Understanding the experiences of South Asian survivors of domestic abuse who have sought help for their mental health.

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Abstract

Introduction: Domestic abuse (DA) is a public health problem, adversely affecting millions of women in the UK every year. There are clear links between experiencing DA and subsequent psychological distress and mental health difficulties. There exist a multitude of complex pathways to support after experiencing DA, none of which are documented clearly in the literature. Women's experiences of seeking help for their mental health after experiencing DA are severely under-researched. The overall help-seeking and particularly mental health help-seeking experiences of Women of the Global Majority (WGM) are addressed only in a handful of UK based studies. Little is known about what this process looks like and how it is understood and experienced by the women who must navigate it. One UK based study exists, focusing on the DA, mental health, and help-seeking experiences of South Asian women (Anitha et al., 2009). This research seeks to expand on these findings.

Method: Semi-structured interviews were carried out with six South Asian women who had experienced domestic abuse and sought emotional support from services.

Results: Interview data was analysed using interpretative phenomenological analysis (IPA), resulting in a rich and detailed account of how these women understand and assign meaning to their experiences of mental health-help seeking after DA.

Discussion: This study aligns with some of the existing literature on mental health help-seeking in South Asian communities and adds to the very limited evidence base around South Asian women's experiences of mental health help-seeking after DA. Implications and recommendations from the findings are made for services working with South Asian survivors, as well as for future research.

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Chapter One: Introduction

This chapter will clarify and explain the key terms used and areas of focus for this research. Information on the prevalence of DA and the status of DA service provision in the UK will be provided to set the scene. I will then detail my position as the researcher, in relation to the subject matter and focus of this research.

1.1 Clarification of Key Terms and Areas of Focus

1.1.1 Domestic Abuse

A variety of terms have been used across contexts, to refer to violence and abuse in a domestic setting, including family violence, intimate partner violence, and spousal abuse (Capaldi et al., 2012; Fyfe et al., 1997; Rentz et al., 2006). The use of 'domestic violence' has, in recent years, fallen out of favour, due to its lack of recognition of the spectrum of abusive behaviours that are present in such relationships, including financially, physically, sexually, psychologically, and emotionally abusive behaviours, as well as coercive control and stalking. Terms solely identifying intimate partnerships fail to recognise abuse between parents and children, adult siblings, and extended family members sharing a household. In this paper, fitting with the terminology favoured by a majority of women's organisations, domestic abuse (DA) will be used. Leading DA organisation, Women's Aid (2020), provide a comprehensive understanding of what the term encompasses, "...an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer" (Women's Aid website, 'What is domestic abuse?' section).

1.1.2 Focus on Women

Before further discussion of this thesis's focus on women, it is important to acknowledge the experience of male victims of DA. A growing body of research demonstrates the need for increased understanding and service provision in this area (Hogan et al., 2021). It is however the case, that the majority of DA and DA related homicide is perpetrated against women, by men (World Health Organization, 2017). Nearly one third of women worldwide experience DA or wider forms of violence against women and girls (VAWG) in their lifetime, with Women of the Global Majority (WGM) facing a higher risk (World Health Organization, 2019). This firmly identifies VAWG and DA as forms of gender inequality, public health problems, and violations of human rights. Feminist theories of DA identify its cause as a patriarchal system which perpetuates male privilege and gender inequality, with DA being a key form of control, allowing men to exert power over women (Dobash & Dobash, 1979). Critiques of this approach name its neglect of other forms of power and privilege exerted over people or groups due to their race, class, physical and intellectual ability, mental health, sexuality and other intersections of difference and diversity (Bograd, 1999).

It is for these reasons, and the wish to work in partnership with a women's support organisation to incorporate their expertise in the design and carrying out of the research, that I will be focusing on the experiences of those self-identifying as women, including transgender women. The term 'women' when used throughout this paper, will refer to those who identify as women who have experienced DA, perpetrated by persons of any gender, unless stated otherwise.

The experiences of DA of those who identify as transgender and non-binary are significantly under researched. The very small amount of research available generally focuses on lesbian, gay, bisexual, transgender (LGBT) and non-binary people together, and demonstrates comparatively high levels of DA within these communities (Magić & Kelley, 2018, 2019). DA service provision for LGBT and non-binary people in England falls far below the levels needed to meet demand. For trans and non-binary people in particular, there are significant barriers to accessing mainstream DA support which is most often commissioned to support either women or men (Field & Rowlands, 2020). Although the focus of this research will not be on the particular experiences of transgender or non-binary people, those who are in receipt of services from the host organisations will be invited to participate.

1.1.3 'People of the Global Majority'

A variety of terms are in frequent use to indicate membership of different ethnic communities. Recent discourse around the commonly used acronym, BAME (Black, Asian, and Minority Ethnic), details problems with its focus on skin colour and generalisation of varied ethnic groups (Bunglawala, 2019). Calls for the use of minoritised (Gunaratnam & Hier, 2005), racially minoritised (Milner & Jumbe, 2020), ethnic minority, and minority ethnic group (Wilson, 2010) detail the usefulness of these terms in recognising the individuality of the identities of the people they refer to, rather than simply their skin colour. They are also hailed as drawing attention to the power involved in minoritisation occurring as a social process.

Throughout this paper, the term People of the Global Majority (PGM) or Women of the Global Majority (WGM) will be used to refer to people who are "Black, Asian, Brown, dual-heritage, indigenous to the global south, and or have been racialised as 'ethnic minorities'" (Campbell-Stephens, 2020). PGM takes a conscious stance in not centring Whiteness as the norm. This is not to dispute that the process of racial minoritisation does happen to PGM in many countries but refers to their existence without placing it within the context of Whiteness.

It is important to note that people can be minoritised in different ways such as through sexuality or disability. The experiences of women minoritised in these ways are valid, important, and worthy of research attention. The focus of the current research, however, will remain on the experiences of WGM.

1.1.4 South Asian

Differing definitions for this group of people exist, although most involve a stipulation of a familial or cultural background linked to some combination of the following countries: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. For the purpose of this research, South Asian will refer to anyone who identifies with this as their cultural or ethnic group. This decision was made on the advice and consultation of the VAWG manager of the host organisation for this research. This organisation which specialises in providing DA support to South Asian women will be discussed in further detail in the methods section.

1.1.5 Mental Health and Emotional Wellbeing

A number of terms are commonly used to refer to the experience of psychological or emotional distress. Some of these, such as mental ill health, mental disorder, and mental illness, align with the understanding of distress as a symptom of psychiatric disorder and diagnosis. In line with the position statement of the British Psychological Society (BPS), outlining the empirical limitations of this psychiatric classification system, and advocating for the understanding of psychological distress in the context of psychosocial experiences, alternative terms will be used in this paper (DCP, 2013).

For simplicity, ‘mental health’ will be used in reference to services and the criteria for receiving support from services, e.g., mental health services provide support for people experiencing mental health difficulties. To capture a wider understanding of distress, avoiding the exclusion of those without psychiatric diagnoses, the language in this paper will follow the BPS guidelines on psychologically informed language (DCP, 2015). The aim of this language is to describe the experience of psychological distress in a way which acknowledges its interpersonal, systemic, and political causes. The term ‘psychological distress’ or closely related terms such as ‘mental wellbeing’, ‘emotional wellbeing’, ‘emotional distress’ will be used throughout, alongside ‘mental health’.

The limited applicability of the psychiatric classification system used in the Diagnostic and Statistical Manual (DSM-IV) to cultures which are not White and western is much documented (Department of Health and Social Care, 2018; Thakker & Ward, 1998). In a study using interviews with South Asian women living in Bristol, Fenton and Sadiq-Sangster (1996) documented the understanding of, and language used to describe psychological distress. Amongst all women interviewed, their language for psychological distress avoided any diagnostic or medical illness related terms and instead created a rich explanation of the feelings and emotions related to distress, as well as the life events which precipitated them. Although this only represents the experience of this particular group of women and their community, with most having moved to the UK from the Punjab region of India and Pakistan, it is an indicator that the language used in this paper should align with the communities this research is for. US (Karasz et al., 2013), UK (Hussain & Cochrane, 2010), and Bangladesh (Ahmed et al., 2001) based research have reported similar results, with South Asian women favouring social and descriptive definitions of psychological distress that situate distress as an expected response to difficult life problems and experiences.

1.2 Prevalence of DA

Accurately quantifying the true prevalence of DA experienced by women in the UK is a difficult task which no organisation is yet to achieve. Many women will not feel able or want to report their experiences to the police or support services, resulting in the true scale of DA being underestimated in existing data sets. Perhaps the best estimate available comes in the form of the Crime Survey for England and Wales (CSEW). This extensive yearly record of experiences of crime, regardless of whether reports have been made to the police, goes some way towards understanding the impact of DA.

Prevalence rates for the year ending March 2022 found 6.9% of women experiencing DA with 29.3% of women reporting having experienced DA since the age of 16 (ONS, 2022). In total, 1.7 million women were estimated as experiencing DA in the past year, with 74% of DA related crime victims being female. Within the overall sample of those recorded as being of ‘Asian’ ethnicity, 3.2% women reported being victims of DA. In figures covering the years ending March 2019 to March 2021, 373 domestic homicides were recorded by the police. 56% (210) of these were female victims killed by a partner or ex-partner and 16% (59) female victims killed by a family member. Of these 269 female victims of domestic homicide, 10% (27) were recorded as being of South Asian ethnicity (ONS, 2022).

It must be considered that the nature of DA and its propensity to create feelings of shame and experiences of stigma (McCleary-Sills et al., 2016), particularly for South Asian women (Gill, 2004), will result in many women not responding openly in survey interviews. Others will not feel safe enough to disclose their experiences of abuse, particularly if interviews are carried out where their perpetrator may overhear. Although the law has made advances in recognising a wider range of DA, such as coercive control and forms of emotional abuse (Serious Crime Act, 2015) the focus of the CSEW on specific criminal offences, will inevitably miss some of the nuanced forms of DA that women experience. The CSEW also states that smaller sample sizes within communities of PGM are likely to limit the accuracy of estimations of prevalence.

1.3 Context: DA Service Provision in England

Prior to the 1970s, there was no formal provision of support and services to women who had experienced DA. In 1971, Refuge, currently the largest UK based DA organisation, opened the first safe house for women and children fleeing DA. In 1974 the Women's Aid federation was formed, creating a nationwide network of frontline DA support providers. Refuge, Women's Aid and subsequent services pushed for the recognition and protection of women's rights and wellbeing, aligning with the wider Women's Liberation Movement at the time (Binard, 2017). Since then, provision of DA support within the UK has grown, maintaining its links to feminist groups and movements.

Women's Aid, now a federation of over 170 DA services, produces a yearly report of service provision across England. As of May 2022, they recorded a total of 395 services run by 226 providers. The support provided by these services includes refuge accommodation, resettlement, phone and chat-based helplines, support groups, counselling, and community-based support such as DA advocacy, floating support, and outreach. Many local services provide a combination of these types of support, with women able to access a variety within the service, concurrently or consecutively. 67.1% of services in England are provided by specialist DA organisations with the rest being provided by organisations with a wider remit such as local authorities and housing associations (Women's Aid, 2023). It is well documented in each yearly report that this current provision is not enough to meet demand. From 2020 to 2021, 15 fewer services were able to offer counselling, and the number of refuge spaces available each year consistently falls below the recommended amount set by the Council of Europe, 24.2% below in 2021 (Council of Europe, 2008).

This yearly report also collates data on the support needs and characteristics of women who use these services. Their most recent sample is of 38,045 women who had successfully used DA services across England during 2021-2022. Data is gathered using a database accessible to, and used by, many DA organisations. Although this data does not cover all DA services in England and is reliant on staff across many organisations systematically recording support offered, it provides a useful snapshot of support being accessed. Around 7-9% of women who had accessed support were of a South Asian background. Within the wider sample, 41% of women had mental health support needs with a higher percentage in women using refuges services (50.1%). 6% were recorded as having additional support needs around drug and/or alcohol use as well as mental health.

1.3.1 Specialist DA Provision

The above is likely an underestimation of the true prevalence of these support needs within the population of women who have experienced DA. Women’s Aid acknowledges that women facing multiple forms of inequality, with multiple support needs, will face the greatest difficulty in accessing DA support (Austin, 2021). Barriers were most commonly experienced when services failed to respond adequately to those who were minoritised in terms of their race, mental health or immigration status. Part of this problem stems from the difficulty faced by general DA services in being able to provide support both to the wider population and to those with more specific support or cultural and language needs. Providing holistic support to women experiencing severe psychological distress, particularly in residential refuge settings, is a significant challenge for staff who often do not have access to specialist mental health training. Women’s Aid’s most recent annual report found only 0.6% of nationwide refuge bed spaces can be offered to women with mental health or substance use support needs (Women's Aid, 2023). A previous report detailed that only 14.5% of refuge services in England have specialist mental health support workers and 9.3% specialist substance use support workers (Women's Aid, 2021a).

Many WGM report markedly more positive experiences of being supported by specialist ‘by and for’ services, staffed by women who speak their language, understand their culture, and are situated within their community (IMKAAN, 2018). Although there are a number of culturally specific 'by and for' DA services providing support to WGM, this is a very small proportion of total DA provision with only 9.2% of nationwide refuge beds being dedicated for WGM (Women's Aid, 2023). These specialist services are more vulnerable to funding cuts in a commissioning system which favours large organisations that can provide more competitive offers during tendering. In 2022 around 70% of generic DA services in England were funded by relatively reliable and secure local authority commissions, in comparison to only around 45% of ‘by and for’ services (Women's Aid, 2023). The longer women must remain in abusive relationships without support, the more severe the impact on their emotional wellbeing and safety (Thiara, 2021). WGM, who are more likely to be subject to multiple levels of intersectional oppression based on their gender, ethnicity, socio-economic status, or religion (Crenshaw, 1989), are at a heightened risk whilst they are underserved by support organisations.

1.4 Positioning Myself in the Research

Various aspects of myself are important to consider in the context of this research. I identify as a cisgender, White Irish woman. Many of my cultural and life experiences will be markedly different from those of the women involved in this research. Throughout, I continuously assessed the assumptions these experiences may have led me to make about the data, and how these may have differed to those of the participant. In attempting to understand the experiences of South Asian women, my Whiteness and the power and privilege it affords me were continuously present and attended to with the South Asian women in my research team.

In deciding on the demographic focus of this research, I was aware of my position as a White researcher, attempting to understand the experiences of South Asian women. White privilege ensures that I will never understand many of the experiences, particularly those of racism, which PGM live through. My decision to go forward with the research was influenced by several factors: current literature which highlighted the severe need for further understanding of the experiences of South Asian women, the involvement of one of my supervisors who is a South Asian woman, the involvement of Sara (pseudonym), also a South Asian woman, who acted as an expert by experience and field supervisor, the involvement of the host organisation who provided advice and feedback rooted in their years of expertise as a women's centre set up by and for South Asian women, the involvement of Anowara, an interpreter and South Asian woman who works at a different South Asian women's centre, and lastly the knowledge that around 88% of Clinical Psychologists in the UK are White (BPS, 2015), with 76% of trainee clinical psychologists accepted to courses in 2021 being White (Clearing House, 2021). Although I would not have chosen to complete this project without the invaluable input of those mentioned above, my decision was guided by my opinion that the responsibility for carrying out research with PGM should not lie solely with the minority of psychologists who are PGM. The above results suggest that the profession may be moving in the direction of becoming more diverse, but that PGM clinical psychologists remain in the minority currently.

Every major decision throughout the process was discussed with one of the above-mentioned people, checking for blind spots resulting from my Whiteness. In presenting the results of this research, it is important to note that my analysis of the data cannot be representative of the experiences of all South Asian survivors of DA, that I do not adopt a position which would allow such a generalisability. The aim of this research was to explore the experiences of the six women interviewed and provide a basis for further dialogue and research.

This chapter has provided an introduction and some context to the key areas of focus in this research. I have also clarified my position as the researcher. The next chapter will provide a detailed literature review of relevant existing research, as well as a rationale for the current research and research questions.

Chapter Two: Literature Review

This literature review will first cover the impact of DA on psychological wellbeing and an overview of how mental health services work with experiences DA. The literature on help-seeking will then be looked at, with a focus on how shame, stigma, South Asian cultural values, and experiences of DA impact on help-seeking. An overview of existing UK based research on DA survivors' mental health help-seeking journeys will be covered, before a detailed discussion of the small number of papers looking at the experiences of WGM and South Asian women. This section will then conclude with a rationale for the focus of this research and a detailing of the research questions.

2.1 Impact of DA on Mental Health

DA and psychological wellbeing are inextricably linked, with a multitude of published research drawing links between experiencing DA and the development of a wide spectrum of mental health difficulties (Coker et al., 2002; Jones et al., 2001; Pico-Alfonso et al., 2006; Romito et al., 2005; Trevillion et al., 2012). Much less research exists, particularly within the UK, on the interaction between DA and mental wellbeing in WGM. US based studies identify a complex intersection of heightened risk of DA, higher likelihood of other life stressors such as economic deprivation, and a lack of culturally competent service provision, leading to greater incidence of DA related mental health difficulties in WGM (Rodríguez et al., 2009; Stockman et al., 2014).

Research from across South Asia demonstrates similar links between experiencing DA and developing mental health difficulties or emotional distress. In Bangladesh, women were reported to be significantly more likely to experience poor mental health and suicidal thoughts or actions if they had experienced DA (García-Moreno et al., 2005; Naved & Akhtar, 2008). A study with a sample of 150 Pakistani women found 73% of women who reported DA having difficulties with anxiety and low mood (Fikree & Bhatti, 1999). A large-scale study of Indian women found DA to be a significant risk factor for low mood and attempted suicide (Chowdhary & Patel, 2008).

