On the outside looking in: the shared burden of domestic violence

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Abstract

Domestic violence and abuse (DVA) is experienced by one in four women in the UK, and research suggests that most survivors will access support from people in their social networks. Support from these relatives, friends and colleagues has the potential to buffer against effects on the survivor's physical and mental health, and has been shown to be protective against future abuse. There has, however, been an absence of research directly studying members of survivors' networks, to consider how impacts of DVA might diffuse to affect *them*. The research undertaken fills this gap by exploring the impacts on the health and wellbeing of members of the survivor's social network.

The themes generated from a systematic literature review formed the basis of a topic guide for qualitative interviews conducted with adults in a variety of close relationships with a survivor. Participants were recruited using social media, radio, and flyers in community settings. Interviews were conducted face-to-face, over the telephone and using Skype. A thematic analysis of the narratives was conducted, and five major themes emerged: psychological & emotional impacts, physical health impacts, direct perpetrator impacts, relationship impacts and practical impacts. It was clear from the findings that a great deal was being shouldered by adults close to the survivors, and that tolls were multifaceted, potentially profound, and often long-term.

Certain factors appeared to mediate impacts experienced, including the supporter's gender, the closeness of relationship between supporter and survivor, the severity of abuse experienced by the survivor, and whether or not the survivor had children. Participants also described the extent to which their experiences included direct coercive control behaviours from the perpetrator.

Currently there is almost no support available which is directly aimed at friends, family members and colleagues of survivors. These research findings therefore have practical and policy implications, so that the needs of informal supporters are both recognised and met.

Background

With the high life-time prevalence of domestic violence and abuse (DVA) for women across the globe,[1] it is reasonable to assume that most people at some point will be in the position of friend, relative, colleague or partner to a survivor. Domestic violence research suggests that in most situations, adults close to a survivor know about the abuse their loved one is experiencing,[2, 3] and that most women in an abusive relationship will try to access support from people in these networks.[4-6] Theories and models of domestic violence and abuse, even where they acknowledge the social system of which the survivor and perpetrator are part, tend to ignore interactions with or between the people considered more on the periphery, such as friends, extended family and colleagues. The World Health Organisation (WHO) sought to acknowledge the complex and multi-dimensional nature of DVA by proposing an integrated ecological model, which acknowledges the *'community contexts in which social relationships are embedded – such as schools, workplaces and neighbourhoods'*.[7] However, even with these ideas, there

remains something two-dimensional about the model because it builds around the individual, missing possible scenarios where there are more than one perpetrator or more than one person being victimised.

We know that domestic violence and abuse damages the health, wellbeing and safety of survivors in a multitude of ways, [8-13] and research demonstrates that these impacts can be reduced or buffered against if the survivor experiences positive support from those around her,[14-19] so these informal supporters are a potentially vital source of input. Recently there has begun to be an appreciation in some sectors of the valuable role informal supporters can play, for example in the UK, the Home Office has recognised the importance of involving family members in domestic homicide reviews,[20] and the charity Advocacy After Fatal Domestic Abuse (AAFDA) has been set up to support relatives to take part in the homicide review process. Whilst this acknowledges something of the importance of considering relatives in the worst-case scenarios for DVA, there is clearly a case for more generally supporting members of survivors' networks.

Most of the existing studies which consider the survivor's social network are chiefly concerned with the function of these people, and their willingness, or not, to be involved in the situation, [2, 5, 21-23] which still leaves a gap in our understanding about the ways in which these people are impacted. The research reported here fills this gap by directly exploring the impacts on members of the survivor's social network using a qualitative interview study.

Methods

A qualitative approach to this research was taken due to this being both an unexplored topic, and an intensely emotive and complex issue. The research aimed to capture breadth of experience and viewpoints rather than commonality and dominant discourses, and it was anticipated that there would be a lot of emotion attached to responses, so a group-setting for the research was not considered appropriate. The interviews were semi-structured in order to explore the topic in detail, unearthing new ideas not anticipated at the outset, but with sufficient structure to ensure that the research question was addressed.

Ethical considerations

This qualitative study was granted ethical approval by the Research Ethics Committee in the School for Policy Studies at the University of Bristol on 14th June 2012.

