natal depression' and they medicate you. It increases his control…. I used the medication the health visitor gave me to kill myself. He came home and forced more down my throat."
"I was given anti-depressants. The GP thought it was post-natal depression (it was the abuse). The anti-depressants took me back into being suicidal. So, I stopped taking them."
"They should not 'label women'. They don't think about the fact that the anxiety could be because of him. Instead, the woman gets pathologized with post-natal depression or being 'over-anxious or having some sort of 'personality disorder'. It's abuse!"
"He compared me with other mothers saying that they were better mothers than me. It already started in the maternity hospital. I broke down and told the midwife. The doctor said it was just post-natal depression and gave me anti-depressants."

Instances where the GP, dentist, midwife in hospital and paramedic helped the survivors – for which the survivors were extremely grateful. The survivors described this scenario in the following ways:

"I was taken to hospital in an ambulance because I had had a panic attack from a beating. The hospital called the GP and the GP called persistently, telling me I can decide to leave him. I couldn't talk to the GP, but the GP booked an appointment for me to review how I was, ask if I was okay and offer help.
"It was the midwife who helped me. She saw that I was depressed and very stressed and self-harming. She said if I keep harming myself, I will kill the baby. She said I had to tell her what was going on. I told her: "I have no life, I want to die." and she called the hospital and the police. The hospital called in mental health people and the domestic abuse midwives. They kept me in hospital for three days and they got me into a woman's hostel; away from him (and his parents)."
"I was crying all the time. My mother-in-law said it was post-natal depression. But when I saw the midwife, she said it was coercion."
"When I was in hospital after attempting to kill myself, the midwife who delivered one of my children recognised me and helped me. She asked me what was really going on, she saved me."

There were also occasions when health staff practice was inappropriate:

"When we went for a scan, the obstetrician asked if I wanted to know the sex of the baby. I said yes, but my husband said no don't tell her; and the obstetrician (who was a Jamaican man) said: 'That's right, you tell her, I can see you're a man's man'."

Devries et al. (2011), in their study of survivors of domestic abuse (women), 25 – 50% of survivors with suicidal thoughts in the previous month were in contact with a health care provider during that time. Stark and Flitcraft (1996) went further reporting that medical interventions for female domestic abuse survivors with suicidality exacerbated the situation rather than providing relief or support for the survivor. Attempted suicide was seen as a 'gesture' and two-thirds (65%) of survivors sent home with no referral for help at all. Domestic abuse was not considered and instead partners and families tended to be seen as protective (Stark & Flitcraft, 1996; Devries et al., 2011).

Stark and Flitcraft also note the problems caused by prescription of anti- anxiety drugs aimed at treating presenting symptoms, rather than practitioners taking the time to explore with survivors the underlying causes of their emotional and psychological distress. Espinet et al. (2019) questioned whether the high lifetime risk of suicide (78%) among drug and alcohol users (including domestic abuse survivors) is due to the focus abstinence and relapse prevention, rather than on addressing psycho-social problems.

4.6 Findings: final outcomes

4.6.1 Suicide ideation, suicide attempts and cultural background

The survivors were asked about whether, during the time that they were in the abusive relationship, they had thought about suicide – explained as 'not wanting to be in the world anymore'; and if so, whether they had acted on those thoughts by attempting to take their own lives. Twenty-eight / 82% of the survivors thought about suicide and between a third and a half (39%) of these attempted suicide. The responses are set out in Table 15.

Table 15 Survivors' experience of suicide ideation and attempts

Survivors	Number of survivors	Proportion of survivors
Survivors who did not think about suicide (not wanting to be in the world anymore)?	4	12%
Survivors who thought about suicide with and without attempting suicide	28	82%
Survivors who thought about suicide (not wanting to be in the world anymore) but not follow through?	19	56%
Proportion of survivors with suicide ideation, who attempted suicide.	11	39%
Survivors who thought about suicide and attempt it?	11	32%
All survivors	34	100%

We considered the findings in relation to the survivors' self-reported ethnicities. As noted above this was to understand whether survivors' cultural backgrounds might influence whether or not a survivor might choose suicide. The analysis is set out in Table 16.

Table 16 Survivors' ethnicities

Survivors' actions	Number	Proportion of the total survivors	Survivors' ethnicity	Number in ethnic group	Proportion of the total survivors
Survivors with suicide ideation who attempted suicide (n=11)	1	3%	British Pakistani	9	27%
	7	21%	White British	15	44%
	3	9%	Other	10	29%
Survivors with suicide ideation only (n=19)	8	24%	British Pakistani	9	27%
	6	18%	White British	15	44%
	5	15%	Other	10	29%
Survivors without suicide ideation/ attempted suicide (n=4)	0	0%	British Pakistani	9	27%
	2	6%	White British	15	44%
	2	6%	Other	10	29%

The number of participants who were British Pakistani was 9 / 27% of all the survivors. They all thought about suicide, however, only one / 3% attempted suicide. The number of participants who were White British was 15 / 44% of all the survivors. Thirteen (87%) of them thought about suicide and 47% / 7 of them attempted suicide. The number of participants who were from 'other' ethnic backgrounds was 10 / 29% of all the survivors, 8 / 80% of them thought about suicide but only 3 / 30% attempted suicide (see Table 1 for a breakdown of the 'other' ethnicities).

Information emerged from the survivor's narratives rather than being a response to a question, was that 10 / 29% survivors were educated to degree level. Six / 55% of these survivors attempted suicide.

4.6.2 Additional information relevant to final outcomes

Additional information emerged from the survivors' narratives which provide a context for the survivors' suicide attempts. As noted above, individuals who move from suicide ideation to attempting suicide need to have the capability (access to the means) to take their own life. Our additional information includes the means chosen by the survivors who attempted suicide; also whether any of the survivors had made more than one attempt; whether being a mother with caring responsibilities might influence the decision to choose suicide. Finally, we identified who saved the survivors who attempted suicide. This information is set out in Table 17.

Table 17 Information relevant to final outcomes

Means chosen for suicide	Actual attempt – swallowing pills, swallowing hair dye and hanging,

	Planned but not followed through – in addition to those above, cutting her throat with a knife, slitting her wrists, swallowing household cleaners/bleach, jumping off a cliff or a bridge and driving the car into a tree.		
More than one suicide attempts	2	6%	One survivor tried five times.
Suicide attempts by mothers	11	32%	This was an exploration of whether having children precluded attempting suicide. These mothers said that they reached a point where they felt their children would be better off without them. Several mothers said that they had come close to attempting suicide post-separation as a result of the abuser claiming to want custody of the children and using the Family Court system to stalk them for years afterwards.
Ages of the children of the survivors who attempted suicide	3 teens 3 under 10 yrs & a baby 1 yr 10yrs 2yrs & 1 yr 4 children & a baby 6 children under/over 10 yrs 4 children in 6 yrs 1 & 4 yrs old 5 children under 1-12 yrs 2 children in their 20s & a baby		This was an exploration of whether the children's ages in any way influenced to a decision to attempt suicide. In 9 (82%) cases some or all of the children were fathered by the perpetrator.
Parties who saved the survivors who attempted suicide	Her sister and the police who tracked her mobile phone, by her daughter three times, by a neighbour and her mother; by police who found her in the street; by her son; by the abuser's friend. Saved from attempt by a midwife; by a passer-by; by the smoke alarm and the fire brigade.		

The survivors described thinking about suicide and attempting suicide in the following ways:

"I did think that the boys would be better off without me. But I knew what it was like when my mom tried to take her own life. So, I made no plans."
"I became suicidal when he was stalking me – because when you are in the relationship you think to yourself: 'I can potentially end this by getting out of the relationship'. But when you are being

stalked and the police don' stop him, you know you can't 'get out of the world' other than by suicide.
"I assumed that the police would stop it [the stalking] – arrest him, taser him, or something. When I realised the police weren't going to do anything, I thought, 'this is never going to end'."
"I didn't attempt suicide because my religion does not allow it. I would not have done it because of my daughter."
"I attempted suicide in my first marriage because I was trapped. The control was relentless, every moment of every day. …I swallowed hair dye. Someone got me to hospital."
"I left him once but my feelings got bad again after I had left him because the processes for getting support are so slow. I was very, very depressed. I was in a woman's hostel but there was no help. It was just dark ahead – nowhere to live, no way of earning money (pregnant and a single mother with two young children) and no friends. I was crying all the time. So, I went back to him; and I thought about ending my life."
"When he started with the 'angry voice' and body movements and slamming doors. If someone scares you this much, you just want to disappear. My hands would go cold like they had been in a freezer and my spine would start to shiver. I know he was going to hold me down (strangle or rape). And afterwards he would laugh. I thought about suicide."
"I started seriously considering suicide. I thought, they want the son without the mother I called the Samaritans and they told me to leave. So, I packed my bags (see above); with help from my family and the police I left."
"I was trapped because I had the threat of death from him. He was going to beat me to death before or later I told someone and my family were saying: 'Stay'. So, I was trapped. I had no work training and no way of getting a job. I had two children. No money. No house. I was so depressed I wanted to end my life. I attempted to kill myself twice."
"Suicide? I couldn't see any way out. I thought if I am out of the picture, maybe my children have a better chance. S hated our daughter; he was always jealous of her. With me out of the way he would not be able to blame her for taking me away from him."
"You can't breathe, you're suffocating. The controlling and the stalking suffocates you." I was waking up every morning feeling suicidal. you are just desperate that someone will help you. That was the light at the end of a tunnel. Near death the light wasn't there."
"My mother and sister died, I had no-one. I had no job. I had thoughts to kill myself. I still do now."

Bereaved families

4.7 Findings: abuse, impacts and outcomes

As part of our fieldwork for this research we were able to gather information from two families who had lost family members to suicide linked to domestic abuse. In one case the family member who chose suicide was female and subjected to honour-based violence and abuse. In the other case the other family member who chose suicide was male (and the perpetrator was a female partner). Their descriptions of the history and circumstances of the domestic abuse survivors' decision to choose suicide closely reflected many of the experiences described by the individual survivors in this research.

4.7.1 The abuse

These included:

Severe physical abuse, including the use of weapons and attempts to kill: "He [the perpetrator] invited her to 'go for a walk' and tried to push her onto railway tracks into the path of an oncoming train." There were also threats to kill e.g., to burn the house down during the night. Both survivors had injuries which required them to take time off work to recover.

Serious emotional abuse; including in particular, shame. One family described the fact that the perpetrator had spread stories about the survivor in the community which were relayed back to her and which she experienced as “earth shattering” and “deeply shameful”. The other family described the intense shame felt by the survivor being “unable to maintain his position as both the breadwinner and solvent”.

Coercion and control.

In one case control was exerted through the survivor’s wish to avoid bringing honour-based shame on the family. In particular she was protecting her daughters from being viewed as ‘unmarriageable’ by their community which would have been the case if she had become a divorced mother: “It is the women who hold the honour in the community”.

In both cases the survivor was isolated from friends, family and work colleagues. In terms of work, the female worked in the perpetrator’s business and the abuse was known about but: “No-one spoke about it.” In the other case the perpetrator ensured that the survivor did not remain in any job long enough to develop a supportive relationship with work colleagues.

“Each time he got a new job she would find something wrong with it and he would end up leaving and finding another one – because she didn’t trust what was going on at work. Over the three years he had 15 jobs."

In both cases financial control was used. In one case the perpetrator gave the survivor a minimal weekly allowance. In the other case the perpetrator amassed enormous debts in the survivor’s name – such that in the suicide letter the survivor explained that the sums involved were so large that he could not foresee ever being free of them to build a new post-separation life.

All the feelings experienced by the individual survivors. In one case the family members were close enough to the survivor to be able to report first-hand how she was feeling. In the other case, the survivor was isolated from the family however, he left a comprehensive suicide letter which reflected the feelings experienced by the individual survivors

4.7.2 Emotional and psychological impacts and coping strategies

These included:

In terms of coping mechanisms:

In one of the cases the survivor did talk to family members and work colleagues about the abuse. The family members reported that the survivor to a large extent minimized the abuse (a form of denial). They speculated that the survivor had ‘normalised’ the abuse. In that case also, the survivor turned to religion as a way of coping.