One UK based study which explored the DA experiences of South Asian women, found negative impacts of abuse in the form of low mood and anxiety, as well as low-self-esteem which became worse the longer they were subject to abuse, making it more difficult to leave. These women felt that anxiety and low mood, related to the potential negative response from their community if they were to leave, were linked to them remaining stuck in abusive relationships (Gill, 2004). A review of all available UK based literature highlights the exacerbating impact of the other difficulties faced by WGM who experience DA. Social isolation of women who have emigrated to the UK, involvement of extended families in abuse, having to escape far from community support, honour-related violence, and structural racism and misogyny all add to the detrimental effects of DA on mental health and wellbeing (Thiara, 2021).

2.1.1 DA and UK Mental Health Services

Various studies suggest that as many as 50% of women who access NHS mental health services have experienced DA (Department of Health, 2002; Trevillion et al., 2012). Alongside research highlighting significant numbers of women who do not disclose abuse to services (Trevillion et al., 2014), this highlights the importance of the mental health system having an understanding of women's experiences of DA and psychological distress, and their subsequent help-seeking behaviour. National Institute for Health Care Excellence (NICE) guidance names multi-agency partnership working as the most effective form of DA intervention (NICE, 2014). Other than statements that healthcare staff should routinely ask service users about DA, and refer them to specialist DA support services, the guidance is absent of any recommendations relating to how multi-agency partnership working should look in practice. A recent government briefing paper (Macdonald, 2021) outlines a range of guidance created by healthcare bodies, aimed at GPs, nurses, psychiatrists, and other health professionals, none of which address anything beyond the point of disclosure and referral to DA services. There is a dearth of research, and therefore guidance, addressing the role of mental health services and systems in the support of women who have experienced DA and the trauma associated with it.

Whilst recognising the role of health services, it is important to acknowledge the position of DA and the distress it causes, as social and political issues, rather than events which are experienced and managed only on an individual basis. Lavis et al. (2016) highlight the roots of DA support being in refuges set up by feminist collectives of women, where much of the expertise in the field developed, and still lies.

2.2 Mental Health Help-seeking

Early ideas around help-seeking focused on people's responses to illness symptoms in their bodies, finding that many failed to seek help from medical professionals in the presence of symptoms (Tuckett, 2013). As predominant forms of illness in society began to shift away from mostly acute and infectious diseases with clear symptoms, to less easily detectable chronic illnesses and psychological difficulties, the importance of understanding help-seeking behaviour became a focus within research (Field, 1976; Rickwood & Thomas, 2012).

Prevalence estimates of those experiencing psychological distress but not seeking help range from 70% worldwide (Thornicroft, 2007), 67% in the USA, (Kessler et al., 2005), 74% across Europe (Wittchen & Jacobi, 2005) 72-84% in the UK (Oliver et al., 2005), and more in low- and middle-income countries (Eaton et al., 2011). The accuracy of these estimates is hindered by methodological differences across studies using varied measures of psychological distress and help-seeking, as well as limitations in sampling and response bias. Despite these limitations, barriers to help-seeking clearly exist.

2.2.1 Barriers to Mental Health Help-seeking

A large-scale World Health Organisation (WHO) survey across 24 low-, middle- and high-income countries reported a perception that they did not need support as a leading cause of people with mental health difficulties not seeking help. Other barriers included the wish to deal with the problem personally and thoughts that the problem was not serious enough, or that it would get better on its own (Andrade et al., 2014). Disorders of mental health defined by diagnostic criteria were used to determine psychological distress in this study, risking the exclusion of those who do not conceptualise their difficulties in this way, and those whose difficulties are missed by diagnostic screening tools. The efficacy of this approach, using the same inclusion criteria and survey questions across all 24 countries must be questioned. How mental health is conceptualised and measured differs widely across cultures (Gopalkrishnan, 2018), limiting the applicability of concepts and measures developed in White, western contexts.

A systematic review of mental health literacy in Pakistan found a preference in some Pakistani people of seeking support from religious leaders, faith and homeopathic healers, and primary care before approaching mental health services. Residents of urban areas were found to be comparatively more likely to seek out mental health services, with the most common form of treatment being psychoactive medication (Munawar et al., 2020). Similar results have been reported in India (Kaaren et al., 2015; Mishra et al., 2011) and Bangladesh (Hossain et al., 2014), with lack of mental health infrastructure and service provision, as well as traditional cultural views on the causes of mental health difficulties also contributing to lower levels of help-seeking.

As well as those identified by Andrade et al. (2014), a UK study of young adults found embarrassment or shame, dislike of talking about feelings, and struggling with the cost of seeking help as significant barriers (Salaheddin & Mason, 2016). The qualitative element of this paper expanded on the influence of stigma on help-seeking, with participants reporting worries about being labelled and judged.

2.2.2 Stigma and Help-seeking

Stigma can be conceptualised as a process whereby individual differences such as illness, disability, gender, membership of a group, or skin colour are regarded by some as undesirable, and are subject to negative stereotyping. Those who possess these individual differences are then categorised by others as being different, distinct from the norm, and experience both interpersonal and systemic discrimination as a result (Link & Phelan, 2001). This process and the widespread beliefs it creates among the population, directly influence the self-concept of those with stigmatised individual differences. In the case of those with mental health difficulties, living in a society which devalues people with this experience can lead to the belief that others who know about their difficulties will view them negatively and reject them (Furnham & Bower, 1992; Link, 1987).

A worldwide systematic review of the impact of stigma on mental health help-seeking found a negative association between stigma and help-seeking, with stigma identified as a common barrier to seeking help. Fear of discrimination, shame, and embarrassment around negative judgement from others were identified across a number of studies. Qualitative analysis demonstrated that people's anticipation of negative experiences led to them hiding their mental health difficulties from others and avoiding seeking help. Actual experiences of stigmatisation after seeking help had a similar effect (Clement et al., 2015).

The inclusion of studies which looked at those who self-defined as experiencing psychological distress or emotional difficulties has strengths over those which focus solely on diagnostic criteria. The majority of studies included were carried out in high-income countries, likely limiting the applicability of the findings to non-western cultures. However, important findings were reported within subgroups containing samples of PGM. These subgroups were more likely to report stigma related to family and community, and the importance of keeping things 'within the family'.

2.2.3 Stigma and Help-seeking in South Asian Communities

The experience of being stigmatised is closely linked with feelings of shame (Carr & Ashby, 2020; Johnstone et al., 2018). Shame has been conceptualised as an umbrella term covering a range of emotions including embarrassment, humiliation, and guilt, all linked to a threat to social bonds between individuals and groups (Scheff, 2003). Within South Asian communities the concept of 'Izzat' is common. It refers to cultural rules which are intended to uphold family honour and respect (Wellock, 2010) and although based on overarching ideas about appropriate conduct, will differ across families based on socio-economic status, religion, education and other individual factors (Toor, 2009). Izzat often requires both men and women to adopt strict gender roles and prioritise the needs of the family unit over their own (Gill, 2008; Jafri, 2008).

The concept of 'Sharam', translated to shame, is closely linked to Izzat. This refers to the negative shaming experience of both the individual and their family when Izzat is not adhered to (Allan & Gilbert, 1997). Fear of this shame and the negative impact it can have on social standing within the community can often discourage South Asian people from behaving in ways which would go against the rules inherent in Izzat (Gill, 2010). Within the concepts of Izzat and shame, South Asian women are often placed in positions of subordination, expected to conform to strict patriarchal rules which place the control of women's liberty, decisions, and roles with their male family members (Gill et al., 2014; Mesquita, 2001). It is important to note that these mechanisms of patriarchal control are not exclusive to South Asian cultures and exist across all societies and groups (Epstein, 2007). The focus of this research is on South Asian women's experiences, making the consideration of South Asian cultural values and practices essential. This must not be construed as evidence of South Asian culture being alone in having problems with patriarchal and controlling behaviours towards women.

Gilbert (2002) describes the concept of 'reflected shame', in which an individual feels ashamed and guilty for bringing shame to others, often family members, and how this is linked with the concepts of Izzat and Sharam in South Asian cultures. There can be differences in the way emotions are experienced and expressed in collectivist and individualistic cultures with the former placing emphasis on how emotions like shame reflect on others, and the latter on how they reflect on the self (Mesquita, 2001). In a focus group-based exploration of South Asian women's experiences of mental health and help-seeking, in relation to Izzat and shame, themes around putting the needs of others first, keeping things to yourself, and fear of breaches of confidentiality were raised. Women spoke about feeling blamed by their families for having mental health difficulties and not wanting to speak about these in case their family found out. This was a particular issue when health professionals such as GPs were part of their community, having links to their family members. A strong sense of responsibility through Izzat, to not go outside the family for help discouraged participants from seeking help (Gilbert et al., 2004). Other research has documented discourses of shame around mental health difficulties as disordered, abnormal, and therefore shameful, discouraging help-seeking particularly in girls and women who feel responsible for upholding Izzat (Baldwin & Griffiths, 2009; Sangar & Howe, 2021).

Research from a number of South Asian countries including Bangladesh (Hossain et al., 2014), India (Mathur Gaiha et al., 2014), Afghanistan (Nine et al., 2022), and Pakistan (Munawar et al., 2020), identifies shame and stigma related to mental health difficulties as significant barriers to mental health help-seeking. Factors such as avoidance of people displaying psychological distress, societal narratives of people experiencing distress as dangerous, and an expectation that family members, particularly women, should uphold family honour by keeping distress hidden were all implicated. All the above research also recognised that mental health service provision is unable to meet the needs of these populations, inevitably meaning that many will seek support elsewhere.

2.2.4 Other Factors in Help-seeking in South Asian Communities.

Although shame and stigma do present barriers to help-seeking within South Asian communities, strengths that these communities hold may make professional help-seeking less common or less needed at times (Anand & Cochrane, 2005). Religion, prayer, faith healing, community support and informal support from family and friends have all been found to be of importance to South Asian people experiencing psychological distress (Beliappa, 1991; Hussain & Cochrane, 2003). In a review of the UK literature, Anand and Cochrane (2005) found a number of studies identifying the value placed on family as a source of support for psychological distress. The same review highlighted the multiplicity of options considered by many South Asian people in the UK in seeking help for their mental health. Rather than seeing professional services as their only course of action, support from family members, community elders, faith healers, and friends may be sought out (Sheikh & Furnham, 2000).

A lack of understanding within services, of the values, culture, languages, experiences, and ways of conceptualising psychological distress of South Asian people has been widely identified as a barrier to help-seeking (Gilbert et al., 2007; Gilbert et al., 2004). Additionally, WGM who have experienced, often throughout their lives, inadequate or harmful responses from services working within an inherently racist system are often discouraged in deciding to seek help (Femi-Ajao et al., 2020). A qualitative study found South Asian service users in the UK commonly experiencing mental health services as unwilling to provide interpreters, carrying out appointments in English whilst knowing this was a barrier to understanding and being understood (Bowl, 2007).

2.2.5 Help-seeking in Women Survivors of DA

Much research looking at gender differences in mental health help-seeking has evidenced lower levels in men than women (Doherty & Kartalova-O'Doherty, 2010; Haavik et al., 2019; Oliver et al., 2005; Wendt & Shafer, 2015). Social narratives around masculinity, resulting in men feeling pressure to be ‘strong’ and self-reliant, have been implicated in this imbalance (Robertson, 2003), as well as men experiencing more internal stigma related to mental health difficulties (Judd et al., 2008). Although this may be the case across the wider population, as discussed in the upcoming sections, care must be taken in considering the ability of women who have experienced DA to safely seek help, with South Asian women facing specific and multiple barriers.

2.2.5.1 Intimate Partner Victimisation Model.

The negative, and at times hostile, treatment of women who have experienced DA, by services such as the police, courts and health and housing sectors has been linked to feelings of stigmatisation in these women (Barata & Stewart, 2010; Beaulaurier et al., 2007). Women's experiences of these services will be detailed further in section 2.3. The Intimate Partner Violence (IPV) stigmatisation model (Overstreet & Quinn, 2013) outlines how cultural stigma about survivors of DA, can influence their feelings of anticipated and internalised stigma. Cultural stigma was found to be demonstrated through judgemental behaviours and victim blaming from services, family, friends, and the public. Anticipated stigma refers to an expectation that stigmatisation will occur and anxiety about this, something which was found to be a common barrier to help-seeking in the research supporting the model. The model proposes that these two processes can lead to stigma internalisation or self-stigma, through which women feel ashamed about their status as a victim of DA and are strongly discouraged from seeking help and disclosing their experience. This model and the research on which it was based provide important information on the impact of stigma on women's help-seeking, however, other factors must also be considered.

2.2.5.2 Three Step Framework.

Liang et al. (2005) use existing models of mental health help-seeking to look at the stages of DA related help-seeking decisions, and the individual, interpersonal and sociocultural influences on these. Three steps, not necessarily linear in nature, are proposed to take place in the lead up to seeking help; recognition and appraisal of the problem, deciding to seek help, and choosing where to seek it.

2.2.5.2.1 Problem Recognition and Appraisal. The framework identifies a number of factors that influence a woman's appraisal of the DA she is experiencing. A key point is the wide variety of definitions for DA across individuals, families, cultures, and professional groups. These disparities also exist, perhaps on an even larger scale, in defining psychological distress and deciding at which point it becomes problematic, with research identifying significant differences in the way mental health is conceptualised across gender, culture, religion, professional groups and generations (Gopalkrishnan & Babacan, 2015; Hackney & Sanders, 2003; Palumbo & Galderisi, 2020).

2.2.5.2.2 Deciding to Seek Help. Liang et al. outline research pointing to women's socio-cultural identity influencing her help-seeking decision making, both around mental wellbeing and DA. As well as cultural influences such as those discussed in section 2.2.3, women's personal characteristics, shaped through life experiences will be at play. Those who tend to relate to, and seek support from others more generally have been found to be more likely to seek help after experiencing DA (Rose & Campbell, 2000).

2.2.5.2.3 Selecting a Help Provider. Finally, the model outlines how the previous two steps will influence which type of support women will seek. Within UK DA and mental health services this presents a complex and difficult choice. As will be outlined in section 2.3, there are a multitude of avenues for women to choose from after experiencing DA. The framework proposes that those with problem-focused coping styles are more likely to choose services that offer practical solutions and those who tend towards emotion-focused coping, support services. Although there is merit in thinking about the reasons behind help-seeking decisions, this may not be as straightforward in practice. There is significant overlap in the types of support provided by certain services, as well as downfalls and deficits across services, causing many women to fall through the gaps.

2.3 UK Experiences of Mental Health Help-seeking after DA

Help-seeking after DA tends to take many forms across a variety of services. This is reflected in research which includes records of women's experiences with housing, police, courts, criminal and legal justice systems (Banga & Gill, 2008; Belur, 2008; Coy et al., 2015; Hester et al., 2003; Thiara & Gill, 2012; Westmarland et al., 2017). The focus of this project is on help-seeking journeys relating to emotional wellbeing and mental health. It follows that this review will focus on research detailing experiences of services whose remit is to provide some form of emotional support, rather than the range of support provided by the organisations above.

2.3.1 Mental Health Services

Most available research points to shortcomings and negative experiences regarding access to, and support from, mental health professionals. A lack of knowledge concerning DA and its impact on women, as well as unhelpful, unsupportive, and victim blaming responses are evidenced (Trevillion et al., 2016). Women have reported experiences of their distress being viewed within a medical model and labelled as mental illness such as psychosis (Oram et al., 2013) or personality disorder (Stark & Flitcraft, 1996). At the other end of the scale are reports of denial of support for mental health difficulties by professionals who believed these problems would resolve if a woman was to leave her abuser (Trevillion et al., 2014). Despite the mostly negative experience detailed here, there were some positive reports within the literature of acknowledgement of needs (Trevillion et al., 2014), a non-pathologising approach, and care and trust from and with mental health professionals (Oram et al., 2013).

In a longitudinal study looking at the experiences of 100 women, Kelly et al., (2014) documented instances of long waiting lists for NHS mental health support with women naming this, along with long periods of being prescribed psychotropic medication, as instrumental in prolonging their distress. Women who did access Cognitive Behavioural Therapy (CBT) through the NHS spoke of this as unhelpful due to therapists not addressing DA, or useful only as an add on to DA specific counselling. This three-year-long study provides a rare insight into the difficulties women face at different points of their long journey of help-seeking and recovery from DA. It is one of very few studies which has a sample reflective of the wider population in its representation of WGM. In working with a London based DA service, the sample is limited to women based in London, where the highest concentration of both generic and specialist DA services lies. The experiences of women in other parts of the UK, with less service provision, may be markedly different.

2.3.2 General Health Services

Most of the research in this area focuses on disclosures of DA rather than ongoing emotional support. This reflects the role of health services such as GPs and hospital teams who will often encounter women who have experienced DA, seeking help for physical conditions both related and unrelated to DA (Dunn, 2000). A small evidence base points to various problems encountered by women who do choose to disclose in these settings, including a lack of support or signposting, lack of empathy and focus on the woman's needs, and dismissive attitudes from professionals (Robinson & Spilsbury, 2008). Women reported wanting a response from health services that was supportive and empathic despite this not being where they accessed ongoing emotional support (Bacchus et al., 2003).

In a UK based study of help-seeking after DA, 27 of a total 31 women had consulted their GP, mainly to request help with low mood and anxiety. None of these women were asked about DA by their GP and of the 16 who did disclose experiencing DA, all reported that this was prompted by them, not their GP. Of these 16, only two women who disclosed DA were referred on to specialist DA support, and four to counselling. Although 12 of the women who did disclose reported their GP being empathic and understanding, most were prescribed antidepressants with no further action, an outcome which women reported as discouraging and unhelpful (Evans & Feder, 2016). Again, this only provides a picture of the experiences of the women included, limiting confidence in the study's wider representativeness. Despite this, the in-depth insight into the journeys of these women adds great value to our limited understanding of what help-seeking after DA looks like.