DVA presents a risk of harm not only to survivors but occasionally to those around them and, with this in mind, recruitment of participants included safety screening, and interviews took place away from participants' homes (in university and community venues), over the phone or using Skype. In addition, in order to minimise the possibility of unintentional emotional harm, the option to withdraw was highlighted throughout the recruitment process, the researcher was alert to signs of distress during the interviews, and an information sheet about local and national support services was shared with participants.

In addition, with regards to ethical respect for research participants, written informed consent was sought, with the study information shared at least 48 hours prior to the interview, and the implications

of consenting discussed at length. The voluntary nature of the research was emphasised, and due to the nature of the research, the limits of confidentiality (regarding the legal and moral obligations requiring professionals to report particular information, especially around the safety of children) were expounded. To ensure anonymity, an enhanced level of masking was performed to conceal participant identities.

Participant sampling and eligibility

The community of interest were adults who had a friend, family member (including: in-laws, and step-family members), colleague or neighbour who was experiencing or who had experienced domestic violence and abuse. Due to the lack of previous research in this area, it was important to try to recruit participants who might have a range of differing experiences, attitudes and beliefs, so maximum variation sampling was used. This sampling approach turns the problem of heterogeneity between individual cases in small samples from ostensible weakness into strength by applying the logic that: because diversity is so likely in such a varied sample, any common patterns that *do* emerge are of considerable value or interest.[24]

Participants were eligible to take part in the study if they had had a close relationship with a DVA survivor. They had to be aged 16 or over, both at the point of recruitment, and during the time that they knew the survivor. The abusive relationship they knew about needed to fit the UK Home Office definition of domestic violence and abuse[25] and, because of the gender asymmetry around DVA, and that much less is known about the ways male survivors interact with their social networks, [26-30] the focus of this work was on the supporters of *female* survivors, though the perpetrator could be of either gender. Whilst English did not need to be their first language, participants needed to be sufficiently fluent to take part in an in-depth interview, and since first-hand experience was key, people offering third-party perspectives were ineligible.

Procedures and data collection

Potential participants for this study were a hard-to-reach population, both in terms of the sensitive and stigmatised nature of the topic, and also in terms of access. In order to recruit, and in order to optimise diversity, a varied approach was taken over an 8-month period including: posters in community venues, social media and web-advertisement, and promotion on local radio. Particular emphasis was placed on the recruitment of participants from ethnic backgrounds other than 'White British', in recognition of the general under-representation of individuals from minority ethnic backgrounds in research.[31] When contacted by potential participants, the researcher followed a recruitment protocol including: ensuring that the respondent was safe to communicate about the research, assessing eligibility for the study, and talking in detail about what was involved. If the respondent wished to proceed, a provisional date was set for the interview, and the participant was mailed a study information leaflet, and a copy of the consent form.

Immediately prior to the interview consent was obtained, and a socio-demographic questionnaire was completed to inform the analysis, to contextualise participants, and to provide information about sample diversity to inform on-going recruitment strategies. During the interview, the researcher used a topic guide which was developed from the findings of a systematic literature review she had previously conducted on this topic. In keeping with qualitative research principles, the initial topic guide evolved, so that insights gained in early interviews informed subsequent ones.[32]

At the end of the interview, participants were given an information sheet about support services, and were reimbursed for time and travel costs incurred. All interviews were conducted by the first author, were audio-recorded and ranged in length from 35 to 90 minutes. Recordings were transcribed *verbatim* and the anonymised transcripts were imported into NVivo10 software. The analysis was carried out concurrently with the interviews and recruitment continued until the point of data saturation.

Data analysis

Thematic analysis as a method for detecting, examining and reporting patterns within data, is an accessible form of analysis, and part of its flexibility lies in it not being wedded to any particular theoretical framework.[33] Since it can be conducted in a theoretically driven (top-down) or in a data-driven (bottom up) manner, it can be used in research taking a wide range of different ontological and epistemological standpoints. A systematic literature review had been previously conducted by the researcher so she necessary came to the interview study with some broad *a priori* themes in mind, and yet, due to the general lack of relevant research in this area and the dearth of related theory, most of the analysis was in fact carried out inductively. Once the researcher had familiarised herself with the data, it was line-by-line coded in NVivo 10 software, the codes were arranged into themes and then honed using *constant comparison*.[34] The process was iterative and each theme was refined through discussion with the researcher's supervisors. In the presentation of findings, exemplar quotes from participants' narratives are used for illustration. The brackets after each quote contain the pseudonym chosen by the participant and their relationship to the survivor.