In the other case, the survivor did not disclose the abuse to anyone; but left a comprehensive description of the abuse and his feelings in a suicide letter.

Support from family or services:

In one case the survivor’s family and work colleagues knew about the abuse but did not act on this knowledge to support her. There had also been visits by the survivor to her GP and police callouts to the home. There had also been contact with a psychiatrist. The family described the responses from services as follows:

GP: "She approached her GP in the month before her death. However, the GP prescribed anti-depressants. By that stage she needed more support than that to cope… "

Police: "We did not call the police because when we did so before they did not do anything helpful and them coming round made things worse." The family also said that subsequent to the survivor's death it was discovered (as a result of the inquest) that the police had not recorded the call outs to the family home and in consequence there was no record of the build-up of the abuse over the years. This would have meant that even if a police officer had looked for repeated abuse in the process of assessing the seriousness of the situation, they would concluded that each incident as a 'first time' offence.

Solicitors: the family said that the survivor saw two different solicitors (accompanied on each occasion by a daughter). The solicitors' descriptions of the survivor's options and the steps she would need to follow to achieve them were too complex and stated in language which was too confusing for her to follow. This is likely to have been compounded by the fact that their attitude was 'condescending' and unsympathetic – one of them said: "Well, why are you still there?".

In the other case over the three years of the abusive relationship the survivor's family never met the perpetrator who refused to go to any functions attended by his family and friends. She got him to stop working with his brother whom he had been working with for the previous 25 years and she stopped him seeing his children who eventually rejected him. The survivor did not disclose the abuse to any family or friends and did not contact any services. His family think this reflected the high degree of shame he felt being a victim [sic] of domestic abuse.

4.7.3 The final outcomes

For both survivors the means they chose for suicide was hanging. We asked the bereaved family members whether they could identify any factors which might have prompted the timing of the suicide.

The family of the male who chose suicide thought that the context for his decision was that even if he separated from her, everything he owned would be swallowed up by the debt and he could not envisage a future in which he would be clear of it. If he managed to keep a job (with no home, car etc) his earnings would all have gone to paying off the debt for years to come. However, the timing of his decision was, in the family members' view, related to rejection by his children. The family members concluded from the suicide letter that the shame of failing as a breadwinner and being a man in the relationship, is what kept him from confiding in them and seeking their help (along with fear of what she might do to him if he did make contact). They thought that, similarly, this would have prompted him to feel that he could not face his children and repair the rejection by his children

The family of the female who chose suicide described the following incident as potentially having prompted the timing of the suicide:

The perpetrator announced his intention to divorce the survivor; and in response to her 'weeping and begging him to change his mind and help reconstitute the family', he laughed and said he did not care about the family. The impact of this incident could be understood in the context of the survivor having spent 25 years accepting unimaginable, all encompassing, abuse to avoid damaging the family honour and protect her husband and her children from possible ostracization as a result of divorce (by the extended family and community), only to have her efforts belittled and dismissed. Her perspective may have been that, in terms of the past: all she had achieved (the family honour) was destroyed and her efforts deemed worthless. And in terms of the future: she would be shamed and her children would suffer and her daughters potentially not be marriageable. Furthermore, due the cultural context of this catastrophe, she may have needed to seek support outside of her community but would not have felt confident that in doing so she would be understood.

This case reflected the circumstances for many of the individual survivors who were South Asian. That was, that their life experience was limited to moving directly from their father's household to their husband's household, entering into the relationship without the life skills and confidence to cope on their own. Once in the relationship, the husband (often supported by his family) did not allow the survivor to acquire life skills and confidence, so these survivors were significantly disadvantaged in this way, over and above any other deterrents to separation such as, lack of housing or a means of supporting themselves and their children financially.

See Appendix 5 for a profile of the findings in bullet points.

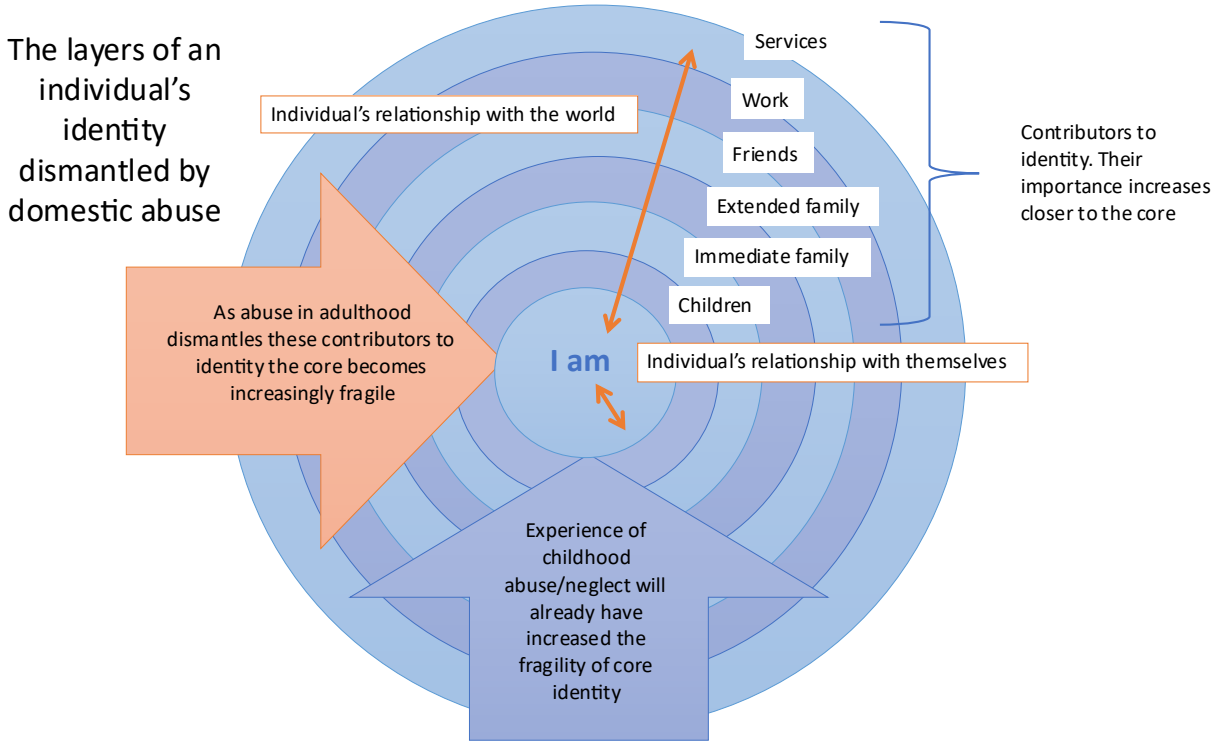
5 Theoretical Framework

Conceptual frameworks can benefit from incorporating a theoretical framework. A theoretical framework is built on a relevant existing body of knowledge which validates and can offer models for deeper understanding of the relationships between the initial inputs, the interim impacts and the final outcome.

5.1 The social construction of identity

As the context we are studying is one of relationship (between the survivor and the abuser) we chose as our theoretical framework, a social constructionist perspective of identity or self (Burr, 2015; Gergen, 2011; Berger and Luckmann, 1966). Social constructionism holds that whilst there is an objective reality, much of how people construct and negotiate identities for themselves and others happens through their everyday social interactions. In other words, identities arise from the subjective reality created through individuals' relationships with each other. To illustrate this, we used Bronfenbrenner's bioecological approach (Bronfenbrenner, 1999, 2000, 2001; Bronfenbrenner & Evans, 2000; Bronfenbrenner & Morris, 1998, 2006). See Diagram 3 in which the core (I am) represents the individual's self-identity. The categories/concentric circles emanating outwards from the core represent the likely spheres from which an individual's relationships may be drawn. In general, the importance of the relationships diminishes towards the periphery of the set of circles. The more important the relationship, the more influence it could be expected to have in the construction (or maintenance) of the person's identity. In our view this could well be the individual's partner and children, followed by other close family members, then the extended family, their friends, colleagues from work and community; and finally, people from services such as health, the police and social care. Whilst the latter contacts may be brief and/or time limited, their influence is often heightened the individual's perception of the authority or power they wield and the fact that the relationship often occurs at times when the individual is very vulnerable.

Diagram 3 Theoretical framework: relational identity construction



"On my birthday he said: 'You're looking so nice. I joked back to him, saying: 'Shame about you.' He slapped me really hard. I apologised."

And,

"When I arrived in England he met me at the airport. I was very happy, a new bride coming to my home. We stopped on the way home to get a coffee and when we got back into the car I spilt some coffee on my dress and the car. He slapped my face."

Berger and Luckmann go on to explain that conversational apparatus both maintains and modifies reality. Items are discontinued and introduced, weakening some elements of what is being taken for granted and reinforcing others. In this way, the subjective reality of something that is never talked about becomes shaky and conversely, conversation makes real or brings into existence, items which were previously fleeting or non-existent. For the survivors the positive aspects of their identities (e.g., their attractiveness, ability to make good judgements, their competence as cooks or mothers or in the workplace) were 'dropped' in this way. While their insecurities were magnified, and incompetences manufactured e.g.,

"He would criticise me all the time. Telling the children: 'Your mother can't do anything; she doesn't know anything.' But I was the one running the home, the house, looking after the children's wellbeing, schooling and happiness. I was the one worrying about money and coping with his abuse."

And, "I lost all my confidence and I became clingy – just like he said."

This process of using language to shift subjective reality was referred to by the survivors as mind games or 'gaslighting' and the examples they gave of this were remarkably similar e.g., the perpetrator would move an object in the house and then deny that it had been moved or the perpetrator would deny incidents or conversations which had taken place when the survivor reminded him of them. In all instances the perpetrator followed the denials with the statement that the survivor was 'crazy', e.g.,

"He manipulated my mind, turning things round e.g., he would say: 'I don't remember that; or it wasn't like that or I didn't say that…' If I asked him where he put something, he would say: 'you didn't give it to me.' It made me completely confused and I ended up not being able to trust myself."

This, together with the verbal attacks had the effect of destabilising the survivor's subjective reality i.e., her confidence in herself, e.g.,

"They make you scared with the beatings, strangling and threats to kill you with knives; but then on top of that they plan to make you think you are crazy; that you are losing your mind."

Berger and Luckmann confirm that the psychological self or identity that is constructed within relationship is also vulnerable to being deconstructed [in this way] within relationship. A survivor described the perpetrator's destruction of her closest relationships:

"My eldest child started talking to me in the same abusive way that he talked to me – he was damaging her relationship with me. I felt really bad about my relationship with her."

Furthermore, the more emotionally charged the relationship is (e.g., because it is with a husband or partner rather than an acquaintance) the quicker and more effective the deconstruction is likely to be (Berger and Luckmann, 1966). It can be easily seen that the deconstruction of a survivor's identity can also be quicker and more effective by coercion and control. One survivor described this as being quick because of fear: "I was so scared of him that I 'disappeared as a person'. Me as a person no longer existed. The real me? I didn't know her; who I was, what I wanted.". Other survivors described a relatively slower process: "Who you are and what you do is your identity. He dismantled all of it – he dismantled me." and*:* "He got me to a point where I had no identity. I am having to relearn how to live again. How to care for myself, meet other people and do normal things." An example of a normal thing was given by another survivor who said: "It has taken me four and a half years to be able to read a book without guilt. Before I met him, I used to read voraciously."

In circumstances where the survivor is engaged in a range of relationships, a relationship which unpicks or dismantles her subjective reality and self-identity can be balanced by a sufficient number or intensity of other positive relationships. These other relationships (e.g., a survivor's birth family and social or work networks) can shore up or rebuild a fragile and/or crumbling subjective reality and identity. However, where the survivor has limited or no access to other positive relationships (e.g., because they are being isolated by the perpetrator) the impact of a negative relationship can have serious consequences. This is illustrated by of the survivors:

"Nothing I did was okay or good enough. He objected to everything I said or did or wanted. He said I was a bad influence. He isolated me from anyone outside the home and he gave me the silent treatment. I had no one to balance the negatives."