Gill (2004) details additional difficulties in disclosing DA for South Asian women whose communities often place great importance on protecting honour and dignity by not speaking openly about matters considered private, such as DA. Also highlighted is a lack of experience across health services in competently supporting South Asian women who have experienced DA and must overcome these additional barriers to disclosure.

2.3.3 DA Services

In contrast to many of the other papers discussed, those which have looked at experiences of DA services provide generally positive accounts. Research demonstrates a wide variety of practical and emotional support, aimed at women's individual needs, being offered by specialist DA services (Brooks & Burman, 2017). Services having a clear understanding of DA and its impact on women, adopting an empathic and empowering approach, and the therapeutic value of the support offered are identified as strengths held by specialist DA organisations (Brooks & Burman, 2017; Madoc-Jones & Roscoe, 2010; Robinson & Tregidga, 2007). This reflects the position detailed by Lavis et al. (2016), that DA services hold much expertise in supporting women, something which statutory services can learn from.

Predictably, negative experiences involving DA services typically involved issues related to a lack of funding. A lack of long term support and difficulties accessing oversubscribed specialist services are reported (Kelly et al., 2014; Wilcox, 2000). Independent peer reviewed research into the experiences of women using DA services in the UK is extremely limited. Whilst we know from a number of audits and reports carried out by DA services (IMKAAN, 2018; Women's Aid, 2021a, 2021b) that millions of women are accessing a wide variety of support, we are far from establishing a clear picture of how women experience this process.

2.3.4 Counselling and Third Sector Support Services

There is currently no UK research looking at this type of support provision. The small amount of evidence available in this area comes from papers looking at the overall help-seeking experiences of women. Within this, a range of experiences are reported by women who have accessed this kind of support, from being satisfied with prompt referrals and responses (Kelly et al., 2014) to dissatisfaction with waiting times and a lack of understanding of DA (Oram et al., 2016). There is clearly variability across services in this sector which the evidence base cannot currently provide an understanding of.

2.3.5 Siloed and Fragmented Service Provision

As is evidenced above, we are developing the beginnings of an understanding of some women's experiences of support systems, albeit from research which sticks within the boundaries of respective services. This mirrors the reality of women needing to navigate a range of services to have their varied emotional needs met. Reports focusing on women facing multiple disadvantage, with experiences of DA, demonstrate a confusing landscape of siloed and fragmented support, across a variety of services, with further geographical inconsistencies in support offered (Holly, 2017; Scott & McManus, 2016).

In a large-scale project examining multi-agency working across 10 areas in the north of England, women reported difficulties with professionals from different backgrounds having differing understandings of DA and approaches to support, as well as a lack of communication and co-working to resolve these differences. The project also found that the large number of services working with individual women and families proved detrimental in meeting their needs, particularly due to a lack of cross service co-ordination (Peckover et al., 2013). Although focusing primarily on the geographical displacement and difficulties with housing services faced by women on their journeys to escape abuse, Bowstead (2017) reported the detrimental impact of a lack of continuity across services. The knock-on effect of lost momentum on women's journeys away from abuse and the difficulty women face in exercising control over their next steps is also identified.

The Three Planet Model (Hester, 2011) argues that different professional groups struggle to successfully integrate their approaches to DA support due to them existing on separate 'planets'. The differing histories, priorities, structures, and cultures of each of the service systems discussed above, restricts the ability of professionals within them to respond adequately and coherently to DA. Although this model focuses primarily on social services and DA services, the underpinning concept of 'habitus' (Bourdieu, 1989) supports its application to a wider range of service systems. The habitus of groups refers to the way individuals within a group perceive and interact with their world in ways prescribed by an internalisation of group culture and ideas. Professionals working under the habitus, or on the planet of mental health care may struggle to inhabit the habitus, or step onto the planet of DA services.

2.3.6 Integrated Approach

In a rare attempt to pilot an integrated approach across healthcare and DA services, The Pathfinder project ran from 2017 to 2020 across 18 NHS trusts in England (G.J. Melendez-Torres, 2021). Specialist staff from a range of community-based DA organisations were embedded in NHS mental and physical healthcare settings, allowing NHS staff to refer women directly within their service. Nearly 3000 healthcare staff were trained in DA recognition and support, and policies and procedures were reviewed with input and guidance from DA professionals. Independent analysis of the outcomes found consistent and significant increases in the number of women identified and referred for support across all regions where the project took place. Qualitative data demonstrated improved experiences of support with professionals across the services generally being perceived as empathic and helpful.

Problems with data collection from services based in areas with high levels of ethnic diversity, combined with generally lower levels of racially and otherwise minoritised women being supported by health services, resulted in a lack of evidence of any effect in populations of WGM. Women who are subject to intersectional inequality and oppression inevitably face the greatest barriers in accessing any service provision, particularly those which are not tailored to their needs.

The Pathfinder project is an early step in bridging a gap between services which have traditionally worked in isolation of each other. It is of utmost importance that WGM are not left behind in further initiatives in the same vein.

The LARA Project piloted an integrated DA and mental health services approach within five UK Community Mental Health Teams (Trevillion et al., 2011). Mental health staff were provided with training in DA, resulting in improved understanding, attitudes and actions taken in working with DA survivors. Service users surveyed reported their needs from services being better met after the introduction of the programme, as well as a significant reduction in the violence they were experiencing. Of the 34 service users who provided feedback, 68% were PGM, an uncommon strength in this research area.

A similar pilot, carried out within a London based NHS mental health trust, placed an Independent Domestic Violence Advocate (IDVA) within a community mental health team (BEH-MHT, 2018). The IDVA acted in their usual role of supporting and advocating for people who had experienced DA, with referrals coming directly from the community mental health team. As well as this, they provided training and guidance in working with DA, to mental health team staff. The pilot demonstrated a 660% increase in referrals from the mental health team to specialist domestic abuse services. Although staff restructuring significantly limited the number of staff who completed DA training, those who did reported increased confidence in understanding, recognising, and working with DA.

2.4 Experiences of Mental Health Help-seeking in WGM Survivors of DA

WGM are widely under-represented across the majority of literature referenced in the above section 2.3, with only one paper focusing specifically on WGM (Gill, 2004), demonstrating a significant gap in the literature. The first systematic review of UK based qualitative research looking at DA and help-seeking in WGM, provides some insight into their experiences (Femi-Ajao et al., 2020). Of the eight included studies, four relate to help-seeking situated mainly within the legal, state policy, immigration, and criminal justice sectors and so will not be discussed in this report. Three papers formed part of one study which will be addressed in detail below (Batsleer et al., 2002). The final paper has been discussed previously (Gill, 2004) and focuses mainly on culturally specific barriers to disclosure of DA for South Asian women.

Key findings included some of the main barriers to disclosure, some of which have been discussed previously in this report such as pressure, and discourses of blame and shame from the community, as well as a lack of cultural knowledge and expertise from support services. Several papers explored the impact of insecure immigration status and fear of deportation, creating a reliance on abusive partners and families and difficulty reaching out to services. These difficulties were compounded by most services being unavailable for those with no recourse to public funds. Femi-Ajao et al.'s review demonstrates just how little we know about the mental health help-seeking journeys of WGM. Although its findings on the general help-seeking process are helpful in understanding the experiences of these women, more specific research is needed.

One paper included in the review involved interviews with staff from a range of organisations including refuges, housing and social services, police and drug and alcohol services. Interviews were also carried out with 23 women, about their use of services. As well as focusing on WGM of South Asian, African, and African-Caribbean ethnicities, this study included two White minority groups in Irish and Jewish women (Batsleer et al., 2002). Some of the findings relate to barriers to disclosure, similar to those discussed previously. Separations in role and responsibility between professionals of different services were evidenced, with women's needs going unmet as they fell through the gaps. Professionals of all involved services repeatedly identified feeling unsure about how to support women whose needs fell outside their normal remit. Some women reported their emotional needs being neglected by organisations that simply did not have the capacity to support with anything other than the most urgent practical matters.

The results of this research and the themes identified, provide recommendations for changes in service provision to improve accessibility and quality of support for minoritised women which can be applied to a variety of services and sectors. Statutory services are recommended to place great importance in working alongside culturally specific community organisations, particularly for women who have had to leave their communities. A greater availability of culturally specific services is called for, and in the absence of this, all organisations are called to work in an anti-racist manner. Of note is the recommendation that all services broaden their approach to preventing DA and supporting the women who experience it. Batsleer et al. push for a more holistic approach with effective multi-agency working.

Although this research provides a multitude of useful insights and proposals, the wide focus on the whole spectrum of DA experience and general help-seeking does not allow for a narrow and detailed focus on the specifics of WGMs' help-seeking journeys in relation to their mental health. The significant links between the experiences of DA and psychological distress calls for a focus on this aspect of help-seeking. Recommendations from research which looks at help-seeking across criminal justice, legal, immigration, family courts and other systems are limited in their applicability to services that provide emotional support. Further research in this area is needed to establish how the mental health needs of WGM are being met after experiencing DA.

The applicability of findings from a sample inclusive of women from such a diversity of cultural backgrounds must also be considered. As has been highlighted in various reports, the services which have been found to provide the most effective support to WGM are those which are specifically set up ‘by and for’ women from specific ethnic groups (Thiara, 2021). It stands to reason that the experiences and support needs of a woman who identifies as African-Caribbean may be markedly different from those of a woman who identifies as South Asian (Thiara, 2005). Indeed, the loss of specialist services for particular groups, due to funding constraints forcing most organisations to cater for all WGM, has been deemed a great loss within DA service provision by staff and service users (Austin, 2021; IMKAAN, 2018).

2.5 South Asian Women’s experiences of DA and Mental Health Help-seeking

Before looking at the very minimal amount of UK research looking at the mental health help-seeking experiences of South Asian survivors, some relevant research from South Asian countries will be detailed.

2.5.1 Research in South Asia

A review of available research in Bangladesh estimates around 66% of DA survivors did not tell anyone what they were experiencing or seek help (Naved & Persson, 2005), with this rising to over 90% in rural populations (Bhuiya et al., 2003). Reasons for this low level of help seeking include fear of risking family honour, a lack of knowledge about and availability of DA support services, women avoiding seeking help until their situation became life threatening, and beliefs that services would not be able to help (Johnston & Naved, 2008; Naved et al., 2006). A large-scale study with a sample of 19,125 women in India found less than 25% had sought help at all, with less than 1% seeking help from formal services (Leonardsson & San Sebastian, 2017). Widespread acceptance of DA, victim blaming discourses, stigma and shame, and a lack of options for safe support have been implicated (Decker et al., 2013; Ragavan et al., 2015). Similar results have been found in Afghanistan with the pressure to uphold family honour by staying silent about DA being a leading factor in the majority women not seeking help (Mukerji et al., 2023). Research from Pakistan identifies the commonality of women marrying then moving away from their family of origin and support network, making help-seeking, already a taboo, even more difficult when DA occurs (Aamir, 2004; Hussain & Khan, 2008). There are methodological differences across all these studies, as well as a wide range of sample sizes. The picture of DA help-seeking across South Asian countries is certainly still unclear, with these studies giving just a preliminary idea of what this looks like for women living there.

2.5.2 Research in UK

Although there is almost no UK based research focusing solely on mental health help-seeking for South Asian DA survivors, research in related areas provides an insight into South Asian women's experiences. One large-scale study has detailed the DA experiences, mental health needs and service experiences of South Asian women who have experienced DA. (Anitha et al., 2009). 72 women living in the Manchester area took part in surveys and were interviewed, and this data quantitively and thematically analysed to look for patterns in help-seeking and women's experiences of this. Most women interviewed had experienced mental health difficulties including low self-esteem, suicide attempts, self-harm, low mood, anxiety, difficulties with eating and sleeping, and panic. These experiences were felt to be a direct consequence of the DA the women had experienced.

45 of the 72 women relayed experiences of contacting their GP for support with their emotional wellbeing with very few feeling able to tell their GP about the DA they were experiencing. 21 of these women were prescribed medication for the symptoms of their psychological distress without any exploration of their cause. Others were advised to use exercise or walking, underestimating the severity of the women's situations, and overestimating their responsibility in resolving the abuse and its effects. Some positive experiences were reported by six of the 45 women who approached their GPs, where they were taken seriously and referred to both DA and mental health services.

Of these 45, 13 women were referred to NHS mental health services. Continued DA, a lack of childcare, and fear of the potential stigma around having mental health difficulties stopped some women from accessing their referrals. Those who did had varied experiences. Four women who spoke English reported positive but too brief experiences with mental health staff. Others' experiences were not as positive with difficulties cited with language barriers, a lack of cultural understanding, and fear of their experiences giving their community a bad reputation. Women felt a more positive experience would be likely with staff members who worked in a culturally competent way or who were from the same cultural background.

A number of women received support from third sector mental health services. These experiences were reported as mostly positive, with the close working relationships between these organisations and DA services identified as a strength. The understanding held by these organisations of the women's cultural and DA experiences, as well as the lack of language barriers, contributed to their positive experiences.

The women in this study were asked about their experiences of DA support generally. Much of what they reported related to practical, and safety related support offered by a variety of organisations including police, law centres and social services. However, the importance of the emotional support offered by DA services was raised by many. Women appreciated the empathic, person centred, and language and culture specific support provided by specialist South Asian DA services.

In asking women about their help-seeking journeys, this study provided a list of possible services where women may have gone for mental health support, including NHS services, third sector mental health services and GPs, and asked women about which of these they had used. This was then repeated for a range of services where women access DA related support. This may not be reflective of how many women are having their emotional support needs met, with DA services providing significant amounts of mental health support despite not typically having staff members who are trained in this area (Austin, 2021; Women's Aid, 2021b). This is often a consequence of the barriers faced by women in accessing formal mental health support.

This exploration of South Asian women’s experiences of mental health support, provided an essential and novel insight into how they experience this help-seeking process. The results report difficulties in accessing appropriate emotional or therapeutic support through GP services, and negative experiences of NHS mental health support services with language differences and a lack of flexibility and cultural understanding implicated. Reports of DA services and third sector mental health services were more positive with collaborative working, an understanding of DA, and cultural competence identified as strengths. As well as these results, the overall focus of this research was broad, also looking at general help-seeking across a variety of services and experiences of DA itself. The use of Thematic Analysis allowed the identification of key emergent themes across a large sample of women.

This broad focus, involving a large sample of women provides an excellent overview of the DA and help-seeking experiences of South Asian women in the UK. It also serves as an ideal recommendation and starting point for smaller scale research focusing on sub-sections of its results. This current project aims to take a detailed look at how mental health help-seeking journeys are experienced by South Asian survivors of DA, in the hopes of building on, and making clearer the picture which has been developed so far. The use of IPA in this research will allow for a more in depth, idiographic focus on the unique, individual stories and sense making of a smaller sample of participants, focusing only on the mental health help-seeking experience.

2.6 Research Questions

The research question is:

How do South Asian women who are survivors of DA experience the process of seeking help for their mental health?

Within this question I wish to explore:

- How do South Asian women who are survivors of DA experience gaining access to mental health support?
- How does having a South Asian cultural background impact the mental health help-seeking journey of South Asian women who are survivors of DA?
- What is the impact of the mental-health help-seeking journey on the emotional wellbeing of South Asian women who are survivors of DA?

This chapter has detailed a range of existing literature which is relevant to this project, including research with a focus on the impact of DA on mental health, how mental health services work with DA, help-seeking, shame and cultural stigma, and the mental health help-seeking journey for UK based survivors, including WGM and South Asian women. The research questions were then outlined after detailing how this research relates to the existing literature. The next chapter will outline the design and methodology of this research, detailing how it was conceptualised and carried out.

Chapter Three: Method

This chapter will cover the design, methodology, and epistemological stance of the research, with an explanation of why Interpretative Phenomenological Analysis (IPA) has been chosen over other approaches. The reasoning behind the choice to include inter-language interviews in the research will then be explained. Finally, the method and procedure will be outlined in detail, covering the whole research process including linking with the host organisation in recruitment, carrying out interviews, data analysis, ethical considerations, and reflexivity.

3.1 Design

A qualitative design using semi-structured interviewing was adopted, with IPA being used to analyse the transcripts of individual interviews and identify themes across all participants' experiences.

3.2 Methodology

Qualitative methodology covers a range of approaches and practices which are bound by the common principles they follow, as well as by a grounding in the philosophy of interpretivism – that reality is accessed via social constructions and demonstrated in the beliefs, motivations, and understandings of individuals. Data collection and analysis which are flexible, socially engaged, and concerned with the depth and detail of human experience are some defining values (Mason, 2017). A qualitative approach was chosen in keeping with the aim of documenting women's rich and unique experiences in their own words.

This approach allowed for the flexibility required in carrying out research within this population. The very fact that the experiences of South Asian survivors of DA are largely missing from the evidence base is a demonstration of the need for adaptations to the process. Examples of flexibility are detailed throughout the following sections and include adopting a participatory approach with South Asian co-researchers and supervisors, spending a significant amount of time building a relationship with a host organisation, adopting a broad inclusion criteria, meeting participants at a separate time before interviews to build rapport and increase feelings of safety, working with a language interpreter, negotiating what was covered in interviews with members of the research team, host organisation, service user consultant, and interviewees, creating recruitment and information materials in multiple languages, developing a pre-interview case study to ensure participants understanding of topics, and giving participants choice and control over interview date, time, location, and the presence of support workers.