Results

Sample description

Between August 2012 and April 2013, 23 interviews were conducted, twelve face-to-face, seven over the telephone and four using Skype. The relationships that participants had to a survivor were: mother (4), father (2), sister (2), niece (1), daughter-in-law (1), current partner (3), friend (10) and work colleague (2). There were more than 23 different relationships described because some participants had had more than one survivor in their social network. The majority of participants were female, most were white (including 'White British', 'White European', and 'White Other' ethnicities) and their ages ranged from mid-twenties to eighty. Participants were predominantly heterosexual, and highly educated, and there was variety both in their prior experience of DVA, and in whether the abusive relationship was on-going.

Findings

From the thematic analysis of the narratives five major themes were generated regarding the impact on informal supporters: psychological & emotional impacts, physical health impacts, direct perpetrator impacts, relationship impacts and practical impacts. Not all of the impacts were negative, but it was generally clear that a great deal was being shouldered by adults close to the survivors, and that tolls were multifaceted, potentially profound, and often long-term:

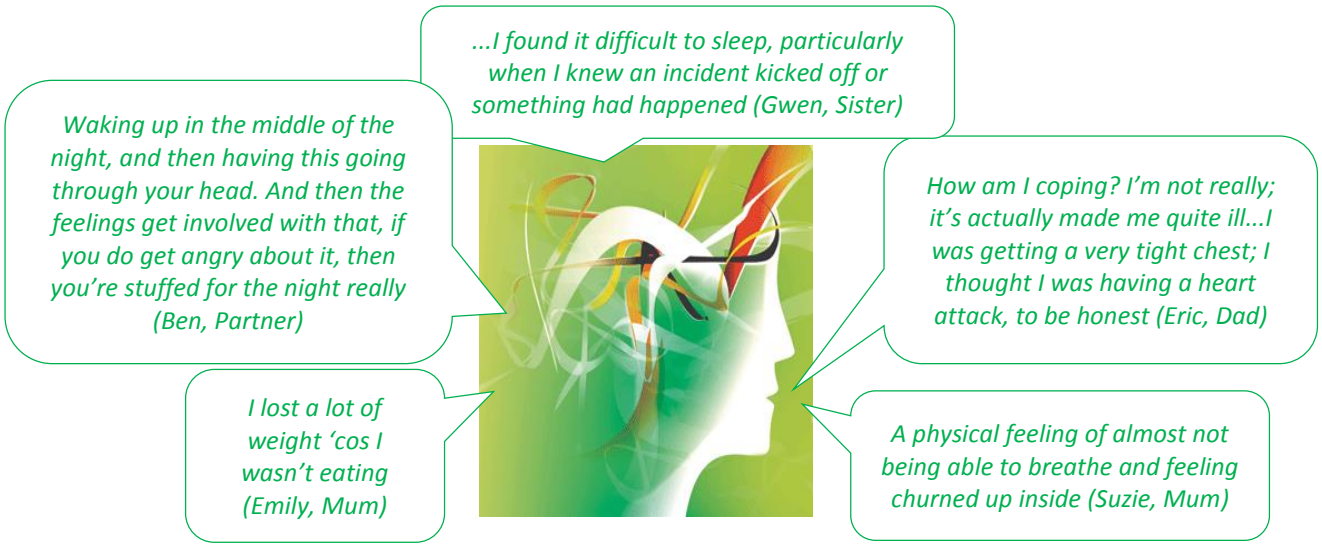
Psychological and emotional impacts

The impacts that people spoke about most were the psychological and emotional ones, and there was a real range of experiences with people describing feeling a bit disappointed with themselves for not understanding what their loved one was experiencing, right through to feeling that they no longer wanted to live as a result of the abusive situation.

Participants not only talked about different impacts from one another, but they also spoke about the experience of different impacts at different stages during their individual journeys, with shock, anger and fear often earlier on, and powerlessness, anxiety, low mood and self-blame coming later and potentially persisting.