5.2 The impact of trauma

Another way individuals' subjective realities, and through them their identities, can be impacted is when their relationships are disrupted as a result of trauma. In Diagram 3 trauma experienced in

adulthood is represented by the orange arrow and for the purposes of this study this is assumed to take the form of domestic abuse.[20] A survivor in our research described the impact as follows:

"You walk away from the abuse but the trauma is a monster. Your body keeps telling you not to enjoy yourself. There is a voice in your head 24 hours a day. I have nightmares. I wake up depressed. I bite my tongue and grind my teeth at night. I now have asthma."

And,

"So many things trigger my body into fight/flight. My legs go numb and like jelly. It's like a hot air balloon going up, no amount of sandbags will get it down. I wet myself when something triggers me. Sometimes it takes three or four days to come down again."

The potential additional effect of childhood trauma being retriggered by the domestic abuse, is represented by the blue arrow in Diagram 3. A survivor described is as follows: "I had always suppressed my feelings. I was sexually abused as a little girl (9 years old). I was really scared then, and the rapes triggered it all again." The impact of adverse childhood experiences (ACEs) is associated with heighten vulnerability for depression, PTSD, and other mental health problems (Heim & Nemeroff, 2001; Heim et al., 2000, 2002). Fuller-Thomson et al. (2016) found that the lifetime prevalence of suicide attempts among adults who had been exposed to chronic parental domestic violence during childhood was 17.3% compared to 2.3% among those without this childhood adversity. A strong relationship has also been found to exist between childhood sexual abuse and later suicidal behaviour in women (Dube et al., 2001; Fergusson et al., 2008), and child sexual abuse was found to be responsible for approximately 11% of all suicide attempts in women, in the 2004 comparative risk assessment of the global burden of disease study (Andrews et al., 2004). We note this additional vulnerability which may prompt a survivor to choose suicide, as described by a survivor in our research: "Looking back, I was very vulnerable when I met him, I had had all my boundaries violated and I was carrying deep shame from childhood sexual abuse."; although we do not discuss it in any more depth (as noted earlier we did not ask any questions about ACEs in our fieldwork).

To explore the impact of domestic abuse trauma on self-identity we selected one of the abuses listed in section 4.1 – rape. Several large-scale epidemiologic studies have emphasised the importance of cumulative adversity for increased risk of experiencing mental health problems (e.g., Breslau, Chilcoat, Kessler, & Davis, 1999; Kessler, Davis, & Kendler, 1997; Lloyd & Turner, 2003; Resnick et al., 1993). So, the actual impact will reflect the number of different abuses the survivor is subjected to. The average number of abuses experienced by the survivors was 17 and the average length of time over which they were repeated was 8 years (6 years for the survivors who attempted suicide).

We chose sexual assault/rape for several reasons:

Thirty-three out of the 34 of the survivors in our study were raped, the majority of them repeatedly throughout the relationship.

Rape is overlooked as a potential contributor to a survivor's trauma because it is so rarely disclosed (due to fear of the perpetrator, fear of police rape investigations or of not being believed; or to feelings of shame); almost none of the survivors in our research had disclosed the rape to services.

Rape can indicate potential impacts for other abuses in as much as it involves violation of both a survivor's physical and emotional/psychological integrity.

[20] Other traumas which could have a negative effect but are not the focus of this research might include a significant accident or loss of health, a bereavement, a terrorist attack or a natural disaster.

Rape can also indicate potential impacts for other abuses in so far as rape can be perpetrated with or without additional physical threats and/or injury.

We have good information about the impact of rape because it has been relatively well researched.

There is a large body of research which supports our understanding that the majority of rape survivors experience PTSD, clinically significant fear, panic disorder, depression, anxiety and other negative mood states (e.g., social phobias and obsessive compulsive disorder), sexual dysfunction, problems with self-esteem and problems with self-agency (the ability to control their life) and social adjustment (the ability to adapt to changes in their physical, occupational, and social environment) (Burgess & Holstrom, 1974, 1979a; Rothbaum et al., 1992; Veronen et al., 1979; Feldman-Summers et al, 1979; Kilpatrick et al., 1979a; Atkeson et al., 1982; Calhoun et al., 1982; Resick, 1986; Zepinic, 2016).

Rothbuam et al. (1992) reported that 94% of rape survivors had PTSD symptoms in the aftermath of the rape[21] and Kilpatrick et al. (1987) found that survivors of repeated rape were six times more likely to have PTSD than survivors of other crimes. A survivor in this research described typical PTSD symptoms as follows:

"I have not managed to move on from it all. When I sit, the events come back to me, and I have flashbacks. No matter what progress I think am making, I keep relapsing into panic, crying and depression."

Kilpatrick et al. also reported that 80% of survivors of repeated rape met a diagnosis for lifetime depressive disorder. Resick found that rape survivors had substantial long-term problems with self-esteem. In view of the lack of respect implicit in the violation of a survivor's physical and emotional and psychological integrity, it is not surprising that survivors struggle with low self-esteem. Research consistently shows that this is exacerbated by self-blame by survivors (Janoff-Bulman, 1979; Libow & Doty, 1979; Meyer & Taylor, 1985; Schnicke & Resick, 1990). Weissman & Paykel (1974) found that rape survivors experienced problems with social adjustment at work, leisure, extended family, birth family the family unit and managing finances and social relationships. Resick et al. (1988) reported that rape survivors particularly struggled with work and Kilpatrick et al. (1987) found that they were almost six times more likely to suffer from social phobias (stemming from relational distrust) than survivors of other crimes. This distrust is succinctly described by Jean Améry, a Jewish refugee, of his experience of humiliation by the Gestapo (in Leask, 2013):

'What is lost is 'an element of trust in the world' and the certainty that by reason of written or unwritten social contracts the other person will spare me – more precisely stated, that he will respect my physical, and with it also my metaphysical being. The boundaries of my body are also the boundaries of myself. (p28). (Leask, 2013)

Finkelhor and Browne's (1985) traumagenic dynamics model identifies traumatic sexualization, betrayal, powerlessness, and stigmatization as the critical mechanisms that make the impact of sexual assault particularly traumatic. Hedtke et al. (2008) reported that in their research with domestic abuse survivors, nearly all of the significant violence categories predictive of mental health problems included sexual assault, from which the researchers concluded that sexual assault is a particularly strong predictor of short-term and long-term psychopathology. A survivor in our research described the antecedents to attempted suicide as follows:

[21] Whilst longer term, given time to recover, the proportion reduced to approximately half, the survivors in this research were being repeatedly raped and therefore did not benefit from having time to recover.

"It was humiliation and shame because of the sex he forced on me….and terror. Going from on emotional extreme to the other. Hopeless, helpless and trapped – 'I couldn't go on'."

Becker at al. (1986) found that 37% of sexual assault survivors had at least one sexual dysfunction attributable directly to the assault, compared to 17% for individuals not subjected to sexual assault. The importance of this lies in the effect of sexual dysfunction on sufferers. It includes stress and anxiety, concern about sexual performance, relationship problems, depression, guilt, self-consciousness and, for survivors – intrusive thoughts and feelings related to past sexual trauma (Cleveland Clinic, 2015). Other psychological and emotional impacts rape survivors have been found to struggle with include anger and hostility (related to the distrust noted above), confusion/worrying about the clarity of their own thinking this will have facilitated the 'gaslighting' the survivors in our research experienced – 91% of those who attempted suicide; Table 5) and exhaustion (Kilpatrick & Veronen, 1984; Kilpatrick et al., 1987).

Many of the survivors in the above research would have been living in circumstances which were at the very least neutral if not overtly supportive. The impacts for them are likely therefore to have been less negative than would be the case for the survivors in our research, many of whom were experiencing repeated rapes, who were raped by their partner and who did not have a supportive home life or easy access to a network of social or work colleagues, or the ability to reach out without fear to professionals for support. Ruch et al. (1980) confirm this likelihood, reporting that women who had experienced major stressors in the year prior to being raped were most traumatised. Interestingly, Ruch et al. also found that women who had not experienced any stress were also very traumatised. This may be relevant for the survivors in our study from South Asian backgrounds who described themselves as having had a protected upbringing and having moved straight from their birth family into the abusive relationship.

"Girls in British Pakistani culture are raised to get a good education but also to be married early. We were brought up really strictly. I knew a man wasn't supposed to treat a woman like this. But we are not taught about abuse. I didn't know about abuse. I knew it wasn't right, but I didn't understand what was happening."
"We women don't know how to protect ourselves. We are brought up so that we won't be able to live without a husband, a man. We have no knowledge about how to be an independent adult. So, we are very scared in the world. We are protected from society; we don't learn about society. I had no exposure to the world. This was the first man who came into my life. We won't recognise a man with a bad attitude and a plan to use you."

Wirtz and Harrell (1987) found that prior life-threatening events were associated with greater post-rape fear (e.g., see non-fatal strangulation in in sub-section 2.2.2); described by a survivor as follows:

"He was very verbally abusive. He started beating me very badly almost every day. Strangling me. I thought: 'I will never see tomorrow…'. The fear was terrible."

The role of non-fatal strangulation in this is important. A survivor explained it as follows: "He stabbed me six times with a bread knife, but the strangling makes you live just on your survival instinct." Perloff (1983) looked for a link between pre-assault cognitive appraisal and post-assault trauma and found that people who believe that they control their lives and environments make the poorest adjustments to events outside of their control. This conclusion was supported showing that rape survivors who appraised the situation as safe prior to the assault had greater fear and depressive reactions than women who perceived themselves to be in a dangerous situation (Scheppel & Bart, 1983; Frank & Stewart,1984). This is relevant to the survivors in our research who assumed that their husband/partner was safe.

In singling out one abuse we wanted to emphasise that each form of abuse brings a unique constellation of negative impacts. These are cumulative and the harm is accordingly heightened (Hedtke et al., 2008). Additionally – relevant to our study, in which 97% of the survivors had been raped, Bichard et al. (2021), in a study of over 4,000 women, found that nearly all of the serious violence categories which predict mental health problems included sexual assault. They conclude that this would suggest that sexual assault is a particularly powerful driver of short-term and long-term psychopathology, in particular PTSD and depression. This was supported by Ellis et al. (1981), Kilpatrick et al. (1987) and Resick et al. (1988) who found that between a third and a half of rape survivors had contemplated suicide (Kilpatrick et al. found this to be three times the proportion of non-crime victims) and Resick et al. reported that 17% of the rape survivors in their research had attempted suicide. Also identifying the negative impact of rape, Joiner et al. (2007) and Hetke et al. (2008) concluded from their research that the combination of physical violence and physically violent sexual assault are a strong predictor of future suicide attempts.

5. 3 Theoretical framework summary

We introduced the theoretical framework as a way of exploring in more detail the potential link between the abuses and the emotional and psychological impacts set out in the conceptual framework and suicide. One of the mechanisms through which the perpetrators achieve this is by systematically destabillising and disintegrating the survivor's self-identity (Zepinic, 2016) through disruption of their relationships including their relationships with themselves. The other mechanism is the perpetrators subjecting the survivors to abuse in which each event creates severe trauma (the impact of which can include retriggered trauma from adverse childhood experiences). To explore this we used the example of rape, in the process highlighting the fact that rape is common (experienced by all but one of the survivors in this research) and usually not disclosed by domestic abuse survivors. Rape is particularly associated with short-term and long-term psychopathology e.g., PTSD; particularly when experienced in conjunction with life-threatening events such as, non-fatal strangulation; it prompts suicide ideation and attempted suicide. The link is the dismantling of the survivors' self-identity depleting their psychological and emotional resources and increasing the chances that a survivor might come to view their future, or respond to one more incident, with depressive symptoms of worthlessness (Wolford-Clevenger and Smith, 2016) – and attempt suicide. A survivor described this as follows:

"They take a little bit of you away every day. They chip away at your identity every day. "He took everything that was me away."

The bereaved families provided examples of this – for the male victim it was recognising the enormity of the debt he was left with, together with the shame he felt at not being able to fulfil the expectations he had of himself as head of the family/breadwinner. For the female victim it was facing the perpetrator's dismissal of family honour as irrelevant (and his destruction of it via divorce) after she had endured 25 years of severe abuse to maintain it.