3.2.1 Epistemology in IPA

Many qualitative methodologies are situated within schools of thought which determine the assumptions they are based on. Epistemology refers to ideas around how we can access or come to gain knowledge about the reality that we perceive. Unlike other qualitative methodologies that are rooted firmly within a prescribed set of epistemological premises, IPA research has been carried out under a variety of positions (Larkin et al., 2006). One developer of IPA, Larkin (2022) outlined that theorising about IPA's epistemological position has developed and refined alongside the methodology. He argues that the clearest way to understand the epistemological focus of IPA is through the principles of hermeneutics, phenomenology, and idiography. These will be discussed in the next section.

3.2.2 IPA

Interpretative Phenomenological Analysis (IPA) is a qualitative research approach which explores how people make sense of their own personal experiences. IPA research is idiographic in nature, focusing on how particular individuals experience and understand specific life events, within their particular contexts (Larkin et al., 2006). An idiographic focus is achieved by the collection of rich and detailed accounts from a small number of participants, and their subsequent detailed analysis.

The second theoretical principle of IPA is an emphasis on phenomenology. This involves attending to the individual's perception of their experiences, rather than seeing their experiences as simply events that happened. The phenomenological approach of IPA attempts to explore an individual's personal and meaningful relationship to the events in their life, rejecting the idea that an objective record of the events could be produced (Larkin et al., 2006). The process of attempting to understand an individual's relationship to their life events highlights the interpretative element of IPA. Larkin et al. explain that in a researcher developing an understanding and description of the participant's world, they are entering into co-creation of the account with the participant. IPA then involves the researcher analysing the data at a more speculative level of interpretation, exploring its position within wider cultural, systemic, and theoretical contexts (Larkin et al., 2006).

The third theoretical principle of IPA is the concept of hermeneutics, the theory of interpretation. In IPA, the experiences of the participant are subject to their own sense making which is then subject to the sense making of the researcher. It is impossible for the researcher to directly access the participant's personal reality, they must interpret it through the participant's words, attempting to get as close to it as possible (Larkin et al., 2006). The researcher does this under the influence of their own assumptions, through the lens of their own experiences (Smith et al., 2021). The impact of this double hermeneutic on the process of data analysis must be addressed directly and will be discussed further in the coming section on reflexivity.

3.2.3 Alternative Methodological Approaches

Thematic analysis (TA) was considered as a potential method for this research. TA can be used across a variety of epistemological and ontological stances. It can be applied to a wide range of research questions including those focused on individual experience. However, it focuses mainly on emergent patterns and themes across the accounts of samples of often more than 10 participants (Fugard & Potts, 2015), possibly to the detriment of a focus on the in depth detail of individual experiences.

Grounded Theory (GT) was also considered as a method that allows the development of an explanation or theory about a particular phenomenon within a particular population (Glaser, 1998). GT can be effectively used to explore concepts and patterns within an under researched area of interest, resulting in the production of new theory which is grounded in the data (Walsh et al., 2015). Although this could make it well suited to this project, the process does not tend to acknowledge the influence of the researcher, and their assumptions and biases, on the development of results and explanations (Olesen, 2011). As a White researcher working with South Asian women, I consider it essential that my influence is acknowledged and fully considered, leading to my choice of IPA over GT.

3.2.4 Inter-language Research

This research was carried out using an inter-language approach with some participants speaking languages that I cannot speak or understand. This section will outline the thinking behind this approach and what considerations were made in deciding against single language research. Detail of how the inter-language research process was carried out is covered in section 3.4.3, with this current section focusing on the overall concept and relevant schools of thought.

Despite working under an interpretivist philosophy, qualitative research is often influenced by the dominant positivist philosophy of science, emphasising the importance of rigour and objectivity in establishing measurable fact (Hammersley, 1995). This has influenced discussion and practice around inter-language work within qualitative research. Much commentary emphasises the need to produce a correct, accurate, and direct translation of participants' words which can then be analysed by the researcher (Edwards, 1998). The result is often an avoidance of inter-language research, excluding non-English speakers from English speaking research. The following sections will outline the thinking behind my decision to include non-English speaking participants and use an interpreter to carry out inter-language interviews.

3.2.4.1 Interpretivism, Social Constructionism, and Participatory Approaches.

Interpretivist approaches like IPA are grounded in the assumption that reality is socially constructed and only accessible through each individual's subjective experience of it (Ponterotto, 2010). As mentioned in section 3.2.1, IPA does not prescribe a particular overarching epistemological stance. Although the overall epistemological focus of this research is best understood through the concepts of idiography, phenomenology, and hermeneutics, my decision making around inter-language work was shaped by social constructionist and participatory approaches. Social constructionism opposes the idea that there is one objective reality, instead theorising that reality is created through subjective experiences and the social conventions and interactions that shape them (Burr, 2015). Participatory approaches to research involve collaboration with the people and communities the research is seeking to understand, with their expertise and knowledge being centred and valued (Cornwall & Jewkes, 1995).

These approaches argue that the interpreting of language and meaning is not an objective process with one factually correct outcome but an interaction between researcher, interpreter, and participant which co-produces knowledge (Temple & Young, 2004). Some have moved away from the arguably impossible task of finding equivalence between languages, in a word-to-word translation of complex accounts of experience (Edwards, 1998; Neufeld et al., 2002; Temple & Edwards, 2002). Instead, the interpreter is considered a 'key informant' in the sense making of the participant's account.

In this study, the interpreter was positioned as a co-researcher with her own background, knowledge, and assumptions. As a South Asian woman, she considered herself a member of the community this research was seeking to understand. Rather than seeing this as a problem which might compromise the accuracy of the interpreted speech, I considered it a valuable asset in facilitating a process of mutual understanding across two languages and cultures. A detailed account of how we agreed to navigate this during interviews, and how I attended to the influence of the interpreter's background, knowledge, and assumptions in the analysis of interview data will be covered in section 3.4.

3.2.4.2 Inter-language Research with IPA.

Although IPA is most commonly carried out using a single, shared language, it is possible to conduct successful, inter-language IPA research. IPA is set out as a collection of suggestions which can and should be adapted by the researcher, to best fit their project (Smith, 2004). Smith (2004) recommends researchers using their professional experience to modify interview protocol to ensure enough data is gathered in inter-language interviews. Much of my professional experience has been in emotionally supportive roles of women who have experienced DA and mental health difficulties. In these roles I commonly carried out inter-language work with interpreters. With this experience, I was able to confidently navigate interviews alongside the interpreter co-researcher, ensuring a shared understanding throughout. A detailed account of my approach to the inter-language interview process is covered in section 3.4.

In response to an email from me asking about potential difficulties in inter-language IPA research, developer of IPA Johnanthan Smith encouraged this work but recommended supervision from someone who is experienced in inter-language work (J. Smith, personal communication, 13 November 2020 - see Appendix 1 for full exchange). At every stage of the research process, I discussed my approach and decision making in supervision with a supervisor experienced in inter-language research. This supervision, in combination with my own professional experience was the basis for the decision making outlined here and in section 3.4.

3.2.4.3 Disrupting the Power of the English Language.

I was aware and do acknowledge that single language interviews would likely be more straightforward in terms of understanding meaning and conducting analysis. However, I was also aware that a significant proportion of South Asian survivors of DA are not afforded the opportunity to learn English, resulting in their frequent exclusion from service provision (Anitha, 2011). The South Asian women's organisation I worked alongside advised that most of their service users did not speak English. I was in strong agreement with the host organisation that excluding women who did not speak English, and therefore silencing their voices, would represent an unethical perpetuation of the lack of access they often have to services and would contradict the purpose of this project. My decision to conduct inter-language research was shaped by the philosophies of social constructionism and participatory research discussed above (Burr, 2015; Cornwall & Jewkes, 1995; Neufeld et al., 2002; Temple & Young, 2004), with the driving force being the wish to conduct ethically sound research which serves South Asian women and strives towards social justice.

My decision was also strongly influenced by my rejection of the idea that knowledge and meaning must be communicated solely in one language to be valid, accurate, and valuable. The majority of published psychological research is conducted using the English language (Henrich et al., 2010). Avoidance of inter-language work inevitably excludes a vast number of PGM from research participation, particularly within the UK clinical psychology field where around 88% of Clinical Psychologists are White British, unlikely to fluently speak the languages of PGM (BPS, 2015). Much research carried out in communities of PGM within majority English speaking countries is presented in English with no mention of the role of language in the process. Often neglected is the addressing of whether participants were fully fluent, if English was their second language, if some of their phrasing was in their first language or was not shared by a researcher from a different cultural background (Temple & Young, 2004). Both outright avoidance of, and a lack of attendance to inter-language research processes can be framed as situating English as the arbiter of meaning and understanding. My aim was to attend to, and attempt to disrupt, the position English holds as the top of the global language hierarchy (Berman & Tyyskä, 2011).

3.3 Method

This section will cover the selection and recruitment of participants, the input of a host organisation and service user consultant, interview procedure, inter-language interpreting process, data analysis, my approach to quality checks, ethical considerations, and finally reflexivity.

3.3.1 Host Organisation

It was my wish to work alongside a host organisation (HO) who could provide feedback using their expertise as a ‘by and for’ DA organisation within the South Asian community. Over the course of 10 months, I made numerous contacts with every DA organisation in England that had expertise in working with South Asian women. All of these services receive inadequate funding for the support they provide (Women's Aid, 2021b), and so it took months to develop contact, arrange meetings, and find an organisation that had time to work with me. This organisation is a long-standing, London based women’s centre which provides DA and wider wellbeing related support to WGM. Although the current funding landscape has led to them moving towards the support of all WGM, their background and expertise lies in the South Asian community.

Over the course of several months, during which we discussed and negotiated all elements of the research and recruitment process, an agreement was set up with the VAWG manager of the HO as the contact person for their involvement. The contact person provided feedback throughout, on various aspects of the project.

3.3.2 Sampling

In their guide to carrying out research using IPA, Smith et al. (2021) emphasise the importance of quality over quantity in the gathering of detailed accounts of individual experience. They suggest a sample size of between six and ten interviews for professional doctoral research. Smith et al. and others (Blaikie, 2018) have discussed the risk of qualitative researchers being influenced by dominant positivist discourses around sample size and data saturation, missing the opportunity for a concentrated focus on complex human experience. The assertion that a concrete point exists at which nothing new will be discovered through subsequent accounts of individual experience does not align with the interpretivist view of reality as a socially constructed, subjective set of experiences (Alharahsheh & Pius, 2020).

Purposive sampling is used for IPA, allowing for as homogenous a group of participants as possible, with the relevant experiences, to be selected (Smith et al., 2021). As covered in section 2.2, the concepts of ‘Izzat’ (Wellock, 2010) and ‘Sharam’ (Allan & Gilbert, 1997) within South Asian communities often prevent women from seeking help for their mental health, particularly when DA has occurred (Gill et al., 2014; Mesquita, 2001). This is not to suggest that all South Asian women who have experienced DA and sought help for their mental health are the same, but that focusing on women with this specific set of experiences will allow for an examination of both the common themes and variability that exists within the group.

3.3.3 Inclusion and Exclusion Criteria.

People who met the following criteria were eligible to participate in the research:

- Self-identifies as a woman.
- Self-identifies as South Asian.
- Over 18 years of age.
- Has experienced DA of any kind.
- Has been in receipt of support services from the HO for at least two months.
- Has sought emotional support from any organisation/service, after or whilst experiencing DA.

People who met the following criteria were excluded:

- Lacking in capacity to provide consent (Mental Capacity Act, 2005).

Care was taken in ensuring participants were not adversely affected by the process. This will be discussed in detail in the later section concerning ethics. How this issue relates to inclusion criteria was discussed with the contact person. It was agreed that women who were currently in dangerous or high-risk situations in terms of DA and/or mental health may not be best placed to participate. It is difficult to clearly define this in the form of inclusion or exclusion criteria. Many women’s experiences of DA will be fluid, increasing and decreasing in risk at different times, something which is also true of psychological distress. It was agreed that participants should have been receiving support from the HO for at least two months, allowing for urgent safety needs to have been addressed and for staff at the HO to have built a supportive relationship.

A broad age range was included in order to make the research as accessible and successful as possible. As documented throughout, multiple barriers exist, preventing many South Asian women from accessing services and being involved in research. The HO felt that these barriers, including the requirement for women to talk about difficult experiences with a stranger, would make it challenging to recruit the required number of participants. As well as not wanting to contribute to the exclusion of any women who wished to take part on the basis of their age, I wanted to ensure that I was able to recruit at least six women. All women recruited lived in one of two neighbouring London boroughs at the time of their interviews.

3.3.4 Service User Consultant

My goal was for this research to be as participatory as possible within its practical and temporal constraints. The distinction between participatory and other research approaches lies in the extent to which decisions about area of focus, methodology, and dissemination are influenced by members of the community the research is being carried out within (Wadsworth, 1998). Additionally, the research should be motivated by a goal of improving social justice (Kagan, 2012), a driving force in this project.

A paid service user consultant (SUC) was recruited through email contacts with other DA organisations in London. The SUC is a South Asian woman who has experienced domestic abuse and sought help from services for her mental health. She has chosen the pseudonym Sara to ensure anonymity. Sara provided regular advice and feedback, collaborating in decision making on the methodology and implementation of the research. Her expertise provided an invaluable source of supervision throughout the project, the process being something she enjoyed and valued.

The working agreement with Sara was based around her preferences for the amount, and type, of involvement she wanted to have in the project. Care was taken in considering the risk of the project causing distress or upset related to her own experiences.

3.3.5 Semi-structured Interviews

In-depth, semi-structured interviews are the recommended data collection method for IPA (Smith et al., 2021). The aim of this approach is to create an interaction which will encourage participants to share the detail of their experiences that they regard as important, in their own words. The semi-structured nature of interviews was facilitated via an interview guide containing open-ended questions and prompts which loosely set out the topics I intended to cover. This open-ended approach was taken to allow participants to choose what they felt comfortable speaking about, attending to the sensitive nature of the interview topics. Participants were encouraged to speak about what they felt was important and relevant even if this deviated from the question. Interviews were then shaped around both the guide, and the topics brought up by participants.

3.3.6 Interview Guide

To create the interview guide (see Appendix 2), the research questions alongside the current evidence base were first considered. Feedback from my thesis supervisors, the HO contact person, and Sara helped to shape the guide, ensuring that, as much as possible, it encouraged participants to share their stories in their own words. In response to conversations with the contact person about the variety of differing understandings held by HO service users, an example case study was developed in collaboration with Sara, demonstrating what was meant by the terms 'DA' and 'emotional support'. As well as being given illustrations demonstrating the two concepts, this case study was read to participants prior to commencing interviews. The case study and illustrations are included in the interview guide in Appendix 2.

3.3.7 Pilot Interview

As someone who would fit the inclusion criteria, Sara agreed to take part in a pilot interview and provide feedback on how relevant and useful the guide was in encouraging her to share her experiences, as well as its acceptability. Changes to the interview guide were made in accordance with Sara's feedback, particularly relating to the clarification of participant's language around psychological distress, and the use of this language in subsequent questions.

3.4 Procedure

3.4.1 Recruitment

Purposive sampling was used to recruit participants who were service users of the HO. The contact person spoke to individual support staff, sharing the recruitment posters in English and Bengali (see Appendices 3 and 4) and the participant information sheet (see Appendix 5). Support staff identified potential participants who fit the inclusion criteria and assisted them in deciding if they would like to take part by talking through the information sheet. I then met via MS Teams with potential participants and their support worker to introduce myself, answer any questions, and provide my contact details. Potential participants were not given a time deadline of when to decide, I advised that I would wait until they were ready. After this process, three women contacted me by phone to express interest in participating. All of these participants spoke enough English for us to arrange interviews. Support workers provided language interpreting in the MS Teams meeting for those participants who required it.

I was not able to interview more than three women through the HO. The HO and I both used our contacts within linked DA services in neighbouring boroughs to reach out to more potential participants. Through this, three more participants came forward. I followed the same steps as above with these three women.

3.4.2 Interviews

Participants were given a choice of days, times, and locations. Four chose to have interviews in a private room at the offices of the HO and two requested to have interviews via an MS Teams video call. Interviews lasted between 40 and 140 minutes, with inter-language interviews taking longer. The HO supported with arranging childcare for any participants who needed this. Time was set aside before each interview to build rapport and allow participants to feel more comfortable. I also ensured that I had spoken to all participants at least once via video chat or phone call before meeting for their interview. This allowed us to chat casually, get to know each other, and develop some relational safety before meeting to talk about more sensitive topics. As my only language is English, interviews with participants who did not speak English were carried out with a female interpreter also in the room, this will be discussed further in the following section. Time was set aside after each interview for a check-out and debrief process and to refer any participants who needed further support to HO staff.

Demographic information about each participant was asked at the beginning of the interview to give me an understanding of their context, these questions can be found in the interview guide (see Appendix 2). Directly after the interviews I recorded my reflections on the process and content. For interviews involving a language interpreter, I then recorded us having a reflective conversation about the general process, the process of interpreting and sense making, and the interpreter's overall reflections.

3.4.3 Language Interpreting

An interpreter was sourced from a university approved language service who ensured they fit suitability criteria for the project. The interpreter, Anowara, is a South Asian woman who speaks fluent Sylheti, Bengali, and English, has seven years accredited experience interpreting for therapy sessions and domestic abuse support work, and who works in a South Asian women's centre, in a different city, alongside her interpreting work. Anowara was the interpreter for both interviews where Sylheti interpreting was required.

Anowara met with me prior to interviews to read through the interview guide and discuss the research aims and questions. Based on the ideas in section 3.2.4 and on Anowara's interpreting expertise, we agreed on using a conversational style of interpreting where Anowara was positioned as part of the conversation between three people, with an instrumental role in creating shared meaning (Temple & Edwards, 2002; Temple & Young, 2004). Based on her experience, Anowara felt strongly that it was not possible to find exact equivalence between English and Sylheti for each word spoken. Instead, she used her expertise to translate each question or statement ensuring the meaning was maintained and shared across both languages.