Physical impacts

Some participants also described physical health impacts. This could be a very general physical unease, such as feeling sick or churned up inside, which seemed to be linked-in with anxieties about the situation. A few people spoke of more persistent physical ailments that they felt had resulted from the stress of supporting the survivor, either at the time of the abusive relationship, or in the aftermath, and they talked about health problems such as back and neck tension, migraines, shortness of breath and feeling tight-chested. Many participants also described having lost or broken sleep for a period of time, especially if they had persistent worries for the survivor, and a couple of people mentioned appetite loss during times of intense stress.



Direct perpetrator impacts

The next theme that emerged from the interviews was the impact that the perpetrator (or members of *his* network) had had directly on participants. Much of what was described looked very familiar in terms of behaviours that we know perpetrators use against survivors, particularly around gaining control. A few participants reported being on the receiving end of direct physical violence from the perpetrator, and the context for this violence was most often in the handover of a child between the perpetrator and the survivor's family. In addition, some participants talked about threats that had been made against them, to harm them or to kill them, either by the perpetrator or by members of his family. Others spoke about being treated with behaviour by the perpetrator that was designed to intimidate them, of having their property or finances stolen, or of having felt manipulated by him.

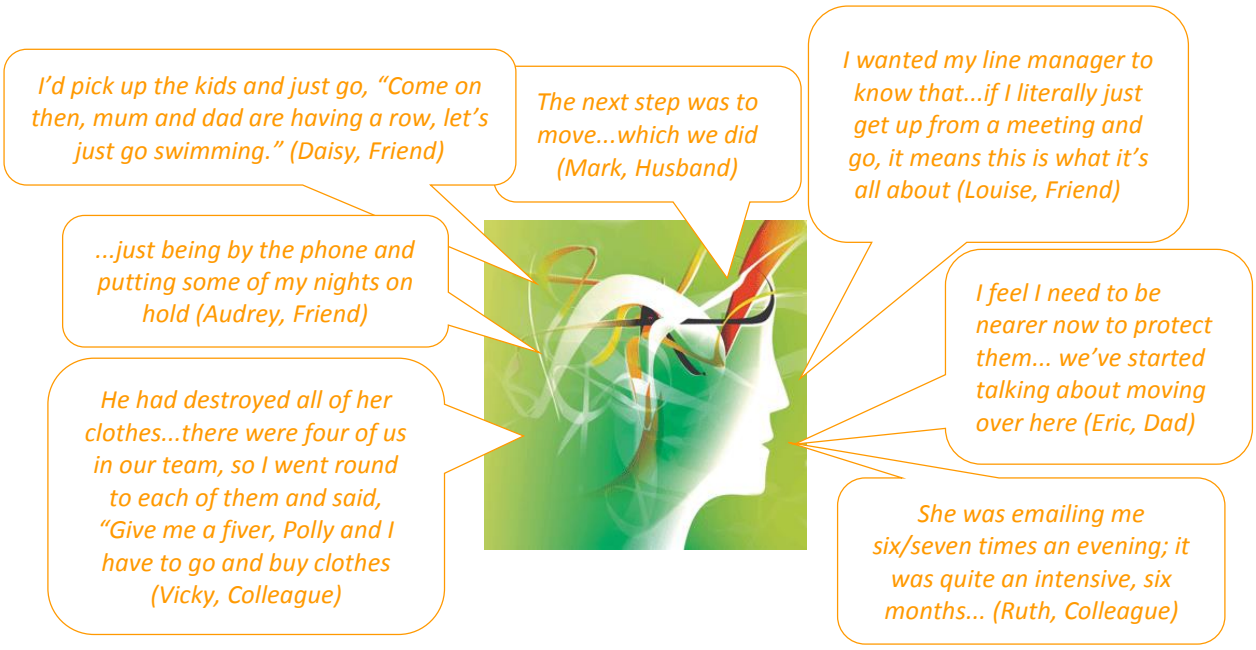
Relationship impacts

All participants described some degree of impact on their relationship with the survivor. It seemed to be particularly the level of contact, and the manner of communication between the survivor and their friend, partner, relative or colleague that changed the most, with some impacts on their relationship enduring and occasionally the relationship terminating completely. It is important to mention that a couple of people talked about the growth of their relationship with the survivor in response to disclosures of abuse, such that a real depth in rapport resulted – so not all the impacts on relationships were negative.