6 Quantitative Analysis

6. 1 Overview

In this chapter we analyse a unique dataset combining police data on all incidents involving domestic violence (DA) matched to data from coroners' offices on suicides. Suicide is mercifully rare, and this limits the number of cases in our data. Our analysis of the data is thus largely a graphical one, building understanding of the relationship between DA and suicide. Our results highlight that a) suicide is around 1.8 times as common amongst those who have been recorded by the police as the victim or perpetrator of DA than in the population as a whole; b) but that this increased risk of suicide is no greater for women than for men, even though women are the victim of abuse in many more incidents

than their male equivalents; c) being involved in a greater number of DA incidents and more recently are associated with increased risk of suicide.

6. 2 Data

The data are from two main sources. Firstly, we use data from West Midlands Police, for Birmingham, Coventry, and Solihull on all records that have an Offence Type of 'DA' or more recently a keyword of 'Domestic Abuse'. These data cover the period 2010-2021 and comprise around 1.9 million individual-incident pairs. That is each record is a description of a particular person involved in a given incident.

These data are matched based on full name and date of birth to data from the Birmingham and Solihull, and Coventry Coroner's offices on all deaths involving suicide. The resulting match covers 1.6 million individual incident pairs, for the period September 2014 onwards (Coventry) and August 16 onwards (Birmingham and Solihull).

An important strength of the data is that we can track an individual over time via a unique identifier. This means that, as below, we can try and understand an individual's behaviour over multiple incidents. Moreover, the fact that the WMP data cover the 4-6 years before the coroners' data means that we are potentially able to understand the consequences of sustained abuse over many years versus an individual incident.

Of course, many people who commit suicide do not do so because of domestic violence. Important for our analysis is that we can compare the rate of DA amongst those who have either perpetrated DA or have been the victim of DA (and thus who appear in the WMP data) and the population as a whole. To do this we also use data from the Coroners' offices on Suicides not linked to DA, and demographic data from the ONS on the underlying age and gender distribution of the population. We thus have two data sets the first describing the *DA-population* (those in the WMP data), and the second basic demographic information on all other suicides, the *overall-population.*

As discussed in the limitations section we are categorising individuals solely based on police reports. This means that if the police data are inaccurate about what happened at some incidents, then our results will be inaccurate. Equally, there will be events that are not reported to the police. We are not able to account for these events in our analysis. Our assumption is that at least some of the events that are not reported to the police are violent, but that the most serious ones are reported – say because medical care is necessary -- and are thus in our data. This is a reasonable assumption, but it is not possible to test it.

6. 3 Results

6.3.1 Rates of Suicide Amongst DA

We begin by comparing rates of suicide amongst men and women in the DA-population and the overall-population. There are a total of 22 suicides by women in the DA sample, and 50 by men. Looking at Table 6.1 we can see that amongst those who commit suicide and who are either a perpetrator or victim of DA, men are much more likely to be perpetrators of domestic abuse than women. Of the 50 male suicides in this group, 45 or 90% involved men as solely a suspect or both a suspect and a victim. On the other hand, in nine out of the 22 female suicides they were purely a victim (on the basis of the police data). (Note that one case is missing here as there is no date of death available.)

	VictimOrSuspect			
Sex	Both	Suspect	Victim	Total
Female	13	0	9	22
Male	12	33	5	50
Total	25	33	14	72

Table 6.1: Suicide by Sex and role

This implies two basic conclusions. First, in many cases relationships are more complicated than a simple abuser-abusee pairing. Second, even allowing for that men are disproportionately likely to be the sole suspect.

To better understand the 'both' classification we defined a second variable *DiffSuspectVictim* which records the number of times more that an individual was classified by the Police as a suspect than as a victim. Thus, a repeated perpetrator who was classified as a suspect ten times, and who was considered both a victim and a suspect at one incident, would receive a score of +9. And their victim would receive a score of -9. These data are presented in Figure 6.1, limiting the x-axis to 40 in absolute value for clarity. The large spike at zero reflects two things. First, that, as above, in many cases an individual is both a suspect and a victim. Second, it reflects the fact that in most cases there are not repeated domestic violence incidents involving the same individuals.

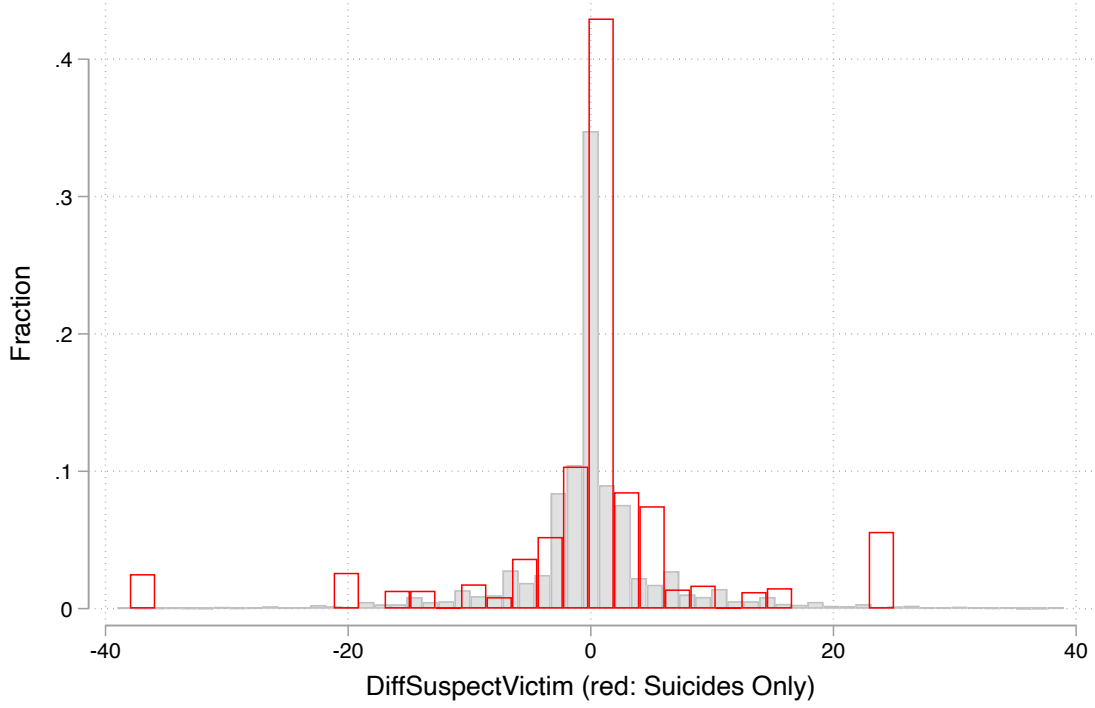


Figure 6.1: The Difference between the number of times an individual was classified as a suspect and a victim.

The long tail either side of zero is not immediately straightforward to interpret as large (absolute) values will reflect both that some individuals are involved in many incidents and that some individuals are almost always a victim or a suspect. To address this, Figure 6.2 presents *DiffSuspectVictim_pct*, which is the *DiffSuspectVictim* variable divided by the total number of times an individual was classified as a suspect or victim. This variable is a measure of the extent to which an individual is a perpetrator or a victim. It is clear that the vast majority of individuals are to a greater extent either perpetrators or victims, and that there are only a small number of individuals who are perpetrators and victims in roughly equal measure. This suggests that that the 'both' classification maybe somewhat misleading. This is true both for those who chose suicide as well as the other individuals in the data.

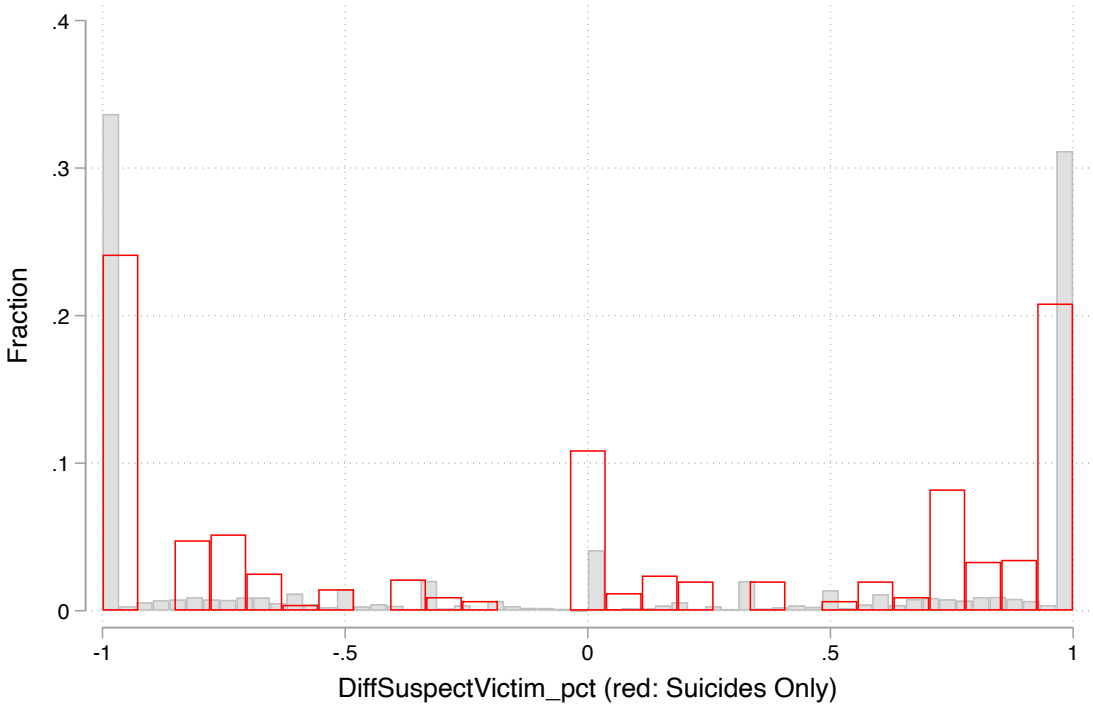


Figure 6.2: The Difference between the number of times an individual was classified as a suspect and a victim as a percentage of the number incidents.

Figure 6.3 presents the same data as Figure 6.2, but now disaggregates by gender and focusses on those who chose suicide. We can see that distribution for women given by the red boxes is concentrated below zero on the x-axis, while that for men is conversely mostly in the positive region. This makes clear that most of the men in our data are disproportionately categorised by the police as perpetrators rather than victims.

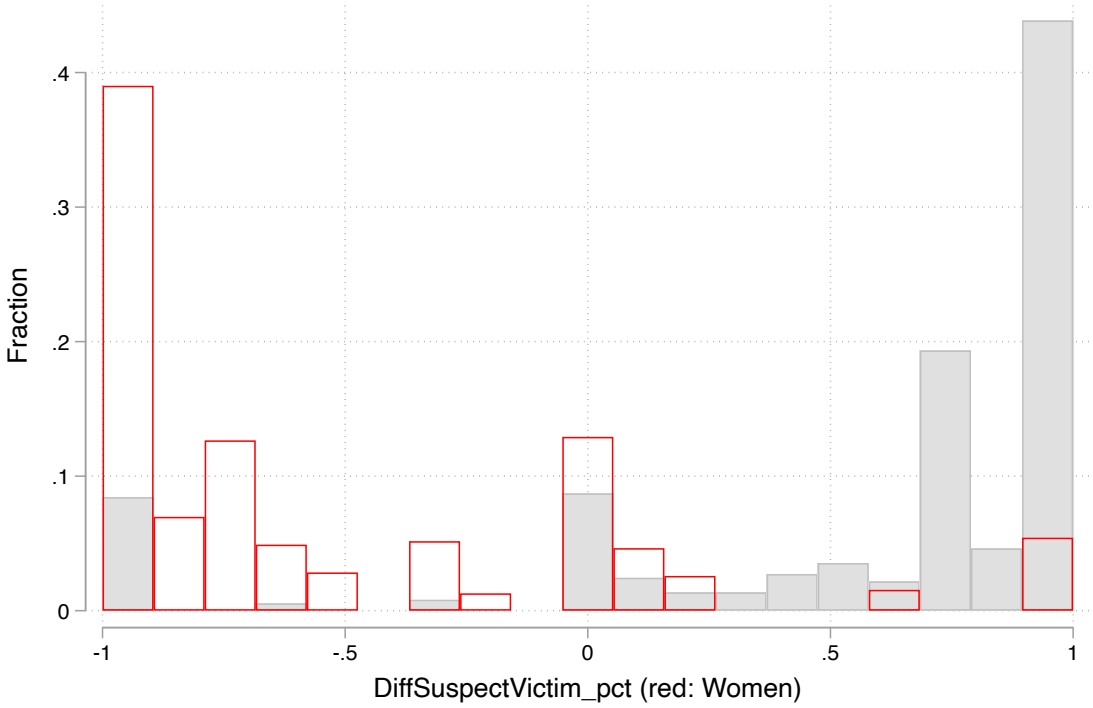


Figure 6.3: Gender Differences in the number of times an individual was classified as a suspect and a victim as a percentage of the number incidents.