Each question, statement, or prompt said by me in English, was translated to Sylheti by Anowara. The Sylheti response of the participant was then translated into English, and so forth. Throughout the interview, I clarified meaning to ensure I was understanding the participant correctly. Before, during, and after the interview I checked with Anowara and the participant about any phrases or concepts which were difficult to translate between Sylheti and English. When asked for their feedback on the interpreting and interview process, both participants reflected that the interview felt like a flowing conversation between three people and that they were easily able to make themselves understood. In a reflective debrief, Anowara stated that she felt the process worked well, feeling like a relaxed conversation between three people. She explained that her expertise in DA and therapy work meant that she did not struggle to translate any concepts, being used to explaining these in both English and Sylheti and checking understanding in both directions.

3.4.4 Transcription

Interviews were all securely audio recorded. I transcribed two interviews personally to ensure a familiarity with process and to immerse myself in the interpretative process. The final four interviews were transcribed by a university approved organisation. Any names or other identifying material was censored or removed from the transcripts. Due to English being my only language, and the analysis therefore taking place in English, only the English sections of inter-language interviews were transcribed. Non-verbal aspects of the participant's communication such as crying, or volume of speech were added alongside the English interpretation of their speech at the time. Prior to beginning analysis, I read through completed transcripts whilst listening to the audio to check for any errors.

3.4.5 Data Analysis

The aim of data analysis under an IPA approach is to acknowledge and evidence the participant's sense making of their experience whilst documenting the researcher's sense making of the data (Smith & Shinebourne, 2012). Psychological theory is used to support the researcher's sense making and insight (Pietkiewicz & Smith, 2014). In my analysis, I followed the six steps set out in Smith et al.'s (Smith et al., 2021) IPA guidance, detailed in full below, first analysing each individual interview, then the group of interviews as a whole. Alongside the written guide, I watched a number of webinars by prominent IPA researchers and discussed my analysis with my supervisors, service user consultant, and peers also using IPA at each stage. As the idiographic approach of IPA sets out, I carried out steps one to six for each individual case before moving on to cross-case analysis. Examples of my work throughout the analytic process can be found in Appendix 6.

3.4.5.1 Step 1: Reading and Re-reading.

This stage of analysis involved me reading each transcript alongside listening to the audio recording several times. During this process, I kept a note of my thoughts, the parts of the interviews which I felt most drawn to, points which felt most important for the participants, as well as separate notes about my thoughts and position in relation to the data, in my reflexive diary. For inter-language interviews I listened to participants speaking Sylheti, attending to their tone, whilst reading the interpreted English.

3.4.5.2 Step 2: Exploratory Noting.

Using a Word document, with transcripts separated line by line into a table, I attended to each line in detail, making comprehensive notes and comments in a column alongside the original data. At first, I noted anything of interest within the transcript. On subsequent analysis of the transcript, I considered the original data and my exploratory notes in the context of the three 'principles of data' suggested by Smith et al. (2021). This guidance sets out that exploratory notes often manifest in particular forms: descriptive (focused on the content of what the participant has said), linguistic (focused on the specific language and linguistic features used), and conceptual (asking questions of the data, focused on the understanding and meaning to the participant). Whilst noting, I frequently attended to my own reflexivity, ensuring that my interpretations were drawn from the participant's experience and not influenced by my assumptions and biases.

This stage involved me going through each individual transcript at least four times. For interviews carried out with interpreter, Anowara, I attended to the translated English responses whilst listening to the participant speaking the response in their own language, noting down points about tone of voice, volume, and conveyed emotion.

3.4.5.3 Step 3: Constructing Experiential Statements.

In a third column alongside my exploratory notes, I began constructing experiential statements, phrases which provide a concise summary of both the participant's thoughts and my interpretation. I went through this process several times, checking my notes against Smith et al.'s (2021) guidance, particularly ensuring that the experiential statements reflected my analytic work rather than just repeating the original data. I kept written prompts about the different types of interpretation common in IPA (Smith, 2004) in front of me throughout this process to ensure my work was rooted in the principles of the approach. In line with Smith et al.'s (2021) guidance, my experiential statements were informed by individual parts of the transcript but also my familiarity with the whole of the data set.

After exploring my process and experiential statements for each transcript in supervision and a peer supervision group, I took sections of the analysis to meetings with SUC Sara, explained my analytic process, and received her feedback. To complete this step, I created a fourth column alongside my first draft of experiential statements and used the feedback to reappraise the data set and narrow the statements down to their final form.

3.4.5.4 Step 4: Searching for Connections Across Experiential Statements.

For each data set, I wrote each experiential statement onto an individual piece of paper and placed them all in random order on a table. I chose to write rather than print the statements to create more familiarity with them. I started to move statements into groupings which felt as though they fit together. After each of the first three configurations, I randomised the statements again to explore different connections and groups. The final configurations were decided based on their success in representing the most important points from the participant's accounts in relation to the research questions. Each final grouping was able to create a narrative of participants' experiences that addressed the research questions (Smith et al., 2021).

3.4.5.5 Step 5: Naming the Personal Experiential Themes (PETs).

I attended to each cluster of experiential statements, organising them into smaller clusters of sub-themes in cases where some statements were inter-related. I gave each cluster, referred to as a personal experiential theme (PET), a title that demonstrated its focus. Sub-themes were titled in the same way. I gathered each PET and its sub-themes in a table, including the relevant experiential statements, transcript page number, and participant quote. I used supervision, peer supervision, and feedback from Sara again at this stage to finalise my PETs.

3.4.5.6 Step 6: Working with PETs to Develop Group Experiential Themes (GETs) across Cases.

After completing steps one to six for all six transcripts, I began the process of bringing ideas together into a set of Group Experiential Themes (GETs). I printed each set of PETs and laid them out on the floor. I also reviewed them in word documents. I created a written table of all PETs and started to colour code similarities across them all. I completed this colour coding process three times, until I came to a final table. I then used this colour coding to go back to individual PETs and ETs to examine whether they fit the theme. At this point, I was moving up and down through different levels of the data, from the original transcripts, up to emerging GETs. After carefully examining all PETs against my table of emerging GETs, I was able to create a first draft of five GETs, each with group-level sub-themes. After re-checking how often each GET and sub-theme was represented, I created a final draft of four GETs, each with sub-themes. I checked and discussed this with my supervisors and Sara, using their feedback to make changes to the structure and wording of some of the GETs.

3.4.6 Quality Checks

As discussed in section 3.2.4, the influence of positivism on qualitative research has led to the commonplace use of strategies aimed at checking the accuracy of researcher interpretations. It can be argued that such attempts at enhancing rigour simply result in the shaping of qualitative research to positivist scientific standards (McConnell-Henry et al., 2009). In this section I will discuss some commonly used quality checks and the approach taken in this research.

3.4.6.1 Multiple Coding and Triangulation.

Multiple coding, involving several researchers analysing interview data, is often cited as improving the credibility of data interpretation (Olson et al., 2016). The interpretivist and phenomenological approach taken in this research sets out that there is not one universal and true reality from which we can measure the credibility or accuracy of different researcher accounts (Varpio et al., 2017).

The concept of hermeneutics in IPA views the resulting analysis as being co-constructed by the researcher and participant, with the researcher attempting to understand the participant's understanding of their own experience. The researcher's life experience, knowledge, and assumptions provide a lens through which they interpret the experience of the participant (Smith et al., 2021). Under this assumption, attempting to combine the interpretations of different researchers to reach a universal, true understanding is ill advised.

Similarly, the commonly used method of triangulation – using multiple sources of information on the chosen phenomena, beyond the participant's account – does not align with the idiographic and phenomenological principles of IPA (Smith, 2011). The use of IPA in this research allowed an in-depth focus on the personal meanings and understandings of the participants in relation to their own experiences, something which cannot be gained by seeking out information from, for example, case notes or the perspectives of support staff.

That is not to say that a single researcher, working alone is the gold standard within qualitative research. Considering alternative perspectives during the analytic process, such as those of supervisors, peers, and a service user consultant in this research, can ensure a more thorough exploration of the data. The aim of this collaboration was not to enhance the credibility or correctness of the analysis but to incorporate multiple valid viewpoints into my own interpretation, creating a more comprehensive understanding using multiple lenses than I could through mine alone

(Richardson et al., 2005). My decision to look at the data through lenses other than my own was based on my position as White researcher working with South Asian women. The experiences and understandings of the South Asian women in my research team were of invaluable importance in understanding the experiences of participants.

3.4.6.2 Member Checking.

Member checking involves transcripts or final analyses being presented back to participants for feedback on their accuracy in reflecting their experience (Goldblatt et al., 2011). Many argue that this adds to the credibility of analysis whilst improving the quality of research by increasing the level of participant participation in the process (Lincoln & Guba, 1985; Littman et al., 2021).

Member checking is generally not used in IPA research due to the importance of the double hermeneutic, where researchers own their role as interpreters of the participants' sense making (Smith et al., 2011). There is a risk that incorporating participants' feedback after analysis removes or diminishes the element of researcher interpretation and introduces a third hermeneutic, moving too far from the principles of IPA. McConnell-Henry et al. (2011) argue that in member checking, researchers are searching for the 'right' or correct interpretation of a phenomena, which does not exist in the context of individuals constructing their own unique realities and meanings.

It has been suggested that ensuring a clear shared understanding during interviews is preferable to attempting this post-analysis (Seidman, 2006). This is the approach that I adopted during interviews, checking back my understanding with participants throughout and in a summary at the end. I paid particular attention to cultural references, use of words or phrases from languages other than English, and times when participants appeared to be searching for a way to explain something in English. In deciding on further steps around member checking, I found myself conflicted between the positions of wanting to complete culturally competent, participatory research with a group of women to which I did not belong, and wanting to carry out methodologically sound IPA research which aligns with the views discussed above. After much reading, discussion, and consideration, I decided to conduct all member checking at the point of interview, as well as using the invaluable input of the South Asian women in my supervision team to guide me through analysis.

3.4.6.3 Inter-language Interviews.

As covered in sections 3.2.4 and 3.4.3, a multitude of factors must be considered when conducting inter-language research. My inability to speak and understand the language of some participants created the heightened need for me to ensure a shared understanding had developed.

Here I will address my decision making around establishing rigour in the use of data generated through inter-language interviews.

Squires (2008, 2009) recommends the use of a second interpreter to check the accuracy of the original interpreting during interviews. My decision to not adopt this approach was informed by ideas discussed in sections 3.2.4 and 3.4.3. In viewing the interpreter, Anowara, as a key part of the meaning making process, I rejected the idea that her contribution could be appraised for its level of accuracy. The impossibility of interpreting meaning through the simple substitution, from one language to the other, of a string of words means that there is no universal, correct translation to which I could compare Anowara's interpreting (Edwards, 1998; Neufeld et al., 2002; Temple & Edwards, 2002; Temple & Young, 2004).

The two interviews which took place alongside Anowara took longer than those conducted in English due to the need to translate back and forth. Although I did the same level of member checking throughout the interviews, time restrictions did not allow for summary member checking of my understanding at the end of each interview. For these two interviews, I arranged another meeting with each participant as soon as we each had availability. For each of these participants, I suggested that the original interpreter, Anowara joined us again. Both participants had upcoming meetings with support workers booked in and expressed that it would be easier for them to take part if I joined these pre-existing meetings, with support workers acting as interpreters. In this meeting I performed the same process as in English speaking interviews, with the support worker's assistance. This process occurred before I commenced analysis of interview data.

There being a gap of several months between interview and member checking, could be considered problematic due to the temporal nature of meaning making (McConnell-Henry et al., 2011). The temporal and contextual space in which a meaning is constructed will inevitably alter its composition (Heidegger et al., 1962). Whilst acknowledging this, conducting member checking directly after interviews would have resulted in participants spending an unsuitably long time engaging with difficult topics. Additionally, it would have required Anowara to complete excessive amounts of complex and demanding interpreting work in one day.

3.5 Ethical Considerations

3.5.1 Ethical approval

Ethical approval for this research was sought and granted by the University of Leeds, School of Medicine Research Ethics Committee on 24th November 2022 (see Appendix 7). The issues taken into ethical consideration for this research are detailed below.

3.5.2 Confidentiality

Confidentiality is of particular importance in this research due to the need to protect the anonymity of women using DA services. All participants were informed about how this would be attended to, verbally and via information sheets, before agreeing to take part in the research. Participants were invited to choose a pseudonym to be used in the write up and any identifiable details in transcripts were anonymised. In the inclusion of direct quotes, efforts were made to ensure they did not identify participants.

There is the possibility that those very familiar with participants' circumstances, such as HO staff, may be able to identify women through the experiences detailed in the write up. This was made clear to all participants as well as circumstances which would have required me breaching confidentiality to speak to a member of support staff at the HO, such as in the case of a participant disclosing a risk of serious harm to themselves or others.

3.5.3 Informed Consent

Participants were given information sheets (see Appendix 5) containing details of the study, what it would involve for them, confidentiality procedures, and their right to withdraw. All of this was also covered in a conversation prior to participants agreeing to take part in the research, alongside their support workers. Participants were reminded of this information before and after interviews. They were also encouraged to take breaks at any point during the interview, not answer any questions they did not wish to, or end the interview if they did not wish to continue. Participants were provided with a consent form (see Appendix 8) prior to commencing their interview and given a copy of this to keep.

3.5.4 Storage and Transcription of Data

All participants consented to interviews being securely recorded and stored on a university cloud system using duo authentication (University of Leeds – One Drive), on a password protected laptop which only I can access. Transcripts were fully anonymised and stored in a different location on the same university One Drive account. Signed consent forms were scanned at HO premises and stored in a different location on the same One Drive account, with hard copies being immediately shredded. All of the above was carried out in accordance with the University of Leeds (UoL) Data Protection Policy.

3.5.5 Potential Distress

Although the interviews did not ask about experiences of DA, speaking about the related help-seeking process could potentially cause distress. This was discussed with potential participants before their agreeing to take part in the research, to allow them to consider how they might experience the process, and what support they may have wanted to have in place. This was discussed again before commencing interviews. Interviews took place on HO premises or online via MS Teams and support workers from the HO were present to meet with participants pre- and post-interview. A check-in and check-out were used pre- and post- interview to allow participants to debrief about the process. Although two participants did become upset during interviews, they requested to continue the interview and felt they did not need further support afterwards.

Although my role in this process was as a researcher, I used my interpersonal skills developed through experience in the VAWG sector and clinical psychology training. Interviews were carried out in an empathic and sensitive manner, being aware of signs of distress in participants and offering breaks or to end the interview if they wished. Throughout the process, I held in mind my position as a White researcher and the power that this confers. I aimed to avoid participants feeling coerced to make any research related decision due to my position of power and discussed this with potential participants prior to their involvement in the study.

3.6 Reflexivity

In IPA studies, as in much qualitative research, any conclusions made are impacted by the relationship which develops between the researcher and the data. The version of reality which results from data analysis holds the participant's experience and voice at its centre but cannot exist in isolation of the researcher and their understandings and assumptions (Reid et al., 2005). Reflexivity refers to the process of noticing and attending to the influence the researcher has on the research process. It is generally agreed within the literature that the process of reflexivity in IPA is not a simple, linear task, but a dynamic process which the researcher must invest effort into at every stage of the project (Engward & Goldspink, 2020; Shaw, 2010). Engward and Goldspink (2020) elaborate further on the importance of immersing oneself in the data and being with it throughout. This encourages the act of consistently analysing the interplay between the participant's words and the researcher's thoughts and decisions about the data. Reflective journalling and supervision are recommended as aids to this process, alongside self-exploration, and acknowledgement of how the researcher's position relates to the subject matter.

3.6.1 My Position

My position in relation to this research is covered in detail in section 1.4 and details my decision-making process in going forward with this research as a White person, as well as the importance and value of my research team throughout.

3.6.2 Reflexive Statement

I identify as a feminist, a woman who has experienced a variety of gender-based harassment and violence, and a trainee clinical psychologist particularly interested in social justice. My time working in the DA field is deeply important to me and shaped the development of the strong value I place on working towards gender equality and an end to violence against women and girls. My experience working with women who have experienced DA and subsequently struggled to access mental health support was a driving force in me conducting research in this area. All the above, as well as my position as White person, had the potential to influence me in my role as researcher and was strongly held in mind and interacted with throughout.

This chapter has provided a detailed account of the design, methodology, and epistemological stance of the research. The choice of IPA has been explained, along with the epistemological stance in using this approach. The reasoning behind the choice to include inter-language interviews in the research was explained. The method and procedure of this research was outlined in detail, providing a comprehensive account of the whole research. Ethical considerations and issues of reflexivity were then presented. The next chapter will detail the results of the research interviews in the form of both individual and group analysis.

Chapter Four: Results

This section will detail the results of the individual and group analysis of all interviews. Table 1 outlines the demographic information of all participants in the sample. A pen portrait and details of individual analysis for each participant's account will follow. Finally, group analysis including the group experiential themes and sub-themes will be covered. This will include a detailed description of all themes and sub-themes alongside relevant participant quotes.