On top of the impacts participants described in the relationship between themselves and the survivor, most people mentioned others in their own social network with whom relationships had changed or altered too. Sometimes, it was the strain of the circumstances at the time of the abuse that caused rifts, arguments, blaming and even breakdowns of specific relationships, and for others there was a more general shift in the way they felt able to trust and relate to anyone, particularly in relating to men.

Practical impacts

The final theme that emerged from the interviews were the distinctly practical repercussions participants described. The main practical impacts that people spoke about were: the provision of childcare, providing accommodation, helping the survivor to move home, and in some cases having to move home themselves. Some people spoke about trying to help the survivor financially, and others mentioned the practicalities of pitching in in the immediate aftermath of abuse behaviours. Several people also spoke about practical implications that interrupted their lives resulting in changes of plan, for example, needing to come home early from holiday and changing retirement plans. Others spoke of needing be endlessly flexible and available in order to support the survivor.



Discussion

In the interviews, the psychological and emotional effects emerged as the primary impact on the wellbeing of members of the survivor's network. Within this theme, there was a spectrum of experience in terms of severity of impact and longevity. Impacts related to trauma often resulted from witnessing events first-hand or from initial survivor disclosure, whereas impacts such as powerlessness, anxiety, loss, low mood, frustration, guilt and self-blame, tended to develop over time. These longer term impacts were akin to those that might be expected in people offering informal support to loved ones in complex situations such as those battling with substance abuse or an eating disorder.[35] However for DVA the source of harm is another person, which adds a further dimension of complexity to the experience. With regards to trauma-related impacts, what friends and relatives reported was consistent with symptoms of post-traumatic stress disorder (PTSD) or acute stress disorder (ASD),[36, 37] caused either by direct exposure to abusive events, or by hearing distressing information about incidents.

In addition, friends and family members described physical health impacts. Lower level symptoms tended to be transient, whereas more persistent physical symptoms were viewed by network members as having resulted from the overall stress of the situation as they supported the survivor.

The behaviour of the perpetrator, and members of *his* network, had direct impact on the survivor's social network. Contact, in itself, could be fraught with difficulties; with friends and relatives sometimes avoiding being around the perpetrator, either because they felt discomfort themselves about being in his presence or because the tension they felt between treading carefully, for the survivor's sake, and the desire to confront the perpetrator was too great. At the opposite end of the scale, network members were at risk of direct physical violence in the context of the handover of children. This danger, and the threatening and controlling behaviours they experienced, impacted on their wellbeing, with a degree of fear, anger and anxiety resulting, even when physical injuries were not sustained.

All participants described relationship impacts, either with the survivor or with others around them. For some, the relationship changes with the survivor had begun before they had become aware that the survivor's relationship was abusive, and they experienced a sense of bewilderment as the survivor behaved towards them in ways that they considered unusual and sometimes hurtful. Once aware of the DVA, there were ongoing challenges for the relationship, especially when well-intended support was seemingly rejected or ignored. Some impacts on relationships endured and occasionally relationships terminated completely; in this scenario, feelings of guilt could be extremely potent.

The practical impacts experienced by network members were spoken about a great deal, and there seemed to be a relational quality operating, with the practical impacting on wellbeing, and wellbeing impacting on the practical. The resultant disruption from providing practical support was sometimes longer-term, causing significant alteration or abandonment of plans. Whilst for some, the practical repercussions had a minimal element of choice attached, it was clear that for others, the active choice to help the survivor in practical ways was a means by which they tried to gain a sense of control within the situation.

Beyond the themes described, two meta-themes emerged which will be discussed below:

Direct coercive control

Stark highlights that coercive control is not only used directly towards survivors, but also indirectly *via* friends and relatives in order to increase the perpetrator's control over the survivor, most often by promoting a distancing between the survivor and members of her social network.[38] Tactics used in this way were not uncommon in participant's descriptions, with perpetrators lying about the survivor to her friends in order to achieve her compliance, contacting survivors' colleagues at work to discredit the survivor, making threats to harm network members, and making accusations against parents of survivors. Some of what was described however, went to another level, which was beyond further controlling the survivor *via* her friends and family, to controlling *them* directly, almost as an extension of her. Some of this related to physical violence, but there was also a less overt sense of menace that people picked up on, an '*aura'* or a perception that the perpetrator was dangerous and that they themselves were at risk of harm. This was expressed by females, where sometimes there were sexualised undertones, and by new partners. Authoritarian, dictatorial behaviour was often experienced, particularly when the survivor had children, with the perpetrator making rules about contact which resulted in punishments if not adhered to. Even if not explicitly stated, people implicitly understood that non-adherence to perpetrators' demands or prohibitions would result in negative consequences. Perhaps, in the same way that abuse of children in a household where there is DVA is more likely,[39] the perpetrator may view others closely related to the survivor in the same way: that by exerting his control over them as well, his sense of power over the situation is heightened. In addition, it was clear from descriptions in the interviews, that just as perpetrators endeavour to continue exerting control over survivors post-separation, the same was true for relatives and partners. The threats, intimidation, harassment, stealing, damage to property, and physical violence could start, continue or escalate once the survivor had left the relationship. There are potential knock-on effects of the directly threatening behaviour, harassment and intimidation that was experienced for wellbeing.[40] Psychologically, we know that depression, anxiety and post-traumatic stress can result, and physically that sleep can be affected for people on the receiving end of these kinds of behaviour.[41, 42]

Impact mediation

A second meta-theme was the possibility of impact being mediated. We know that resilience against the impact of negative events and stressors varies at the individual level, and across time and circumstance,[43] but the findings also indicated a number of factors that appeared to mediate *what* was experienced, depending on the characteristics of the network member (gender in particular), the relationship the network member had with the survivor, the DVA the survivor was experiencing and whether or not she had children with the perpetrator. The first factor mediating impact was the gender of the network member. Both men and women described a sense of powerlessness but the trajectory towards this was often different. In general, men spoke about becoming angry towards the perpetrator, and mentioned their role in relation to *'protecting'* the survivor, feeling that they had *'failed'* her if they had been unable to do so. In addition, women mentioned *'guilt'* more often than men, particularly struggling with the idea that they could have or should have responded to, or managed the situation differently in terms of their interactions with the survivor. With regards to challenges to fundamental beliefs, women seemed more shocked that someone they knew had been in an abusive relationship, particularly when they attributed factors to the survivor that they felt were incongruent with being victimised, such as emotional strength and intellect, whilst men were more taken aback by the behaviours of perpetrators. Regarding direct perpetrator impacts, both men and women were at risk of potential physical harm, injury or assault, although more women described being on the receiving end of behaviours that were designed to intimidate, control or belittle them, sometimes with an underlying sexualised element. One of the important implications of these findings about how gender mediates impacts on people providing informal support, is how resultant responses to DVA situations may be influenced. Women's shock that someone they knew had been in an abusive relationship may lead to responses that are at best surprised or confused and at worst dismissive or victim blaming. For men, the lack of outlet for the blame and anger they feel towards the perpetrator, could potentially lead to a misdirection or an inappropriate expression of these emotions. The possible ramifications of this are substantial because it takes a lot of courage to disclose DVA, and any responses perceived as invalidating or blaming are likely to discourage future disclosures and help-seeking, and the survivor may even feel that she needs to protect or defend the perpetrator against expressions of anger from her supporters.

The second mediating factor was the closeness of the relationship with the survivor, both in terms of intimacy and proximity. The most commonly noted differences regarding the impacts experienced were between family members (including current partners) and friends (including colleagues), though this simple divide is somewhat artificial due to the roles friends and colleagues played if the survivor's family members were themselves abusive or showed a lack of understanding. Having said this, there were some general differences of note. First, whilst the DVA was happening, family members often knew something was wrong but not necessarily what. In contrast, friends tended to be disclosed to more readily and sometimes knew a lot of detail about the abuse. This resulted in friends being more shocked by what they knew or had witnessed, whilst family members described greater uncertainty and confusion. Fear for one's own safety was more often expressed by people who had witnessed or had been in close proximity when physically abusive behaviours were taking place, which tended to be friends. However, family members and current partners appeared to be at greater risk of actual physical harm from the perpetrator. Part of this may have been because friends sometimes proactively chose to reduce or prevent contact with perpetrators, whereas for family members, particularly where the survivor has children and the perpetrator has on-going access, contact may have been less avoidable.