The overall conclusion from these data is thus that in the DA-Population suicide is most common amongst the perpetrators of DA. As discussed below, this raises many interesting questions about mental-health, DA, and suicide.

6. 3.2 Comparison of the incidence suicide in the DA- and overall-populations

We now analyse how the incidence of suicide in the DA-population compares to its incidence in the overall-population. Figures 6.4a and 6.4b presents the distribution of suicides by age and gender amongst the DA-population and the overall-population.

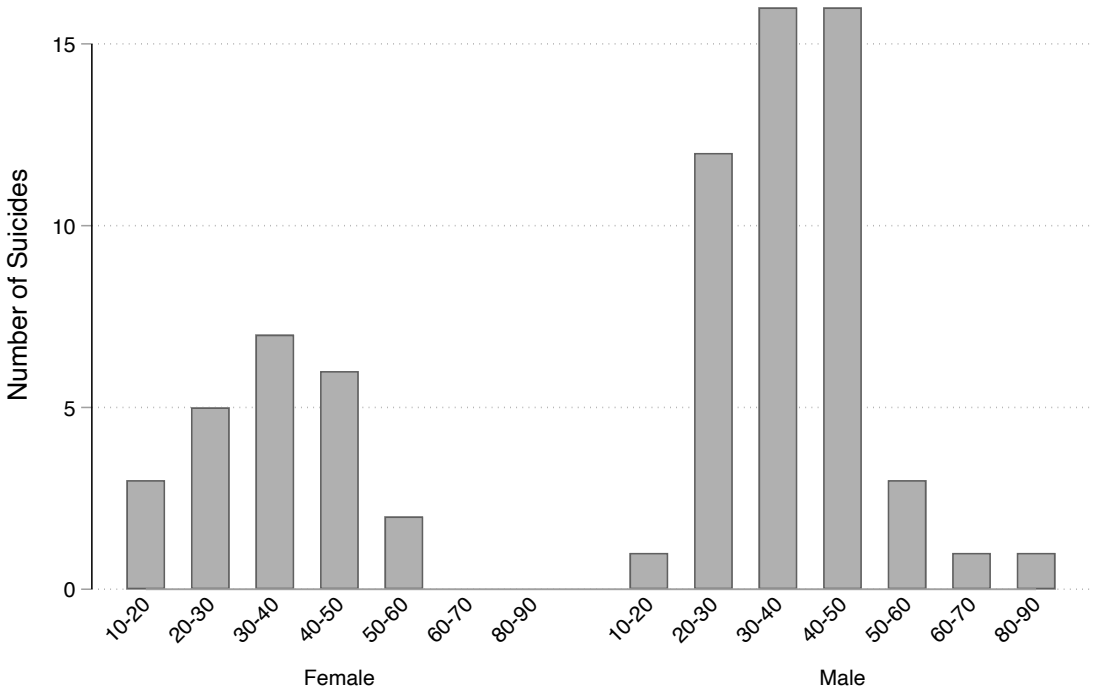


Figure 6.4a: Incidence of Suicide by Age and Gender: DA-population.

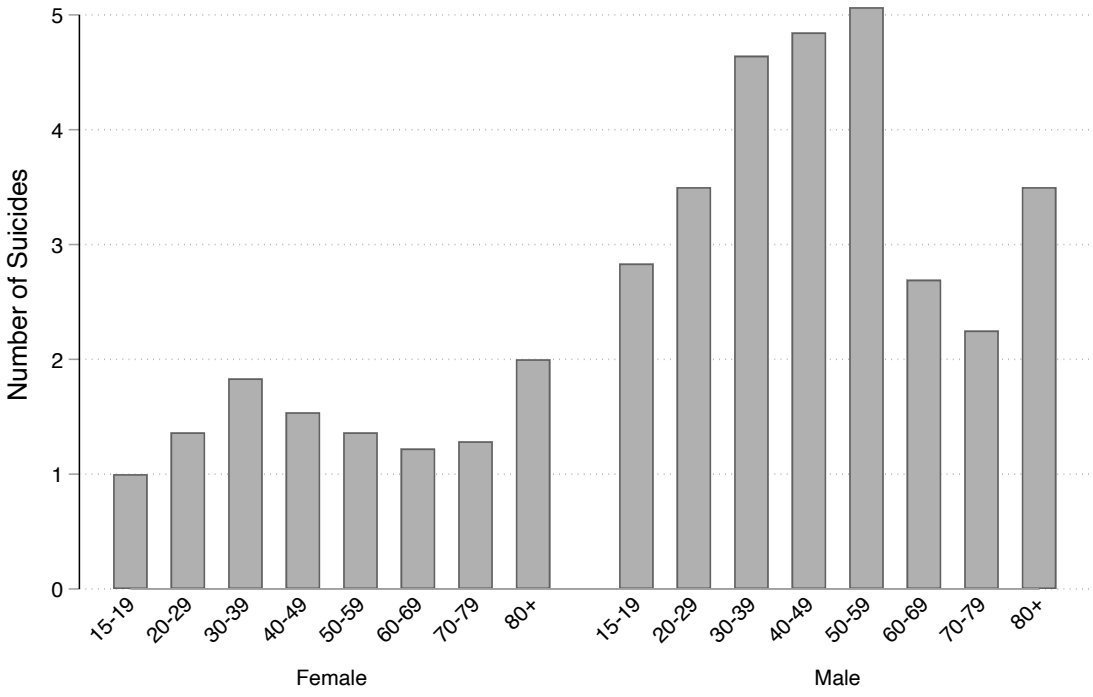


Figure 6.4b: Incidence of Suicide by Age and Gender: overall-population.

We can see that they are very similar. In both populations the rate amongst men is considerably higher than amongst women. One difference between the two is that suicide amongst older men is less common in the DA-population than it is, relatively speaking, in the overall-population. Indeed, we observe no suicides amongst men or women aged 70-80 in the DA-population.

This similarity raises two questions. First, is suicide more common in the DA-population than in general? Second, is the gender split in the DA-population different to that in the wider population?

To address the first question, we note that there are 73 suicides in the DA data, out of a total of 395,532 identified individuals. This is a rate of 0.018%. In the overall-population we observe 441 suicides, and the overall-population is around 1.299 million adults, implying a rate of 0.034%. Thus, suicide is much more common in the DA-population than it is amongst the overall-population.

To answer the second question, we compute the ratio of the share of women suicide victims in the DA-population to the share of women suicides in the overall population. This is (22/73)/(104/441)=1.278. A statistical test suggests that we cannot reject the hypothesis that the two proportions are in fact the same. This is consistent with the relatively small numbers of suicides making statistical analysis more difficult, and the consistency between the two populations we saw in Figures 6.4a and 6.4b.

Thus, in summary, suicide is much more common in the DA-population but there is no statistically significant evidence that it raises the rate of suicide amongst women more than amongst men.

6.3.3 The Relationship Between DA and Suicide.

In our preceding analyses, there has been an implicit link between DA and suicide. In part, reflecting the conclusions of the qualitative analysis. It is beyond the scope of this report and the available data to consider the structure of any causal relationship. However, it is useful given suicide is more common in the DA-population to understand what correlations there are between the form and intensity of DA and suicide.

The WMP data contain a wide range of incidents varying from non-crime DA to murder. We now consider whether the nature of the DA is different between cases where there is a link to a subsequent suicide and those where there is not. In both cases just over half of incidents (52% and 52.7%, respectively) are categorised as 'Domestic Violence Incident - Non Crime'. Of incidents categorised as crimes around 14% involve 'Assault Occasioning ABH' and 8% 'Common Assault'. There is some difference in the remaining 25% of cases. Other common crimes include 'Malicious Wounding, Breach of Restraining Order' and 'Harassment' 'Malicious Wounding', and 'Criminal Damage to Dwelling'. Thus, it would seem that there is little difference in the types of offence associated with suicide and others.

We now consider the number and intensity of events. We note that were there to be no correlation between DA and Suicide, then we should expect there to be no pattern in when suicides take place and DA incidents. In Figure 6.5 we plot the number of weeks between the last DA Incident involving the Police and the date of death. We can see that broadly speaking, the risk of suicide declines the more distant in the past the last DA Incident. One complication is that we should expect the number of suicides to decline over time amongst the population of those who do eventually commit suicide, precisely because they do commit suicide. But, nevertheless we interpret the sharp decline after around a year as suggestive of a correlation between DA recency and suicide.

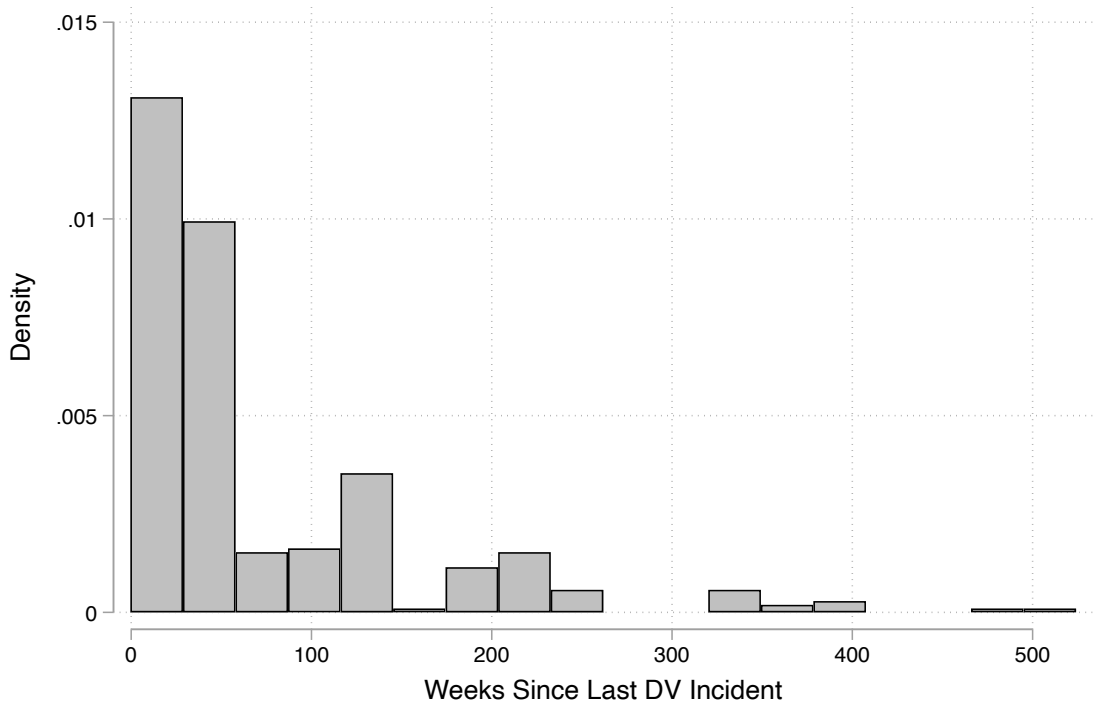


Figure 6.5: Time since last DA-incident and Suicide

We might also expect that a (positive) correlation between DA and Suicide would mean that there were more Police Incidents associated with individuals who subsequently chose suicide. Figure 6.6 plots the distribution of the number of incidents for individuals who did and did not subsequently commit suicide. The distributions are similar, and we should be cautious about over-interpreting small differences given the limited number of suicides. However, the data do suggest that individuals who subsequently commit suicide are involved in a greater number of incidents