Table 1 *Demographics of Participants*

Pseudonym	**Age**	**Country of birth**	**Length of time in UK**	**Religion or religious background**	**Number of children**
Laal	37	Bangladesh	14 years	Muslim	0
Kaalo	53	Bangladesh	12 years	Muslim	6
Golap	43	Bangladesh	24 years	Muslim	5
Wapis	53	Pakistan	20 years	Muslim	1
Saskia	37	UK	Since birth	Christian/Hindu	1
Yellow	20	Afghanistan	9 years	Muslim	2

4.1 Individual Analysis

In this section, in the order I interviewed them, each participant will be introduced in a pen portrait before detailing the key themes from their interviews. A pen portrait is a brief, informal description of a person that provides some context around their descriptions of their experiences. They will be used here to provide information about each participant and their experiences, whilst maintaining their anonymity. As well as contributing to the group analysis, I felt it was important that each individual's experience and story was documented in more detail. Both due to the rich and useful nature of what they had to say, and to honour their voices and add them to the evidence base. Main themes from each individual analysis will be highlighted in bold text. In the structuring of this section, I have taken influence from Wintermeyer's (2020) doctoral paper.

4.1.1 Laal

Laal is a 37-year-old Muslim woman from Bangladesh, who came to the UK on a spouse visa 14 years ago. As Laal and I did not share a common language, our interview took place alongside Sylheti interpreter, Anowara. Laal wanted to take part in the interview so that her story could be documented and put to some use. She described the interview as helpful for her wellbeing, in being able to talk about what had happened to her.

Laal described being brought to the UK as a young woman to meet and marry her then husband. On arrival she described being met with abuse and control from her new husband and his family. A few months into their marriage she was abandoned by her husband and had to find her own way to housing, sustenance, and support, without the use of English. Laal explained that these experiences and the resultant uncertainty around her immigration status have led to her having trouble sleeping, experiencing low moods and regular fear, panic, and nightmares.

Laal's experience of help-seeking was defined by a struggle to access any support, followed by a struggle to access enough support to meet her emotional needs. She was mostly unable to identify particular services or types of services she accessed, instead using the names of different professionals who had supported her. She described being offered short episodes of support from a variety of different services, none lasting as long as she needed. Laal spoke of the significant value she gained from a support relationship with a therapist at a local IAPT service, but that progress and positivity developed through this support were lost when she was again left without support, after the three months she had been offered came to an end.

4.1.1.1 Main Themes.

One of the main themes that came from Laal's description of her experiences was of being **unable to reach help**. She spoke about how coming to the UK alone, at a young age led to isolation and fear, as well as a lack of knowledge and language needed to access support: *"Had I known at the time, I could have called for help… no one seemed to even know I was here" (p. 30).* Laal described that **community acted as a bridge to support,** allowing her to eventually make contact with services: *"It was all when I'd come to my aunties place…" (p. 31)* but that family were unable to meet all of her support needs *"…my cousin knows everything. She helps me by taking me to doctors or other places." "…trying to find someone who's available to take me. Not everyone has time." (p. 19 & 21).*

Another theme that emerged from Laal's experience was around **what good support can achieve**. Once Laal was able to access some support she experienced the development of trusting, connected, judgement free relationships: *"I was able to openly speak about everything I felt. Before that I'd never been so open with anyone." (p. 25).* Being valued and cared for in these safe relationships led to positive changes in how Laal felt about herself and the world: *"…everything will get better, a lot of motivating talk… shared some of her own personal experiences and how she overcame things." (p. 24).*

There was a sense from Laal that **connection and community are fundamental.** As she felt empowered to learn English and connect with more people after the isolation of DA, she developed hope, knowing that she was not alone in her experiences: *"Before…I didn't want to live…Literally at my lowest point… She gave me a lot of positivity… Also, a lot of encouragement to go to college and learn the language, interact with people" (p. 28).* Therapeutic support that focused on growing Laal's connection to her new community gave her agency and confidence: *"…appointments were never in a single room. Sometimes she'd take me out different places." (p. 23).*

A major theme in Laal's interview was her experience of a **reversal of progress** each time her short-term support ended, leaving her dealing with things alone again: *"…everything was better. And then…with the couple of months and the sessions are finished, it feels like I've gone back." (p. 22).* This lack of progress led to a feeling of being stuck which was emotionally devastating for Laal*: "I'm stuck in in the same place for 13 years." "Sometimes I feel like I won't survive." (p. 13 & 14).* There was a sense of regret and disappointment about the **damage done through lack of support**, that services had missed opportunities to support her and had failed her in this way: *"…not knowing what was available to me, I feel like, this is why I am where I am 13 years later." "Even now I feel like there isn't a future." (p. 32, 35 & 36)*.

4.1.1.2 Reflection on the Interview.

This was the first interview I conducted, and also my first time working with interpreter, Anowara. I was mindful and slightly anxious about the complexity of doing this for the first time and ensuring it went smoothly. At first Laal said that she felt nervous but all three of us quickly built a rapport, with Laal commenting that it felt like a smooth, three-way conversation. I had entered the interview hoping to begin by getting an overview of the services Laal had accessed but learned through the process that this was based on my experience of working in and fully understanding the service landscape and did not align with Laal's experience or knowledge. I feel that Anowara and Laal's shared cultural references added depth and richness to the process. We were able to discuss if there were any concepts that were difficult to translate across languages or culture and develop a good, shared understanding of these.

4.1.2 Kaalo

Kaalo is a 53-year-old Muslim, woman from Bangladesh who came to the UK 12 years ago on a spouse visa. She has six children, five of whom were born in Bangladesh and the sixth once they had all arrived in the UK. Sadly, Kaalo lost one of her adult children to suicide in the past few years, something she saw as being strongly related to her and her children's experiences of living with her abusive ex-husband. As Kaalo and I did not share a common language, our interview also took place alongside Sylheti interpreter, Anowara. Kaalo expressed that she was relieved and grateful that this research was taking place and felt it was important she contribute to it.

Kaalo explained that she came to the UK completely alone other than her children, with no family support around her. Experiencing abuse by her husband at the time led to her losing her home, source of income, and right to reside in the UK. These issues and the impact they had on Kaalo and her children's emotional wellbeing have led to her experiencing significant distress, low moods, and frequent tearfulness and anxiety.

Kaalo described great confusion and difficulty in finding her way to DA support and emotional support as a new arrival in a country where she knew no one and nothing about the existing systems. She was very unsure about which services she had accessed and when, remembering only the names of individual support staff rather than the organisation or type of service they worked for. Kaalo described a number of brief encounters with support staff based in a variety of locations, some of which were helpful, others not. She was not aware of how any of these professionals received her details and was not knowingly involved in the referral process for any of the support she received.

4.1.2.1 Main Themes.

One of the main themes in Kaalo's interview was of **needing support but not getting it**. She felt harmed by the lack of support when she and her family most needed it: *"It would have been much better. A lot better than what it was… Things might not have taken the turn they did." (p. 29).* There was also a strong sense of Kaalo having to **struggle to reach support** and particularly finding it hard to navigate this process with language and childcare constraints: *"…no one actually went with me…the language was a barrier and my children as well. That was the struggle…" (p. 22).* Kaalo found that she was able to make progress towards feeling better once she got to know how services worked and what her options were: *"Once I'd been in touch here, that's when they sent me there for help…I wasn't aware, whereas I am now." (p. 32).*

When Kaalo was able to access support, she experienced **the good that support can achieve.** She described the transformative effect of being heard and having someone to share her burden: *"…just being able to speak to someone is comfort, just sort of getting things off my mind and chest." (p. 20).* Positive support relationships helped Kaalo to have hope and positivity for her future: *"looking beyond the bad…motivating me and trying to encourage me, that good will come from it…"*

(p. 20), particularly those that utilised her strengths and her faith*: "to seek spiritual help, turn to my prayers, turn to my recitation… To keep faith." (p. 19).*

Kaalo also experienced what it is like **when services get it wrong**. Part of this experience involved Kaalo being left to cope with things alone, whilst still feeling she needed support: *"It feels like it won't ever go, won't ever leave me, that feeling." (p. 12).* Another part related to Kaalo feeling unvalued, dismissed, and even threatened by some services, leading to fear of repercussions if she criticised these services in our interview: *"I felt like I was being laughed at. There was no compassion.", "Again, I don't want to mention names, but I'm just not happy with the service. I've just had no help at all." (p. 9 & 11).*

4.1.2.2 Reflection on the Interview.

I found the interview with Kaalo a bit more challenging than the previous one. I sensed, and Kaalo later confirmed that she had been given very little opportunity to talk about what had happened to her, meaning there was a lot of expressed emotion as she spoke. I was worried about causing distress to Kaalo and asked several times if she wanted to continue. In these interactions I felt very aware of the power difference between Kaalo and I, particularly in my position as a White, psychologist, researcher. Kaalo insisted that she wanted to continue, that it was important to her that she contribute, helping me to realise this was her taking back some of her power. This was my second interview alongside Anowara, and I felt that we had developed a flow in how we communicated back and forth across languages. Kaalo reflected that she was unused to talking about her emotional experience but that this was made significantly easier by being able to speak in Sylheti.

4.1.3 Golap

Golap is a 43-year-old Muslim woman from Bangladesh who came to the UK 24 years ago on a spouse visa, with her first child. She has five children, four of whom were born in the UK. English was Golap's second language and she felt more confident speaking Sylheti. However, she wanted to do the interview in English as it was important to her to use English as much as possible and grow her confidence in it. Golap felt it was important to contribute to research that hopes to help other women, motivating her to take part.

Golap was brought to the UK when she was 18 years old by her husband at the time who soon became abusive towards her. At this time, she had to flee her home and live with family before she was supported to access housing and benefits. Some years later Golap married again and sadly experienced abuse by her second husband at the time, worsening after she gave birth to her youngest child who has long term health problems. These experiences led to Golap feeling fearful, worried, low, and sad, with her faith and religion helping her through these feelings.

Golap described having a very difficult time initially finding her way to DA support, especially due to not speaking English and being new in the country. Once she knew what support was available, she was able to choose what she did and didn't want, often relying on her faith for support rather than services. Her most positive experiences were with a South Asian community-based service that provided a hub of emotional and practical support and connection.

4.1.3.1 Main Themes.

One of the early themes in Golap's account was of **struggling without support**. It felt that being alone, without support was worse than the impact of DA itself: *"…I cried not because hitting me and shouting at me and swearing, I am crying because I feel bad, I wonder where I go…" (p. 25)* and that her being a young mother, new to the UK made it very difficult to find support *"…I wasn't like that confident like that, and I don't know London, I don't know anything…I was pregnant as well, at the beginning…" (p. 24).* Golap eventually found her way to a therapeutic support service but was deemed unsuitable and denied the support she needed: *"…I go there, and they assess me I think, and they said I'm not that category or something and then I leave." (p. 38).*

Significant for Golap was the **value of family and community** with family both opening the door to support and stepping in in the absence of services: *"…the first time I had lots of problems and my sister said go to *service name*, go to the doctor and go to the police…So, that's why I am getting confident and taking these services." (p. 3).* Connecting with her community through a specialist South Asian organisation was a positive experience for Golap and her emotional wellbeing: *"This service was near my house and then the time will come to party…lots of Bengali people together, same communities feeling great, much better." (p. 44).* Support in her own **language** made the process easier for Golap: *"I told S. I called her in Bengali 'S, it's my second husband, he slapped me and he a problem for me, so maybe soon I tell you everything'." (p. 19).*

Two final themes in Golap's interview gave a sense that her experiences were on the whole more positive than other participants. Judgement free, trusting relationships where Golap felt held, reassured, and empowered demonstrated what it looks like **when services get it right:** *"…you will feel like you've got support. Not like a father/mother support, just free, I think. If somebody support me, you're just free", "I know you, or the doctor, or you people, professional people know and think like that…there's no shame."* (p. 39 & 40). Specialist South Asian and DA services showcased **support at its best**, staying by Golap's side for as long as it took and instinctively providing what she needed: *"…looked after me for the last two years for domestic violence and then I am relaxed…", "…she told* *us you don't tolerate any violence and that is a positive thing to teach us, if anything, any problems at home don't hide, don't hide." (p. 44 & 21).*

4.1.3.2 Reflection on the Interview.

Having spoken to Golap before the interview, I was mindful that there might be some challenges in us understanding each other. Going into the interview I was concerned that communication difficulties might compromise the data I had to work with in the transcript. Despite this, I felt assured that not using an interpreter was the right approach as it allowed Golap to make a choice about how she communicated with me, handing some power in decision making back to her. During the interview, we did have to confirm each other's understanding multiple times, with both of us reflecting that this helped create a solid shared understanding. Golap took care to describe and explain details of her cultural heritage and religion throughout the interview. I was mindful that she likely would not feel the need to do this with a South Asian or Muslim researcher and wondered if this added to the effort required of Golap.

4.1.4 Wapis

Wapis is a 53-year-old Muslim woman from Pakistan who moved to the UK 20 years ago. She has one child who was born in the UK. Wapis was happy to take part in the research with the hopes that her experiences and feedback would create positive changes in service provision for similar women. Our interview took place via video call at Wapis' request, and in English, which she speaks fluently. Wapis currently works in a helping profession with links to the kind of services women might access after DA.

Whilst living what she described as a successful life, working and caring for her daughter, Wapis realised with help from a TV advertisement that her husband at the time was abusive towards her. This resulted in her and her daughter having to flee their home and relocate to refuge accommodation in another city. This had a negative impact on Wapis' emotional wellbeing, leaving her feeling isolated, out of place, and fearful. She described mostly pushing her emotional distress to one side to focus on being an organised, stable, and caring presence for her daughter.

Wapis realised early on that the support landscape was confusing and complicated. Wanting to ensure safety and stability for her daughter, she spent a long time studying the available options before she was confident about the best next steps. Although this set Wapis up for a mostly positive experience of specialist DA services, her level of organisation and confidence resulted in her being denied therapeutic support that she needed.

4.1.4.1 Main Themes.

One of the main themes in Wapis' account focused on the **barriers between her and support.** Without family around her, it felt unsafe to seek support, particularly from South Asian professionals in the area where her then husband was well known and influential *"…I don't want anybody from the Asian background, South Asian background and they said well, they couldn't do it… because it was his comfort zone, people knew him…" (p. 7 & 9).* Wapis described that without her level of education and experience in a demanding career, she would have found it difficult to find her way to support: *"…these are the things that I learned whilst I was studying. I spent all night sitting and reading what do I need to do…" (p. 10).*

Although some **disruptors of support**, like service inflexibility around childcare, got in the way: *"…our times didn't match because my daughter had started 15 hours of school, so it went, I couldn't, that I couldn't compromise with, so I left." (p. 21),* Wapis was able access some support that created **positive relationships and safety**. Experiences of warmth, care, and emotional connection had a significant impact on her, making her feel valued, respected, and held: *"…she motioned me to come on the other side and very discretely she just, as if a mother hen covers you. It makes me emotional." (p. 9).* Refuge support was particularly important in providing a place of safety and preparing her for the reality of the help-seeking process: *"The best part is I think they are there for a purpose… the first thing that I liked, the caseworker, she spoke to me over the phone and in a way she calmed me down…"…she gave me a very candid picture" (p. 14 & 15).*

Another theme in Wapis' account was related to her **strengths being put to use**. Wapis had positive experiences when professionals recognised her strengths and empowered her to use them whilst also being there for her: *"…she said to me, 'Okay, I have heard all your case, what do you want to do?'…she goes, 'Run off then. Go start your life and if anything happens, I am here.'" (p. 17).* Her determination and resolve to navigate the support system left a legacy through the other women she helped along the way and feedback she provided for each service she worked with: *"…I have helped so many women, so it was only I think because of the study I had…" "I have left feedback for every individual resource that I got through." (p. 11, 25 & 26).*

A final theme of Wapis' experience involved **a taste of what could have been and rejection**. Before service inflexibility around childcare brought it to an end, Wapis was able to access therapeutic support that had a lasting impact on her wellbeing: *"Perhaps I was looking forward to it and he said one thing which I carried on and still use now." (p. 21).* All other attempts by Wapis to seek the therapeutic support she needed were met with the response that she was too organised and confident to need it: *"I said, "Seriously, do you want me to be vulnerable and dying and not speaking well in English that you would understand?"" (p. 20).*

4.1.4.2 Reflection on the Interview.

The interview with Wapis felt different to the others I had done so far for various reasons. It took place online, Wapis spoke English fluently making our communication different, and in some ways easier, than with others, and mine and Wapis' level of knowledge around service structure were more aligned. I was mindful of the need for IPA research to have a homogenous sample so felt some concern that Wapis' experiences may be very different from other participants. The justification for interviewing people from differing circumstances is covered in section 5.2.3 but I found the interview in fact focused my attention on the universality of the difficulties all participants so far had faced.

4.1.5 Saskia

Saskia is a 37-year-old British woman with Indian family heritage. She is a Christian who was brought up by one Christian and one Hindu parent, experiencing both cultural influences. Saskia identifies as having a disability and has one child. Our interview took place via video call at Saskia's request, and in English, which she speaks fluently. Saskia currently works in a helping profession with links to the kind of services women might access after DA. Saskia felt strongly that it was important she take part, to contribute to enacting change in the way services work with South Asian women.

Saskia described becoming aware that her then husband was perpetrating abuse on her through the observations of a disability support worker who was visiting her at home. As a result, Saskia had to flee her home and move to another city with her child. Going through abuse and the upheaval it caused in her life had a significant negative impact on Saskia's emotional wellbeing. She described experiencing severe distress, sadness, difficulty focusing, feeling that she was 'falling apart'.

Saskia's experience of help-seeking was polarised, with some very positive and some severely harmful experiences from a range of services including DA organisations, social services, and her GP. She described difficulty inhabiting both her professional and survivor identities, with statutory services responding to this with hostility. She had to overcome a number of barriers to access any support and was left with a sense of having become stronger both through the positive support and through having to defend herself against the negative.