Practically, as other research from survivors' perspectives has found,[18] there was a difference between the support friends and family members provided, with family providing more tangible assistance in the form of childcare, finances and accommodation, and friends and colleagues providing mainly emotional support.

The third mediating factor which emerged was whether or not the survivor had children, which links, in part, to discussions in the previous section because it was family members and current partners who were most affected by this factor. It was in the child handover context when relatives and partners assisted survivors that threats were made, that the perpetrator became violent and that actual physical harm was perpetrated against network members. In addition, people's fears, anxieties, distress, frustrations and anger were generally heightened about the DVA situation when children were part of the picture.

The final mediator was the severity of DVA the survivor had experienced, in terms of the extent of the abuse and how much the network member knew about it. Where people knew the detail about high-end physical and sexual abuse or suspected that this was happening, they were often very engaged with the survivor, experienced a stronger sense of shock, were fearful for her, and felt a strong sense of responsibility in the situation. Where abuse was less extreme or less obvious, people more frequently described their confusion, and their uncertainty of role. As more information became apparent, either by disclosures or by witnessing incidents, people's confusion abated.

Limitations

One of the limitations of this research has been that, whilst using a very broad definition of DVA (in keeping with the 2013 revised UK Home Office definition for domestic violence and abuse)[25] to try to capture experiences relating to as wide a range of survivors as possible, what was captured, almost exclusively, were the experiences of informal supporters of survivors of heterosexual *intimate partner violence*. A second limitation is that, in spite of attempts to recruit a varied group of participants, the sample lacked breadth for certain socio-demographic characteristics, ethnicity in particular.

Implications for theory, policy, practice and research

The findings from this research highlight gaps in existing models of domestic violence and abuse which focus on the primary individuals in DVA situations (the survivor, the perpetrator, the couple or the nuclear family) without considering the wider community context within which the perpetration and victimisation take place. These findings indicate that a whole range of people, including relatives, friends, current partners and colleagues may be impacted, and provide illustrative examples from the experiences of those close to the survivor. We are still very much working with two-dimensional models of DVA, and whilst it is appropriate that the survivor remains at the heart of any model, the complexity around real-life scenarios, including additional victims and multiple perpetrators, remains insufficiently represented. Further development of existing models is required to reflect this.

In terms of policy, where relatives have already been formally recognised, the definitions need to be extended to include friends and work colleagues in recognition that family members are not the only people who may be close to a survivor. In addition, there are any number of DVA related policies where the social context of the survivor is almost entirely invisible. An example of this is the recent report by Her Majesty's Inspectorate of Constabulary (HMIC), which acknowledges the inadequacy of the UK

policing response to DVA, with the stated intentions of forces not translating into operational reality, but hardly mentioning the survivor's network.[44] Clearly there is a need for police policy changes that reflect the potential for informal supporters to be: witnesses to DVA, supporters of the victim, and victims of criminal offences themselves, where perpetration has extended beyond the survivor.

There is also a need to extend the practices of professionals working in the DVA field to all the potential victims in domestic violence scenarios, so that the experiences and needs of a broader range of people are legitimised and met. Thus, the recommendation for all professionals routinely in contact with survivors (including healthcare staff, police, social workers, lawyers specialising in family law, and those in specialist DVA services) is that they need to give consideration to those around the survivor; to reflect upon who might be experiencing impact, and to provide opportunities for disclosure and legitimisation of concerns, experiences and feelings. An extension of the material covered by perpetrator programmes is also needed to address behaviours that perpetrators may be using to directly target members of the survivor's social network.

Future research needs to triangulate perspectives of friends and relatives with that of survivors and perpetrators, so that abusive relationships are considered from multiple viewpoints, broadening our understandings around abuse tactics, disclosure, and helpseeking.

Conclusion

Whilst previous research has highlighted the potential benefits for survivors of interactions with informal supporters, rarely has this group been considered in their own right in terms of the impact they may experience and the needs they may have within the situation. The findings from this study make evident the numerous, often concurrent, and potentially profound and persistent impacts on safety, health and wellbeing that adults around the survivor experience. Recognition of the predicament of informal supporters and provision of support would equip them in this role so that their own safety, coping, and wellbeing are not compromised.

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