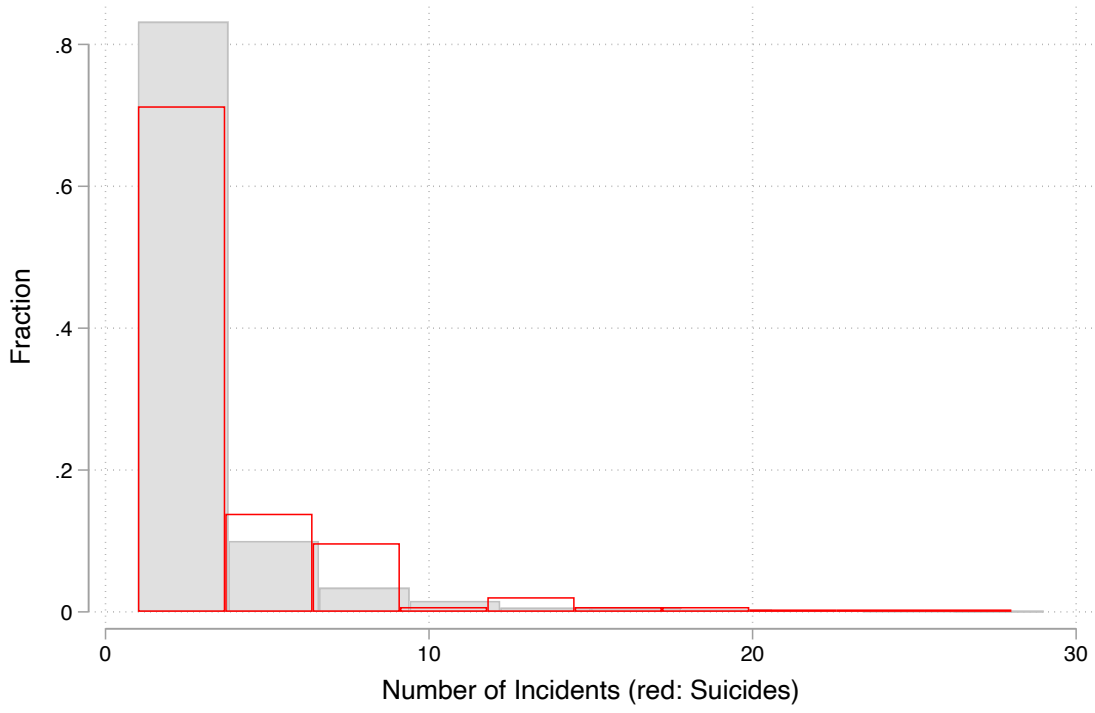


Figure 6.6: The number of DA-incidents and Suicide

6.3.4. Limitations

There are several important limitations of this analysis. First, we do not observe in the data any information about the socio-economic status of individuals -- as might be revealed by their postcode, for example. Other research has shown that DA is disproportionately common in the most deprived neighbourhoods (e.g. Foureaux Koppensteiner, Matheson, Ploga, forthcoming). This is an important confound that would be valuable for future research to address.

Second, the rarity of suicide means that despite comprehensive data for a large area for several years we observe relatively few cases. This, combined with the multifactorial and idiosyncratic nature of suicide means that it is hard to learn as much from the statistical analysis as we otherwise might. It would be useful to better understand what particular crimes, and patterns over time, are associated with increased risk of suicide. To do this one could estimate a regression model in which different crimes had different impacts, and these impacts would have a declining effect on the probability of suicide over time. However, this would require data for a longer period and or a much larger area.

Third, we do not observe DA that is not reported to the police. It is possible, likely even, that the probability of DA being reported to the police depends in a complex way upon the characteristics of

victims, their current mental health status, and the attitudes of their neighbours and communities. This may mean that a number of the suicides we do not associate with DA are in fact related to it.

Fourth, the Coroners' and Police data have improved over time. Earlier records are of lower quality, and this may affect the analysis in terms of suicides not being matched to DA records successfully or suicide not always being accurately recorded.

6.3.5 Conclusion

All demographic groups in the DA-population have a similarly increased risk of suicide compared to the overall-population. In the overall-population, suicide is much more common in men than women. Similarly, suicide in the DA-population is concentrated amongst men. It is important to note that while suicide is more common amongst the DA-population than in the overall-population by a factor of around 1.9, the base rate in the overall-population is very low, meaning it is still very rare in the DA-population.

This increased rate of suicide, and our finding that the number and recency of incidents are related to the chance of suicide, suggest an important link between DA and suicide. However, much is still to be learnt about the underlying causes of higher rates of suicide amongst, largely male, perpetrators of DA.

An important limitation of our study is that we are not able to consider the role of socio-economic factors which may both be a predictor of poor mental-health (Boardman et al., 2015) and associated with higher rates of DA (Foureaux Koppensteiner et al., forthcoming.) It would be worthwhile in future qualitative and quantitative research to obtain better data on both socio-economic factors, and the mental health status of victims and suspects.

7 Discussion, Conclusion, and Recommendations

7.1 Discussion

This research aimed to understand the link between a survivor experiencing domestic abuse and the survivor choosing suicide. Our approach was to apply a project logic commencing with a rapid evidence review which informed a conceptual framework for organising the fieldwork investigating what the drivers of domestic abuse survivor suicide might be. Then we have used a theoretical framework to explore why the drivers of survivor suicide might have the impact that they do, before bringing all the information together here to consider whether we can use it to contribute to improved practice in preventing completed suicides.

A key limitation to our conclusions is the sample size for our fieldwork, however, this is mitigated by research evidence where it supports our findings. From the rapid review we understand that survivors are more likely to choose suicide if the perpetrator has attempted to kill them or the survivor had experienced an assault as life-threatening, and this was similar for the survivors in our research. The literature indicates that survivors are more likely to choose suicide if the perpetrator has subjected them to coercion and control, including in particular, financial abuse. The survivors in our research who chose suicide had also been subjected to coercion and control, primarily, however, by way of the perpetrator telling everyone in the survivor's social network and the services, that the survivor 'was crazy'; the perpetrator manipulating the survivor's children and/or using the children to manipulate the survivor; and/or the perpetrator abusing the children; the perpetrator subjecting the survivor to reproductive coercion and abuse; and the perpetrator subjecting the survivor to stalking.

From the rapid review we understand that survivors are more likely to choose suicide if the perpetrator has subjected them to sexual assault/rape; and also if the perpetrator had subjected them to multiple abuses, in particular physical abuse, and always including rape. All the survivors in our research who attempted suicide were subjected to sexual assault/rape. They also experienced an average of 17 different forms of abuse. The link between these abuses and suicidality is explained in the literature by the fact that they cause depression and PTSD, and are commonly experienced co-morbidly. Unfortunately, we were not in a position to administer diagnostic questionnaires to establish whether the survivors in our research had depression and/or PTSD. However, it is likely that they did have one or both because many of their descriptions include the risk factors for depression and PTSD. These were sexual assault/rape, life threatening abuse, repetition of abuse, multiple concurrent abuses, inclusion in the multiple abuses of physical and abuse and sexual assault/rape.

We were able to establish feelings states consciously experienced by survivors. From the rapid review we understand that survivors are more likely to choose suicide if they experience hopelessness and despair. The survivors in our research similarly described feeling hopeless, feeling trapped by the perpetrator and feeling that life was unbearable with no chance of changing what was happening to them/their family – which we interpret as despair. Notably, in our research, the three survivors who did not have suicidal thoughts or attempt suicide did not feel that their life was unbearable.

Research suggests that survivors are more likely to choose suicide if they experienced feelings of panic, terror, and trauma, with the latter most often stemming from childhood experiences. All the survivors in our research described feeling extreme fear, which we would equate with the terms panic and terror. Unfortunately, we did not ask about prior traumatic events such as adverse experiences in childhood, nevertheless several of the survivors in our research did say that they experienced childhood trauma and/or that they had experienced domestic abuse in a previous relationship.

A last feeling state identified in the research literature as influencing survivors to choose suicide if they experienced it, is burdensomeness – specifically arising from disrupted relationships with self and others. All the survivors in our research who had suicidal thoughts or attempted suicide described feeling that they were a burden and several of the mothers who attempted suicide described thinking that their children would be better off without them. The survivors in our research who had suicidal thoughts or attempted suicide described feeling isolated and lonely, worthless, humiliated and that they were not as good as other people thought they were (feeling like a fraud). These feeling states are all functions of, and contributors to, disruption in a survivor's relationship with others and with themselves – in conjunction with the shame and somatic distress which typically follows from abusive physical trauma.

Additionally, in our research, the survivors who attempted suicide appear to have been influenced by the survivor's family pressuring her to stay with the perpetrator or to take him back when they knew about the abuse. Also, the survivor having had one or more previous relationships in which she had experienced domestic abuse; and, critically, others not acting to help the survivor when the survivor knew that they had seen the signs of abuse and/or the survivor had disclosed the abuse. The importance of this lay in the fact that help from outside of the abusive relationship and wider family was perceived by the survivors as their last chance and when that help was not forthcoming, the survivor's hope of escaping the abuse was extinguished. This seems to be critical information for services who are in contact with individuals who may be experiencing domestic abuse. In relation to services contact with the police is likely to have had a significant influence on the survivors. Many more of the survivors who attempted suicide were in contact with the police than survivors who had suicide ideation or no suicidal thought/did not attempt suicide; and only just over a third of the survivors who attempted suicide said that the police helped them whilst they were in the relationship. Similarly, survivors' contact with health services had a significant influence on the survivors. Almost all of the survivors who attempted suicide had contact with health services. Two-thirds were diagnosed with post-natal

depression and were prescribed anti-depressants. Of the survivors who were diagnosed with mental ill health due to the perpetrator's behaviour and influence, just over two-thirds attempted suicide.

In terms of the extent to which a survivor's ethnicity might influence the chance that they would choose suicide - White British survivors appear to be most at risk. Almost half of them attempted suicide, compared to a third of the survivors with 'other' ethnicities and only one British Pakistani survivor.

In relation to whether being a mother precludes attempting suicide, this does not appear to be the case. In our research a third of survivors who attempted suicide were caring for children at the time and said that they reached a point where they felt their children would be better off without them.

Finally, from the rapid review we understand that survivors are more likely to choose suicide if they try to cope with the impact of the abuse through drugs and alcohol or self-harm. In our research a high proportion of the survivors who attempted suicide did use drugs and alcohol and/or self-harm as a way of coping. They also coped through eating in a disordered way. From the Rapid review we understand that eating in a disordered way is linked to burdensomeness via feelings of self-hatred. Whilst not long-term solutions, there were short-term coping strategies used by the survivors in our research which were positive in the sense that they were not correlated with suicide ideation/attempts. These included a strong reliance on religion, denial of the abuse and the survivor having an ability to distract herself from the abuse and abusive circumstances.

Considerations for practice

Having gathered information on the link between domestic abuse and suicide from the literature and our fieldwork, we introduced a theoretical framework to provide a model which may facilitate translating the findings into practice. This could usefully take the form of assessment of the degree to which a perpetrator has managed to dismantle a survivor's identity by disrupting the relationships which support that identity. The importance of this being that it significantly raises the likelihood that a survivor might begin to contemplate suicide as it depletes their psychological and emotional resources such that the survivor might come to view their future, or respond to one more incident, with hopelessness – and attempt suicide. The assessment questions could directly reflect the categories in Diagram 3.

As one of the survivors said:

"There is a set of behaviours which will destroy another person when aimed at them. All abusers use a mix of the same behaviours, as if they had a written down battle plan. They should be prosecuted for carrying out the destruction/attempted destruction of another person."