4.1.5.1 Main Themes.

A key theme in Saskia's interview was **how identity shapes help-seeking**. She explained that statutory services resisted and were hostile and punitive towards her inhabiting her identity as a professional alongside her identity as a survivor: *"…when you go into court, please don't wear makeup'…you presenting like that is not going to make you, your story is not going to be heard." (p. 14).* Saskia found that services that did not understand or respect her cultural identity often mis-judged and labelled close, loving family relationships as problematic rather than seeing their strength and value: *"…somebody with no experience of particular backgrounds, they might have thought that I was at risk from my family" (p. 23*). In contrast to this, support from people of a similar cultural background was effortless in terms of the impacts of stigma and racism being understood: *"…not having to go through the whole rigmarole of having to explain the cultural specifics of my background makes life so much easier." (p. 22).*

Saskia had positive experiences of emotional support from a range of services including DA organisations, a health visitor, and her solicitor, leaving her feeling **cared for and held**. Perseverance, flexibility, and validation helped to build her self-worth and move forward: *"…I still refer to it now as an emotional crutch when I feel like really…if I think about it, I just needed to be emotionally held I think." (p. 29).* She was supported in **owning her strength***,* with DA services valuing all parts of her identity and working against the shaming and silencing she had been through: *"…when someone was like "did that actually happen?"…I didn't feel embarrassed that I had to retract back into what I was saying…I'd go "absolutely it did happen, that did happen and I've come out the other side as well."" (p. 18).*

A significant part of Saskia's experience involved being **harmed through help-seeking**. She described being failed by statutory services that expected her to jump through hoops and follow procedure, at the expense of hearing her story, in order to be given support: *"…they're very process-driven services that don't allow for, they don't allow for that human narrative to come through." (p. 25).* She experienced some services as more abusive and harmful than the DA itself when they shamed and disregarded her, breaching her trust in them: *"…my self-worth was completely on the floor, really on the floor and I had some really horrific experiences…", "...I feel like they harmed me more than my ex-partner actually did because I trusted them so implicitly." (p. 8 & 9).*

Threatening and dangerous services left Saskia feeling that accepting therapeutic support would make her vulnerable to misjudgement about her parenting abilities: *"…I was just really scared that if I got too involved…as a professional person with a son…if something comes up that triggers some sort of safeguarding referral." (p. 19),* and that it would not be safe to defend herself against malpractice*: "…he got so cross with her he asked her to leave and obviously showing that sort of hostility towards a social worker is never going to end well" (p. 12).* Having to defend herself against this led to Saskia "**becoming a lion"**, bringing out a fierce, proud part of herself that she used to campaign for better treatment of women coming after her: *"…they retraumatised me, they hurt me…they've actually added to my armoury and my resilience…it sounds so cheesy but like a lion.", "…some people become contributors to the community…'you tried to bury me so deeply, more than my ex-partner did, now this is my turn to voice what went wrong.'" (p. 27 & 28).*

4.1.5.2 Reflection on the Interview.

I am mindful that my writeup of Saskia's interview is the longest of all six. The interview was very rich, with Saskia having had more experience talking about her story and its emotional impact than other participants. As the only interview with a native English speaker also born in the British Isles, I wondered how much the richness and ease in sharing was impacted by the many shared cultural references and communication nuances we will have, in comparison to other participants. Demographically, Saskia is different in various ways from all other participants. This is something I considered, and we discussed before interview. Saskia was worried about 'not being South Asian enough' for the research despite her Indian heritage. Through the interview it became clear how much cultural heritage and nuance Saskia shared with other participants and how aligned her experience of help-seeking was with the others.

4.1.6 Yellow

Yellow is a 20-year-old woman from Afghanistan who came to the UK nine years ago with the person who then became her husband. She is of Muslim religious background but identifies as having no religion currently. She has two children, both of whom were born in the UK. English was Yellow's second language and she wished to do the interview in English due to preferring to speak it rather than her native language of Pashto. Yellow wanted to take part to 'help out' and was interested in the results of the research and the recommendations it might make.

After being married, Yellow's then husband soon became abusive and controlling, not allowing her to speak to anyone or leave the house. After family members alerted social services, Yellow was supported to flee her home with her two children. She has since been struggling to gain access to the benefits and housing that she and her children need. This led to Yellow experiencing long term sadness and low moods, feelings of isolation and fear, and a difficulty trusting people.

Yellow described an overwhelming lack of support, particularly emotional support. She had tried many times to reach out for support from health and social services but was turned away. The very minimal amount of positive support she was able to access through a women's organisation was helpful, but there was a sense that it was not enough, leaving her continuing to struggle emotionally. Yellow also described significant judgement and stigma from her own community, leading to her rejecting aspects of her cultural heritage and religion, and putting distance between herself and others from Afghanistan.

4.1.6.1 Main Themes.

A dominant theme in Yellow's story was of **struggling to reach support**. She described very limited options for support that didn't meet her needs: *"You know the help that I want I never get through so…either I took the medicine not talk with anyone…" (p. 4),* and the negative impact of being turned away by therapeutic services: *"…I just spoke once with them, but that time I took overdose, and I went to hospital so, I never talked with them again." (p. 5).*

This linked to another theme around **services exerting negative power** on Yellow by expecting her to side-line her wishes and needs to avoid being rejected by them: *"…I asked them to help me but don't ask about my past, but they said no, you have to talk about your past but if I talk about my past, I felt very sad." (p.4).* Being let down by services in these ways led to Yellow blaming herself for her lack of progress and feeling discouraged from approaching services in the future: *"…they say, you don't do this, this, this. I explain, I do whatever you said, I'm doing but still it's not coming." (p. 13).*

The **impact of cultural stigma** was significant in Yellow's account. Difficult experiences involving judgement from members of her own community meant that South Asian support organisations felt unsafe to access: *"I knew a lot but from their face and from their expression I understand so, they're judging me or not." (p. 26).* However, she was able to develop a trusting relationship with a South Asian domestic abuse support worker who shared her own experiences and understanding of judgment and stigma from her community: *"…she was from Pakistan so similar like our culture…because she said about their personal life and her parents' life so, she kind of understand me." (p. 21).*

A final theme for Yellow was on **what good support can achieve**. She described how being heard, believed, and having someone to rely on was important for her wellbeing and made her feel valued and cared for: *"…it's because she always listened to me, so she understands me, so yes.", "…they ask me about how do I feel…first you need to find out something about yourself and then you can help the children…" (p. 16 & 10).* Being given choice and control in the support she accessed led to her most positive experiences of services: *"…they listened, and you know, they didn't do anything that if you don't want to do, unless you were happy with that." (p.6).*

4.1.6.2 Reflection on the Interview.

The interview with Yellow was the shortest, due to her not talking as much as other participants. Her answers were often short, and she did not elaborate unless I asked specific follow up questions. In exploring this with her, she explained that she wasn't used to talking about her experiences. Although we had a warm rapport, I was mindful of my position as a professional and her repeated rejection from support, meaning she had rarely talked with someone like me. In other interviews I had leaned in to learning more about participant's cultural background, religion, community but with Yellow this felt very different. Her negative experiences within the Afghani community meant that she did not currently identify much with her culture or religion of origin. I was mindful during the interview that Yellow was at an earlier stage of the help-seeking process than all other participants and felt sadness and regret that she was experiencing the same early lack of support that all other participants had spoken about. In all, but particularly in this interview, it was harder to shift focus from the activist, psychologist, feminist parts of myself, towards the researcher position.

4.1.7 Overall Reflection on Interviews

Being allowed to share a space with these six women, hear their stories, and learn from them was a genuine privilege. I was struck that after so many negative experiences of professionals, they trusted me and brought me into their worlds. I felt a warm connection with each of them, was moved by their strength and resolve, and at times angered by how they had all been harmed and let down, time and time again. Their stories will stay with me.

4.2 Group Analysis

As detailed in the previous section, although each participant had a unique experience of help-seeking, there are various similarities across all six accounts. These have been presented in the form of four Group Experiential Themes (GETs), each with their own group-level sub-themes. The GETs demonstrate the journey through the help-seeking process that participants described, from struggling without support, to being both supported and let down by services, and how community and culture influenced this journey. GETs will be referred to as 'themes' from this point forward for ease of reading.

The interaction between themes and sub-themes in the help-seeking journey is demonstrated in a thematic map in Figure 1. Although participants' journeys all began with a chronic lack of support, this was present at different times, repeatedly throughout their help-seeking journeys and is placed along the top of the map, reaching across all other themes. Most participants had both negative and positive experiences with services, not one after the other but at different times, consistently throughout the whole journey. This is represented by the themes in blue and green, placed next to each other. Community and culture, placed in the centre, impacted on all other themes, throughout the entire help-seeking process, from the start of participants' journeys to the present day.

Figure 1 *Thematic Map of Themes and Group-level Sub-themes*

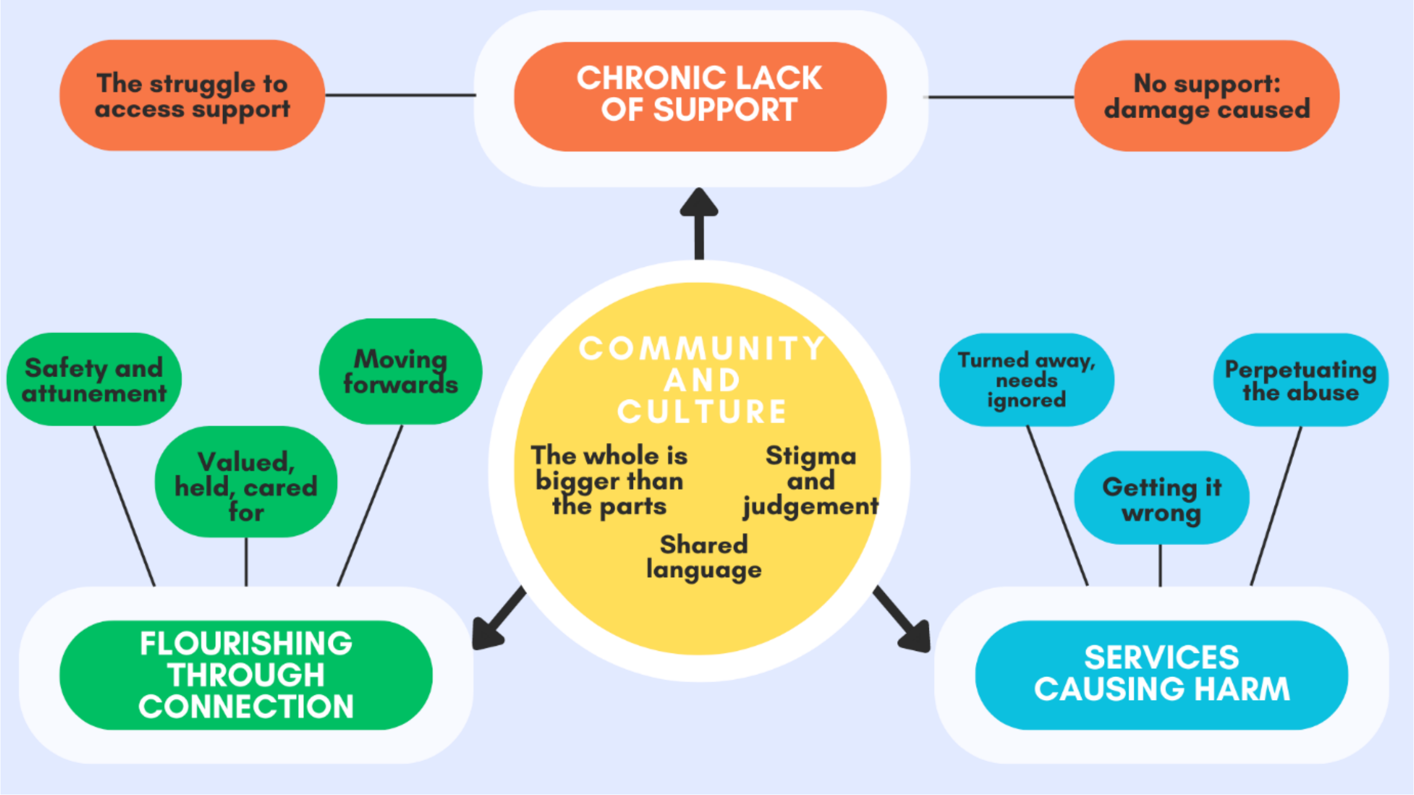

Table 2 demonstrates each theme, its group-level sub-themes, and in which participants' accounts these were present. In the following sections, each theme: '**Chronic lack of support'**, **'Culture and community'**, **'Flourishing through connection',** and **'Services causing harm'** will be presented, along with their sub-themes and relevant participant quotes.

Table 2 *Table of Themes, Group-level Sub-themes, and Participants Represented*

Group Experiential Themes	***Group-level sub-themes***	**Participants**					
		1 **Laal**	**2** **Kaalo**	**3** **Golap**	**4** **Wapis**	**5** **Saskia**	**6** **Yellow**
CHRONIC LACK OF SUPPORT	*The struggle to access support*	X	X	X	X	X	X
	No support: damage caused	X	X	X	X		X
CULTURE AND COMMUNITY	*The whole is bigger than the parts*	X	X	X		X	
	Shared language	X	X	X			X
	Stigma and judgement	X		X	X	X	X
FLOURISHING THROUGH CONNECTION	*Safety and attunement*	X	X	X	X	X	X
	Valued, held, cared for	X	X	X	X	X	X
	Moving forwards	X	X	X	X	X	X
SERVICES CAUSING HARM	*Turned away, needs ignored*	X	X	X	X		X
	Getting it wrong		X	X	X	X	X
	Perpetuating the abuse		X			X	

4.2.1 Theme 1: Chronic Lack of Support

This theme demonstrates the universal experience of all participants in their **'chronic lack of support'**. Participants described persistent difficulties in knowing about, accessing, and continuing to receive support. There was a sense that all participants had experienced significant harm and trauma but were getting by on a minimal amount of support, mostly from third sector services. Participants also described the harm caused to their wellbeing and futures due going through these experiences and not having adequate support to cope with them. To illustrate these two elements, this theme has been split into two group-level sub-themes: **'*The struggle to access support*'** and **'*No support: damage caused*'.**

4.2.1.1 The Struggle to Access Support.

This sub-theme, detailing '***the struggle to access support'*** was present across all six accounts. It related to experiences of participants doing everything they could to try and reach support but facing so many barriers that it proved extremely difficult. Several participants described that being brought to the UK alone, at a young age, unable to speak English, made it very difficult to know what support was available or how to reach it, as well as how daunting this situation was. For those with young children to care for, this process was even more difficult: *"I was quite young, the new country, language barrier, I was afraid and not confident."* (Laal p. 8). There was a sense for several participants that no one knowing they were in the UK added to the isolating and silencing effect of DA until they were discovered or managed to reach services: *"And then her health visitor came home to see her and then she saw my two children…and then asked who are they and my sister was crying and then told her "my sister has come to this country and then no help with two children", and so that's why that luckily this lady said she'll help me."* (Golap p. 28).

Several participants spoke about how complicated and confusing the support landscape was to navigate, with services rarely providing a joined up and coherent approach. Kaalo explained that having to navigate complicated systems alone proved difficult due to not being able to communicate in English and having children to care for: *"…no one actually went with me…the language was a barrier and my children as well. That was the struggle…"* (Kaalo p. 22). Yellow spoke about eventually being in contact with services but experiencing distress and frustration when they did not respond to her attempts to reach help: *"…gave the case to a new case worker but every time I call her, send her a message, email her, she didn't reply me, the biggest stress..."* (Yellow p. 14).

Wapis demonstrated the complexity of the support system in describing that a demanding career and education level was good preparation and needed in navigating the support landscape: *"…I'm a very organised person, I've worked in high profile jobs…I knew that I had to organise myself because of my child, I started studying."* (Wapis p. 6). When she began to access support, she found that service inflexibility and ongoing DA and control made it impossible to continue: *"…finding a day and a way to go to the other one was almost impossible because within my movements sphere…the circumference of my activity was very little."* (Wapis p. 7). Similarly, Saskia described that being able to take time to seek support is a privilege she did not have, due to intersectional disadvantage: *"I had bills over my head, I was being taken to court, I had the threat of losing my home which I'd just* *bought and also, I should mention I have a disability… I just felt this isn't a privilege that I can afford to take right now."* (Saskia p. 5 & 6).

4.2.1.2 No Support: Damage Caused.

This sub-theme, demonstrated in five interviews, outlined the ***'damage caused'*** when participants were left without any support. There was a sense that experiencing DA and having to deal with the consequences alone added another layer of distress on top of what was already present. Some participants spoke about how upsetting and difficult it was to navigate the early stages of leaving an abusive relationship without support from services. Others described reaching out for help but not getting what was needed, and the detrimental impact this had on their wellbeing: *"…if I'd had the right guidance…it would have just made things a lot easier."* (Kaalo p. 31 & 32).

There was a sense of finality in how participants spoke about this theme, as though they were resigned to not receiving enough support and the distress this was causing them. Some described any progress made when support was present being stripped away when it ended prematurely. Others felt as though they would not reach emotional contentment as they had never received the right support to facilitate this: *"…the emotional wellbeing, it never comes in place unless it's available… I am equally suffering…it doesn't mean that in my head I'm in the right state. It can never be possible."* (Wapis p. 28).

Saskia, the only participant who did not have experiences that fit with this sub-theme, did not have any periods without support as health professionals were consistently involved due to her disability and because she had recently given birth to her child: *"other professionals as well like the health visitor gave me their phone number and they would do a home visit"* (Saskia p. 7).