As part of the assessment, and already in focus in existing assessments, would be the sexual/physical assaults and other abuses and coercions, that perpetrators subject survivors to. Again with reference to Diagram 3., additional questions would need to explore with the survivor childhood abuse/neglect; and previous abuse in adulthood. As noted above, the importance of both current and past adverse and traumatic experiences, is that they disrupt to the survivor's relationships (including with herself) and significantly contribute to the disintegration of the survivor's identity.

7.2 Conclusion and recommendations

The research described in this report, in line with previous research, suggests that there are some strong predictors of attempted suicide that if applied in assessments of risk have the potential to prevent future domestic abuse survivor suicides. Accordingly, we make the following practice recommendations for both the police forces and health services:

1. Develop and pilot an assessment tool which aims to identify the predictors of suicide by gathering information from the survivor; taking into account information outside of survivors' awareness as well as information they are conscious of:

   a) Information survivors would be aware of might include:

      - in relation to abuses – whether they had experienced life-threatening abuse; sexual assault/rape, coercion and control; multiple abuses and repetition of abuse

      - in relation to feeling states – despair, hopelessness and burdensomeness/ isolation/self-hatred

      - in relation to the fragility of self-identity (based on Diagram 3):

         - the number of relationships which have been disrupted or terminated. This should also elicit information about a survivor's perceptions of/relationship with the police (and health services) and may assist in building trust; and

         - any previous or childhood experiences which were trauma or terror-inducing, such as, some form of abuse, disaster (e.g., house fire), accident or medical procedure

      - in relation to coping strategies – whether they are using self-harm and/or alcohol and drugs to cope. A challenge will be to elicit an honest answer from the survivors who fear police action in response to admission of using illegal substances.

   b) Information survivors would not be aware might include their own emotional and psychological state, such as whether they have depression or PTSD. Some of this information would be available from the CORE-10 questionnaire.

2. Develop and require commissioning/delivery by police forces and health services of training to ensure that police officers and health staff can:

      - apply the newly developed assessment

      - elicit information from survivors about sexual assault/rape without raising the risk of harm for the survivor (key contributors to survivor silence are shame and fear of police action against the perpetrator on the basis of a rape allegation, which will both prompt retribution from the perpetrator and subject the survivor to the intrusion experienced by victim-witnesses in rape cases)

      - elicit information from survivors about the abuse of children in the context of support for them as the protective parent (a key contributor to survivor silence is fear of being accused of not protecting the children and the children being removed by social services)

      - understand the key role services have in supporting survivors' self-identity (based on Diagram 3); and can act in a supportive way regardless of the constraints they operate under in terms of organisational process and procedure.

3. Develop guidance for police forces and health services to introduce and maintain a domestic abuse survivor suicide prevention/welfare pathway, with local statutory and VCS partners. The framework should contain the information in this report, and any other/up-dated

information about how domestic abuse dismantles the survivor's identity and the link with suicide translated into operational understanding and practice.

We also make the following research recommendations, that:

4. A small amount of additional funding is made available to explore the information collected in this research about the contact survivors had with services other than the police and health services i.e., children's social care, schools, housing, immigration services, the Family courts and voluntary and community sector services (community and residential domestic abuse services and the Samaritans).

5. More, and more nuanced research is commissioned to track the trajectory from abuse to suicidality and, in the process, to differentiate suicide ideation from suicidality. The research should incorporate evaluation of any of the above pilot activities.

6. More quantitative and qualitative research is undertaken to understand the high incidence of suicide amongst male perpetrators (and victims) of domestic violence. It would be valuable for this research to seek to understand the dynamic relationship between socio-economic status, substance abuse, domestic violence, and potential suicide.

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Appendices

Appendix 1 Rapid review: survivor social characteristics

The social characteristics of victims/survivors of suicidality linked to domestic abuse are as follows:

Age

According to the Crime Survey for England and Wales (CSEW) year ending March 2020, 16 to 19 year old women were substantially more likely to experience domestic abuse over the previous 12 month period, than women who were 25 years and over (ONS, 2020). Walby and Allen (2004) also found young people to be most likely to experience interpersonal violence. However, they reported that the majority of high-risk victims were in their 20s or 30s. The age range for survivors of domestic abuse who chose suicide is older. Aitken and Munro (2018) found that nearly three quarters (72%) of victims in cases of suspected victim suicide were under 45 years old. Thirty-one percent of victims were 35 to 44, and the same proportion were 25 to 34 years old.

Gender

The Crime Survey for England and Wales (CSEW), again for the year ending March 2020, estimated that 1.6 million women aged 16 to 74[1] years were subjected to domestic abuse in the previous 12 months. This is a prevalence rate of approximately 7 in 100 women (ONS, 2020). SafeLives (2014 & 2015) reported that women are significantly more likely than men to experience high risk or severe domestic abuse, citing the fact that 95% of victims whose cases are discussed at MARAC or accessing domestic abuse support services are women. The predominance of women as domestic abuse victims was also reported by Stöckl et al., (2013); who also recorded the fact that the perpetrators were current or previous male partners. Stöckl et al. found male partners to be responsible for almost 40% of homicides involving female victims compared with just 6% of homicides against males. Aitken and Munro (2018) reported that 97.5% of suicide victims were female and 84.1% of abusers were male partners or ex-partners (Aitken & Munro, 2018).

Certain forms of abuse, such as non-fatal strangulation seem to be particularly gendered. Strangulation affects ten times as many women as men (Kristie et al., 2014). Douglas and Fitzgerald (2020) found that a majority of domestic abuse survivors (women) in shelters (in the USA) reported non-fatal strangulation. Reporting rates for non-fatal strangulation appear to be between 3% and 68% depending on the sample (Bendlin et al., 2019).

Ethnicity

According to the Crime Survey for England and Wales (CSEW) year ending March 2020, individuals in the Mixed ethnic group were much more likely to be subjected to domestic abuse in the previous 12 months than those in the Black or Asian ethnic groups. In the White ethnic group, women were substantially more likely than men to have been subjected to domestic abuse in the previous 12 months (7.7% of women, compared with 3.6% of men (ONS, 2020). SafeLives (2014) reported on the breakdown of ethnicity in cases discussed annually at MARAC meetings across England and Wales – of the 50,000 high-risk survivors 15% were black, Asian or minority ethnic (BAME); 4% were disabled; and 1% were lesbian, gay, bisexual or transexual.

A majority of the research into suicidality linked to domestic abuse has been carried out outside the UK. In some cases this research concludes that abused women from ethnic minorities, or amongst abused immigrants and/or refugees are more likely to choose suicide than victims from other ethnic groups. The research suggests that this reflects the influence of cultural practices, concepts of so-called

'honour' and 'shame', and language or community barriers that frustrate the women's attempts to get help (Colucci et al., 2004). Based on research in 1998, Chantler et al. concluded that as many as half the Asian women living in the UK who have attempted suicide or self-harm, had also been subjected to domestic violence.

In Aitken and Munro's (2018) sample of victims of domestic abuse 48.5% were white British; 16.7% had either a black British, African or Caribbean background – they made up just over 19.3% of clients when combined with those of dual black heritage; 12.6% clients were south Asian including 0.3% of mixed South Asian heritage; 7.5% were eastern European and 5.1% of an unspecified white background (Aitken & Munro, 2018).

In Bates et al. (2021) Black and minority ethnic suicides represented 11% of all suspected victim suicides, a far lower proportion than for child deaths and adult family homicide. Similar proportions of Black and minority ethnic and white victims had been previously assessed as high-risk. However, 32% of Black and minority ethnic victims were previously known to police, compared with 51% of white victims. Only 42% of Black and minority ethnic victims were previously known to other agencies compared with 58% of white victims (Bates et al., 2021). No cases of so-called honour-based violence were flagged on the police database.

Pregnancy

Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened when pregnant (Lewis & Drife et al., 2001).

Stark's early 1996 paper found abused women were significantly more likely than non-abused women to be pregnant when they attempted suicide. Only 5% of the women who were not abused were pregnant at the time of their attempted suicide compared with 19.2% of the abused women. Conversely, of the 16 pregnant women who attempted suicide during the study year, two thirds (62.5%) were abused. The abused women also had a significantly greater number of miscarriages than the women who were not abused, both in prior pregnancies and in the current pregnancy: 36.5% of the abused women had at least one miscarriage compared with just 2% of the non-abused women (Stark and Flitcraft, 1996).

Almost 22% of Aitken & Munro's (2018) female clients said they were either pregnant or had given birth in the past eighteen months.

Children

Aitken & Munro's (2018) reported that 56% of parents who experienced suicidal thoughts, and who had children living with them, said that their children were the primary reason for not acting on the suicidal thoughts. Aitken and Munro concluded that the absence of children appeared to be a risk for suicidality, with 37.5% of those without children demonstrating suicidality, compared with 18% of those with children. This finding is supported by a number of other studies.

Disability

According to the Crime Survey for England and Wales (CSEW) year ending March 2020, men and women between the ages of 16 and 74 years with a disability were more likely to have experienced domestic abuse in the previous 12 months than those without (ONS, 2020).

Cavanaugh et al. (2011) found that women victims of domestic abuse, who identified as having a chronic or disabling disease were substantially more likely to have threatened or attempted suicide

over their lifetime. They found a high correlation with extreme sexual, but not physical violence. This issue does not appear to have been explored elsewhere.

Appendix 2 **CORE-10 Assessment**

The CORE-10 is a short 10 item easy-to-use assessment measure for common presentations of psychological distress, designed to be used for screening as well as over the course of treatment to track progress. The measure is a shortened version of the 34 item CORE-OM, both of which ask respondents to self-report symptoms over the past week.

Barkham et al. (2013) validated the CORE-10 in primary care patients as well as the general population, finding it had an internal reliability (alpha) of .9. Based on their analysis it was determined that scores of 11 or above were indicative of clinically significant psychological distress, and scores above 13 likely indicated depression,

The CORE-10 estimates an individual's level of psychological distress and is an indication of their mental health.

To complete the CORE-10 Assessment – tick the statement which most applies over the previous week.

Over the last week...	Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1 I have felt tense, anxious or nervous	(0)	(1)	(2)	(3)	(4)
2 I have felt I have someone to turn to for support when needed	(4)	(3)	(2)	(1)	(0)
3 I have felt able to cope when things go wrong	(4)	(3)	(2)	(1)	(0)
4 Talking to people has felt too much for me	(0)	(1)	(2)	(3)	(4)
5 I have felt panic or terror	(0)	(1)	(2)	(3)	(4)
6 I made plans to end my life	(0)	(1)	(2)	(3)	(4)
7 I have had difficulty getting to sleep or staying asleep	(0)	(1)	(2)	(3)	(4)
8 I have felt despairing or hopeless	(0)	(1)	(2)	(3)	(4)
9 I have felt unhappy	(0)	(1)	(2)	(3)	(4)
10 Unwanted images or memories have been distressing me	(0)	(1)	(2)	(3)	(4)
Subtotals					

Total score	

To score the CORE-10 assessment:

1. Check all ten questions are answered.

2. Each answer has a number next to it between 0 and 4. Add up all ten numbers to give a score between 0 and 40. This is the total score.

Broad interpretations of the total score are:

Total score	Interpretation
0-5	Healthy
>5 to 10	Low level problems
>10 to 15	Mild psychological distress
>15 to 20	Moderate distress
distress >20 to 25	Moderately severe
>25 to 40	Severe psychological distress

3. This a snapshot of how things have been in the last week. The score may vary from week to week in the normal course of events.

4. People starting psychological therapy usually score over 10.

5. For a score in the severe range (more than 25) lasting three weeks or more, professional help should be sought e.g., GP or clinical psychologist.

Appendix 3 Forms of abuse defined

The terms in Table 18 are defined here as they have been applied in the analysis for this research.

Table 18 Forms of abuse defined

Physical abuse	
Physical violence	The survivor being slapped, punched, head butted, kicked, pushed, held down or thrown down the stairs. The abuser stamping on her head/face, breaking her fingers and toes, withholding her medication, force-feeding her or kidnapping her.
Non-fatal strangulation	The survivor being regularly choked.
Attempt to kill (other than non-fatal strangulation and use of a weapon)	The survivor being driven at by a car, attacked with a knife, force-fed pills, strangled with a cord, suffocated with a pillow.
Use of a weapon	The survivor being hit with an object e.g., mugs & plates, bottles, toolmakers dividers, a knife, a rolling pin, chairs, an axe. A knife or hot iron held to their neck or face.
Threat to maim, rape or kill	Threat to kill the survivor and/or the children, threat of acid attack, threat to burn the house down.
Domestic servitude/unrealistic expectations	The survivor doing cooking, cleaning, washing, ironing; often together with sole care for the children and/or during pregnancy, and an expectation of perfection in quality and timing of it all; often also undertaking all domestic duties for the abusive partner's parents & siblings.
Several abusers (e.g., family members)	The abuser's parents and siblings, his friends and the wider family/community.
Emotional abuse	
Humiliation	The survivor being subjected to criticism and shaming in front of others; including their children.
Criticism	The survivor being subjected to relentless and all-encompassing criticism (her looks, competence, personality and important others incl. family/friends and children who are not his).
Mind games (gaslighting)	The survivor experiencing systematic distortion of reality through the abuser redefining what has happened or is happening; including by grooming others.
Threats to abuse family members/pets	The abuser threatening to take the children away from the mother (e.g., to be raised by his family); and/or to hurt or kill the children.

Threats relating to forced marriage/honour based violence	The abuser using the threat of dishonour to prevent the survivor leaving/seeking a divorce. In particular involving the taboos of being a divorced woman and depriving a child of a father.
Manipulation of/via children	Using the children in emotional blackmail of the survivor. The abuser getting the children to believe that their mother is bad or mad; getting the children to video or inform on their mother.
Abuse of the children	See additional issues below for types of abuse.
Disrupted sleep/exhaustion	Due to hypervigilance (generally and specifically due to fear of rape); exhaustion from the demands of coerced labour in and out of the home.
Coercion and control	
Isolation from friends and family	The abuser restricts or bans altogether the survivor's contact with friends and family (ranging from poisoning the relationship to physically restricting contact).
Financial control	The abuser controlling/stealing the survivor's money and property (incl. selling her car, transferring her house into his name) and accumulating debt in her name.
Control of behaviour in the home	The abuser controlling what the survivor wears, her makeup, weight, looks – through cosmetic surgery; when/how much she sleeps/eats/toilets, how she cares for children, where she goes, who she talks to, who comes to the house.
Control of behaviour outside of the home	The abuser stalking the survivor in family, childcare, medical, social and work activities. Getting rid of the survivor's car. Not allowing her out at all or unaccompanied, or he times her shopping or walking the children to school to ensure she doesn't stop or deviate from the route to talk to anyone.
Forced marriage	Where the survivor tried to get out of the arranged marriage (this is an under representation because many did not want the arranged marriage, they just did not do anything to escape it due to pressure from the family/community).
Reproductive coercion & abuse There are three forms of reproductive coercion, including pregnancy coercion, birth control sabotage, and controlling the outcome of a pregnancy.	Where the survivor described her experience of having one or more babies as a result of rape combined with pressure not to use contraception. Pressure from the family/community (referred to as 'barren' and ostracised accordingly) and/or the abuser talking about his success in trapping her by getting her pregnant. Also, where his family try to physically induce birth.
Sexual assault	
physical	Rape, including 'gang rape', and buggery.

ICT/online	Intimate/sexual videos made of the survivor and shared with others including her children.
Stalking/surveillance	
physical	The abuser or his family members/friends following by car or on foot, photographing/filming the survivor.
ICT/online	Calls, texts, social media, CCTV inside the house.

Appendix 4 Rapid evidence review findings in bullet points

From the rapid review we understand that survivors are more likely to choose suicide if:

the perpetrator had attempted to kill them (or the survivor had experienced an assault as life-threatening)

the perpetrator had subjected them to coercion and control, including in particular financial abuse

the perpetrator had subjected them to sexual assault/rape; and/or

the perpetrator had subjected them to multiple abuses, in particular physical abuse and always including rape.

In relation to the impact of the domestic abuse on the survivors' emotional and psychological wellbeing, survivors are more likely to choose suicide if, in addition to the other impacts they experience:

depression

post-traumatic stress disorder

For 20% of survivors these impacts will be co-morbid and are linked to repeated abuse, multiple abuses and multiple abusers.

In relation to the impact of the domestic abuse on the survivors' feelings, survivors are more likely to choose suicide if they experience:

despair

hopelessness

panic, terror and/or childhood trauma (ACEs)

burdensomeness, specifically arising from disrupted relationships with self and others.

Finally, in relation to coping strategies, survivors are more likely to choose suicide if they use the following ways of coping:

drugs and alcohol; or

self-harm.

Appendix 5 Findings in bullet points

From the fieldwork findings we understand that survivors are more likely to choose suicide if:

the perpetrator had attempted to kill them (or the survivor had experienced an assault as life-threatening)

the perpetrator had told everyone in the survivor's social network and the services, that the survivor 'was crazy'

the perpetrator had manipulated the survivor's children and/or using the children to manipulate the survivor; and/or

the perpetrator had abused the children.

the perpetrator had subjected the survivor to reproductive coercion and abuse.

Importantly we could not comment on the impact of rape or stalking on survivors' choice to attempt suicide because almost all of the survivors were raped and stalked. However, all the survivors who attempted suicide experienced both staking and sexual assault/rape.

In relation to the impact of the domestic abuse on the survivors' feelings, we found that survivors are more likely to choose suicide if, in addition to the other impacts (see Table 11), they:

felt that they were a burden

felt shame; and

felt that their life was unbearable.

In terms of the survivors' coping strategies, the difference between the survivors who did not experience suicidal thoughts or attempt suicide and those who attempted suicide appears to have been influenced by being able to utilise the coping mechanisms of:

religion;

denial; and

self-distraction.

Whilst not long terms solutions, in the short term these mechanisms were positive in the sense that they were not correlated with suicide ideation/attempt. In comparison the following ways of coping were linked to suicide ideation/attempt:

self-harm

substance misuse; and

eating in a disordered way.

Additionally, survivors who attempted suicide appear to have been influenced by:

the survivor's family pressuring her to stay with the perpetrator or to take him back when they knew about the abuse

the survivor having had one or more previous relationships in which she had experienced domestic abuse; and

others not acting to help the survivor when they had seen the signs of abuse and/or the survivor had disclosed the abuse.

Appendix 6 Findings comparison with Bates et al. (2021)

In the report *Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021*, Bates et al. suggested potential predictors of domestic abuse survivor suicide. A comparison of their predictors with findings from this research are set out in table 19.

Table 19. Predictors of suicide – a comparison between Bates et al. and this research

Bates et al. findings	This review findings		
Demographic			
Victims being female and under 45 years	yes	37	23-54
Not ethnicity, but honour-based violence	no difference	DA=15 (50%)	HBV=15 (50%)
Not having children	yes	23 did not have children (68%)	11 had children (32%)
Having a chronic or disabling disease.	no survivors had a chronic/disabling disease		
Abuses			
The literature debates issues such as whether the presence of two or three types of abuse significantly increases the likelihood of suicide. In Aitken and Munro's group duration of abuse seemed to matter, especially for physical abuse and having multiple abusers was also highly correlated with suicidality	Multiple abuses=average 17 abuses Duration=without ideation or attempt=8 years; ideation=9 years; 6 years on average for survivors who attempted suicide]		
Subject of coercive and controlling behaviour, from a current, or in just under 50% of cases, a previous partner	all survivors were subject to severe coercive & controlling behaviour		
That partner being male and previously coming to police attention for violence against women, particularly for domestic abuse	no		
Any report of sexual abuse or enforced prostitution	some cases i.e., not definitive	Rape=33 / 34	(97%)
Cumulative sexual abuse, especially combined with serious physical assaults	some cases i.e., not definitive		
Any report of financial abuse	no difference		

Bates et al. findings	This review findings		
Reports of isolation from family and friends and experiencing threats of harm with a weapon, threats to kill a family member	some cases i.e., not definitive		
Responses to abuse			
Complex post-traumatic stress disorder	some cases i.e., not definitive		
Depression	some cases i.e., not definitive		
Feeling hopeless and despairing	some cases i.e., not definitive		
Additional needs from disability and drug and alcohol issues, as well as social factors, such as isolation			
Previous plans or, more highly correlated, attempts by the victim, to end their life	some cases i.e., not definitive		
Situations where the relationship had recently ended or there was a threat to end it	no		
Perpetrators			
Having a history of suicide attempts	no		
Problematic use of alcohol and other substances	no		
Mental Health problems including borderline personality disorder and depression	no more than likely trauma from the amount of abuse the survivor was being subjected to		
Protective Factors			
Having children living with them	yes		
Having support from family and friends			

Appendix 7 Semi-structured interview guide

Do you recognise these forms of abuse in relation your experience? *(schedule 1.)*

was coercion part of your experience?

was non-fatal strangulation part of your experience?

Do you recognise any of these feelings in relation to your experience? *(schedule 2.)*

are there others we have not listed?

Were you aware of these feelings before you experienced domestic abuse?

which of the feelings?

Were you aware of feelings starting or increasing when the abuse began happening?

which of the feelings?

- if you felt isolated and lonely, why was this?

Were there occasions when you were experiencing abuse when the feelings were worse (more intense/a greater number of different negative feelings)?

which of the feelings? *(schedule 2.)*

can you think of a reason (in the relationship or external to the relationship) why the feelings became worse?

If the feelings got worse, were they linked to a particular form of abuse? *(schedule 1.)*

did the feelings build up over time?

If the feelings got worse, did this happen while the abuse was ongoing or after the abuse stopped altogether?

if the feelings got worse after the abuse stopped altogether, can you think why?

How did you manage your feelings (what were your ways of coping)? *(schedule 3.)*

did you self-harm in any way?

as there an occasion when you wished you weren't alive?

did you reach out to a service, e.g. a mental health (or any other) service?

Was there an occasion when you actually thought about suicide?

if yes, was this vague or did you plan it?

if yes, was it linked to particular feeling/s?

if yes, was it linked to particular incident/s (in the relationship or external to the relationship)?

If you thought about suicide,

when/why did you stop thinking about it?

when/why did you stop planning it?

Thank you very much for sharing your experience

to help other survivors of domestic abuse

Schedule 1

Forms of abuse

Physical abuse:

physical violence

non-fatal strangulation

attempt to kill

use of a weapon

Emotional abuse:

humiliation

criticism

threats to abuse family members/pets

threats relating to forced marriage/honour based violence

Coercion and control

isolation from friends and family

financial control

control of behaviour in the home

control of behaviour outside of the home

forced marriage

Sexual assault

physical (including in forced marriage)

ICT/online

Stalking/surveillance

physical

ICT/online

Schedule 2

Feelings

Feeling hopeless (not being able to imagine a positive future)

Feeling scared (anxiety and panic attacks)

Feeling that your life is unbearable (unable to live with the pain or circumstances)

Feeling that everything is going wrong when even quite a small negative thing happens (you drop something, someone fails to return your greeting or you mislay your keys or miss the bus)

Feeling that there is no hope of changing what is happening to you/your family

Feeling trapped (by the person who is abusive)

Feeling isolated and lonely

Feeling that you are a burden (always having to be grateful for any help you get)

Having to manage your feelings because they can go (often quickly) from one extreme to another

Feeling worthless (not listened to; valued for who you are)

Feeling shame (thinking that people won't like you if they get to know who you really are)

Feeling like a fraud because you are not as good as people think you are (driven by persistent criticism).

Schedule 3

Ways of coping

Avoidance (planning ways to prevent confrontation, including leaving home)

Religion

Finding someone or a service to confide in for emotional support

Finding someone or a service to help you in practical ways

Self-distraction (watching television, exercising, cleaning, cooking or a hobby)

Denial (telling yourself and everyone else that everything is/will be okay)

Venting negative emotion (angry outbursts or bursting into tears to friends, neighbours/strangers, your children, pets)

Substance use (drinking alcohol, taking over-the-counter drugs or illegal drugs)

Behavioural disengagement, withdrawing into yourself (including not looking after yourself)

Self-blame (telling yourself it is your fault)

Self-harm (e.g., cutting yourself)

Eating disorder (eating too much or too little)