4.2.2 Theme 2: Culture and Community

This theme also came up across all six participant's experiences. It relates to how their **'culture and community'** interacted with and influenced their experiences of help-seeking and support. Participants described differing levels of involvement and support from family and community members, with families often struggling to manage all aspects of support, in the absence of services. Language was an important mediating factor in accessing support, helping participants to have agency and control over the process, and feel connected to others. This came up both in relation to services that provided support in participant's native languages, and those that supported them to learn English. The impact of stigma and shame from the South Asian community was felt in different ways by different participants, with some avoiding support from other South Asian people and others finding it the most beneficial. These three areas are illustrated through three group-level sub-themes: ***'The whole is bigger than the parts', 'Shared language',*** and ***'Stigma and judgement'.***

4.2.2.1 The Whole is Bigger than the Parts.

This sub-theme, which came up in four of six interviews, was based around the interplay between family, community, and service support. There was a sense that all three were important sources of support that would not be enough in isolation. Several participants described how other women around them, in their extended family and community, were the first to connect them with support services after having similar experiences themselves: *"Yes, my cousin knows everything. She helps me by taking me to doctors or other places."* (Laal p. 19). Some had family members around them who were more familiar with their local area and service provision and helped them to reach support. Others found there were limits to the help family could provide, with some receiving no family or community support at all: *"Even though there were people there, I never really got any great advice…rather than helping, they didn't really."* (Kaalo p. 31).

Some had more positive experiences with family and community support. Golap's connection to the Bengali community and her religion and faith of Islam were essential in her wellbeing and recovery after DA. She had positive experiences of community support through a specialist South Asian women's organisation but still emphasised the importance of services being involved, alongside family and faith: *"We're religious, mainly our religion, our book…but still you have to talk to your doctor, still you have to talk to your friends, family."* (Golap p. 6).

Saskia described being very close with her family and community, knowing she could rely on them for support, care, and love, something that DA services were supportive of: *"…because of my disability, I try to be, create a community around me as close as possible…"* (Saskia p. 9), "*I was really open as well with them about what was going on and how much my family are a support to me…I felt listened to, I felt heard…"* (Saskia p. 26).

The two participants who did not have experiences that related to this sub-theme, Wapis and Yellow, notably did not have many friends and neighbours around them. Wapis lived far from her family and purposely avoided those in her community due to her ex-husband's influence there: *"it was his comfort zone, I didn't belong there. I hated it."* (Wapis p. 4). Yellow had separated herself from her family and community after various negative experiences of stigma and judgement from them: *"So on that time everyone said do this, do this, but now I'm doing whatever I want. This feels good, but you know so when I do whatever I want, most of people don't talk to me so, still it's a bit difficult but for me it's okay. I don't want to live for people like before I did.*" (Yellow p. 27).

4.2.2.2 Shared Language.

This subtheme demonstrated how having a ***'shared language'*** with support staff was essential in moving through the emotional support journey successfully. As well as causing difficulties in finding support, a lack of shared language made things difficult for several participants whilst they were receiving support. Golap explained that she didn't know or remember details of her support journey as she had navigated much of it without a shared language: *"I don't remember because of language barriers."* (Golap p. 40). Although Yellow was offered support alongside a language interpreter, negative experiences of the interpreter altering her responses further silenced her voice and increased the barriers between her and services: *"So after that my cousin say that I said something and then that person said another thing."* (Yellow p. 20).

Some participants were offered support in their native languages, allowing them to understand and be understood. This, predictably, greatly enhanced the support they received and its emotional depth. Laal and Kaalo spoke about support in Bengali facilitating connection, empowerment, and hope: *"They were Bengali speaking, so I was able to communicate well."* (Laal p. 17), *"There was a lot of reassurance, they gave me hope that things will get better, to keep faith…There was a Bengali speaking lady…"* (Kaalo p. 25).

Others found being supported and empowered to attend courses and learn English was important for their wellbeing. There was a sense that this allowed participants to connect with and feel more confident in their new community after the isolation of DA. English classes allowed participants to move from the social restriction of DA, to forming connections with others and gaining positivity through this process: *"…so that's why I am out slowly, slowly with people, meet people…and then me and my English classes, lots of English classes during that time and I feel better."* (Golap p. 29).

Notably, Saskia and Wapis, the only two participants who are not represented in this sub-theme, spoke fluent English throughout their help-seeking journeys and therefore did not speak about any difficulties in communicating or understanding what was being said to and about them, further demonstrating the importance of a shared language.

4.2.2.3 Stigma and Judgement.

Five out of six participants spoke about the impact of ***'stigma and judgement'*** on their support journey. All five participants shared experiences of facing stigma, shame, and judgement from the South Asian community. They explained that this often centred around their experiences of DA including separation, divorce and, experiencing emotional distress or mental health difficulties. Golap explained that voicing her experiences of divorce and second marriage to me in our interview was distressing and difficult due to the shame placed on this within her community, mirroring her difficulties with talking to support staff: *"…what I am making wrong, I got two marriages. In our society, only in the Muslim society, Bengali society…this kind of thing is very bad today, but I tried to talk to you strongly but still my heart wanted to cry…"* (Golap p. 8).

Some participants spoke about being sure early on that they could not accept support from a South Asian person or organisation due to knowing they would be judged as they had been repeatedly by members of their own community or made unsafe by its close-knit nature and the influence and status of perpetrators: *"I know from my culture people is judging you, so it is not good, so they judge you from their point of view not from what you suffer and what you feel…That's why I don't like to work with my own country's people."* (Yellow p. 21). Yellow also advised that she would not have participated in this research if I (the researcher) was South Asian, due to this feeling unsafe.

Several participants reported positive experiences when they felt free from stigma, allowing them to feel safe and understood. The belief that professionals do not judge facilitated a sense of movement from feeling stuck and silent under stigma and free and open in its absence: *"…with a doctor or psychiatrist, they won't judge. There's not that stigma, I felt able to express my feelings freely."* (Laal p. 15). Some participants, even those who had been wary of culturally specific support, described developing safe and trusting support relationships with support staff of a South Asian background. Being supported by a South Asian person was described as easier, less effortful than other support relationships due to the mutual understanding and acceptance of experiences such as cultural stigma and racism: *"I felt like sharing that with N, she understood the impact...like it cut so much deeper... but I can imagine that if I had shared that with some particular professionals I can think of at the moment, that would have landed so terribly."* (Saskia p. 23 & 24).

4.2.3 Theme 3: Flourishing Through Connection

This theme detailed the experiences all six participants had at times when they were receiving positive support, leading to them **'flourishing through connection'**. This happened for different participants at different times and with different services. Some described brief encounters with support staff who connected with and supported them in ways that they carried with them throughout their support journeys. Others had longer term positive relationships with particular staff and services that helped them through their distress. All participants were keen to share these examples of good practice and emphasised how essential they had been for them. There was a sense that having had so little support overall, these positive experiences were of great significance. This theme has been split into three sub-themes that represent the different elements of positive support that participants experienced: ***'Safety and attunement', 'Valued, held, cared for',*** and ***'Moving forwards'.*** *All* three of these sub-themes were present for all six participants.

4.2.3.1 Safety and Attunement.

All six participants described support relationships that felt '***safe and attuned'*** to their needs. Safe support relationships developed when participants felt welcomed, listened to, and respected. There was a sense that after the fear and unsafety of DA, safe relationships were important for wellbeing. Services and support staff demonstrated attunement when they provided exactly what participants needed most at that time, noticing and attending to their needs.

Saskia explained that being respected and believed in her experiences of DA led to her feeling safe in her relationship with DA staff: *"…she sent an email almost instantly she said to me 'you don't need to question your experience'…and then the next day she rang me and was like…'If you're telling me that's happened to you, it's happened to you.'"* (Saskia p. 18). Several participants spoke about how being in a trusting and safe relationship allowed for them to open up, share their experiences, and release the distress into the open: *"I'll cry, I'll feel. I'll let my emotions out and after I've done that, I'll feel a little bit at ease."* (Kaalo p. 7).

Specialist DA support services were the most commonly mentioned within this theme and sub-theme. Refuge staff were described as warm and reliable, providing a peaceful sanctuary where women could focus on their wellbeing: *"So, when I went and saw her for the first time at the station, I think we could be the best of friends because of the relationship we had."* (Wapis p 15). Golap explained that during one of her most difficult times involving her ex-husband, her DA support worker knew instinctively what she would need and provided this without asking: *"…S was writing everything…and then S said give the police and S told the police look, this man one month ago slapped her, and then they come home and then they arrest him."* (Golap p. 19). Participants also described several services being involved and working with a joined up and coherent approach being helpful, attending to all their support needs: *"All the services, NHS services, the domestic violence services and then all the doctor services, all the advice. This is very helpful for people's life."* (Golap p. 15/16).

4.2.3.2 Valued, Held, Cared For.

All participants placed emphasis on support that made them feel ***'valued, held, and cared for',*** with this being instrumental to their wellbeing and recovery after DA. There was a strong sense of warmth and connection as participants spoke about these valuable support relationships and the impact they had during some of their most difficult times.

Several participants spoke about support staff investing time in them, dedicating themselves to being present and there for them, showing them that they were valued. Laal described an important aspect of her most positive support relationship with a therapist was that she gave her the gift of time, never rushing their sessions, creating feelings of worthiness, and being valued and listened to: *"She was never looking at the clock. She let me express my feelings, speak openly…"* (Laal p. 26). Similarly, others described the people who had supported them well as having taken an interest in them, investing in their emotions and wellbeing. Having their needs centred emphasised that they were deserving of emotional wellness and changed their relationship with self-care: *"'What is Wapis going to do?' And I said, 'I will when I can.' And he said, 'No, you have to start off with yourself.' So, that's one thing I carried on."* (Wapis p. 22).

For some participants, receiving care and feeling emotionally held went beyond the boundaries of particular services. Warm and caring support did not only come from therapeutic or emotional support services but from individuals within a variety of services who stepped into this role: *"She was loving when I needed to be cared for emotionally, when I would just come in her office and I'd cry, literally I was such a crier as well. I cried so much. She would leave her desk and give me a cuddle."* (Saskia p. 29). Several participants spoke about the emotional support they received from particular professionals but were unable to say which or what type of service they had come from. The type of support the service provided was of more importance than what type of service it was: *"She's there to provide people with emotional support."* (Kaalo p. 17), *"I'm not sure if it was a health service but it helped me…"* (Laal p. 5). Golap described a team of various professionals working across different sectors and specialisms as being like a closely knit family unit, all together backing her up, there for her to rely on: *"…there's lots of support that goes with us, like a pride, behind with lots of support…"* (Golap p. 15).

4.2.3.3 Moving Forwards.

This sub-theme represented how all participants felt that the positive support they had received helped them in ***'moving forwards'***, away from the DA and towards more positivity and wellbeing in their lives. There was a sense of movement in how they spoke about themselves in this process, and a focus on what it was about the support that facilitated this.

Several participants spoke about how being given choice, control, and agency in their support journey increased their confidence and feelings of empowerment. Golap spoke about how her GP trusting her to decide what support she did or didn't need allowed her to step into her confidence: *"…how many times I go to the doctor she advised me like shall I give you counselling and then talk to people, and I said always to listen and I know where I talk, so I am confident…"* (Golap p.

5). Others experienced increased empowerment and wellbeing after being listened to and trusted to make their own decisions about their support: *"…she was very honest, so it's an open business whether or not I go there or not. I choose to go there, and I did, and I think they were right".* (Wapis p. 16).

Several participants spoke about the contrast between their lives during DA shaped by restriction, fear, and isolation and their lives after receiving safe and caring support where they were able to feel free, connected, positive about the future. Positive therapeutic relationships facilitated a change in communication and connection with others, from closed off and restricted to having freedom to be open about what they had been through. Hope and positivity developed through support empowered participants to move away from feeling trapped, allowing them to see a brighter future and experiences changes in their lives: *"…it helped a lot… They were very supportive. I've managed to now get one daughter married. And they've seen all those positive signs."* (Kaalo p. 25). Others spoke about the transformative effect of being believed and validated, helping them to understand what they had been through and move forward defiantly: *"…gave me the reassurance that I'd gone through what I'd gone through... She did so much in terms of moving me forward in that process…"* (Saskia p. 3).

4.2.4 Theme 4: Services Causing Harm

This theme relates to the number of experiences all six participants had of being harmed by services that were meant to be supporting them. Unlike the experiences covered in Theme 1 – **'Chronic lack of support'**, these happened whilst participants were actively engaged with services. The harm participants spoke about ranged from being denied essential care, to services making mistakes and unhelpful decisions, to taking actions which had a similar negative impact as the DA had done. There was a strong sense of being let down, repeat victimisation, and fear and distrust of services and professionals. This theme has been split into three sub-themes: ***'Turned away, needs ignored', 'Getting it wrong',*** and ***'Perpetuating the abuse'.***

4.2.4.1 Turned Away, Needs Ignored.

A common theme for five out of six participants was of being '***turned away'*** from therapeutic or mental health services that they were referred to or approached themselves. Repeatedly, participants were given the message or directly told that they were unsuitable for therapeutic support. Participants spoke about clearly understanding and demonstrating their needs to services but these being ***'ignored'***. There was a sense within this sub-theme of five women who had been through severe harm and trauma, experiencing significant distress, but being expected to deal with this alone, without the therapeutic support that they needed and should have been given.

Several participants described approaching self-referral therapy teams and laying out their experiences and need for support. The responses of services in these cases silenced participants' narratives when they were told they did not in fact need emotional support. There was a sense of feeling let down by services using their strength and confidence as a reason to deny them support or deeming them unsuitable, disregarding their wishes and needs: *"They said to me that you don't need it, you're in a better place… 'Do you think that I would have come to you, filled that whole form to say to you that?'"* (Wapis p. 30).

Others were not able to get as far as discussing their needs after being advised to self-refer to therapeutic services, repeatedly reaching out for help but not receiving it: *"I've had no feedback, nothing… It's not answering calls, impossible to get hold of."* (Kaalo p. 10). Although Laal was able to access therapeutic support, she described being passed from one short term input to another, each with a different therapist. The result was a confusing and insufficient offer of support that left her still needing more: *"…so it was a different person. It was a different place…it wasn't enough sessions. I needed more sessions… now they've referred me again."* (Laal p. 16). Yellow was forced to turn down an offer of therapeutic support as the service expected her to go against her wishes and needs to avoid being rejected by them. Despite knowing that talking about her past would not help, they insisted this was the only way she could access their support, denying her self-expertise: *"…they told me, when you speak with someone, so you forgot about it and you feel better, but I don't think it's possible."* (Yellow p.11).

As is covered in a later sub-theme, Saskia's very negative experience of services led to her turning down or not considering therapeutic or mental health support, meaning that she was never in a situation to be turned away. As a result, she is the only participant not represented in this sub-theme.

4.2.4.2 Getting it Wrong.

Five out of six participants spoke about examples of services ***'getting it wrong'***, taking actions that resulted in negative and disappointing experiences of service provision that they expected to be supportive. The experiences detailed in this sub-theme are individual to each participant, relating to their personal journey, but are all linked to this overarching theme.

Kaalo described a lack of control and knowledge in her support journey being disconcerting. Not understanding how and why a service had contacted her felt unsafe and unsettling: *"I'm not even sure myself where they came from. But I'm very fazed by his. Why this person's got involved."* (Kaalo p. 13). Golap, relying on the many professionals she was in contact with to notice and provide help, doubted that she was really experiencing DA when they did not intervene: *"…I am just waiting* *and the same time lots of professional people come and go…that's why I was understand if there was any problem, then definitely somebody would see…"* (Golap p. 17).

Wapis expressed disappointment and feelings of being let down by services that responded only to her organised and confident appearance, reducing her to one aspect of her identity and ignoring her need for support: *"…people expect me never to, because I'm organised, I do everything…classifying a person as vulnerable…there are physical signs of vulnerability. I don't possess any of those."* (Wapis p. 27). Being given repeated instructions by professionals on how to better support herself and her children, and these not working, left Yellow doubting herself and feeling blamed and dismissed, discouraging her from using services: *"…no one understands me, so whenever I said to anyone, they said you can't do proper, that's why your kids don't listen to you."* (Yellow p. 12).

Saskia shared various experiences of social services interacting with her in a way that was unhelpful and detrimental to her wellbeing. She shared difficulties with services and professionals not understanding or accepting her culture and the way it shapes her family relationships. She experienced negative judgement about her most valuable, loving relationships by professionals who did not understand or accept the way culture shaped her family dynamics: *"…instead of seeing my dad as a protective factor…she wrote a report saying my father's really controlling…"* (Saskia p. 12).

Laal is the only participant who is not represented in this sub-theme. She seemed to have had the least interaction with services out of all participants other than Yellow, and many of her accounts of negative experiences focused on a lack of support and support being removed. It may be that having fewer support interactions overall created less opportunity for negative experiences, or that she simply had positive experiences and wanted and needed more.

4.2.4.3 Perpetuating the Abuse.

Often in IPA research, sub-themes are included only if they are present in at least half of participants' accounts. Although experiences related to services ***'perpetuating the abuse'*** came up in only two of six interviews, this sub-theme has been included due to its significance and poignancy to Kaalo and Saskia. The value of these experiences as vital recommendations for services was also considered. This sub-theme outlines responses from services that Saskia and Kaalo experienced as abusive and harmful, particularly as they expected to receive support and care. They describe these experiences as being severely detrimental to their emotional wellbeing and recovery after DA.

Both Kaalo and Saskia spoke about being met with a lack of compassion, and feeling judged by police and social services whilst they were at their most in need of help. Kaalo was left feeling unvalued, dismissed, and looked down on when she told her story to a new social worker: *"I was* *never given a chance… A couple of times I did ring, and it was just very unprofessional… I could hear laughter in the background..."* (Kaalo p. 9). Involvement from social services and police were the cause of some of Saskia's most difficult moments. She described being met with threatening judgement and derision from social services when at her most fragile point, dealing a blow to her self-worth: *"…'If you don't stop crying, your son is going to be removed from you, that's what's going to happen. If you don't pull yourself together.'"* (Saskia p. 11).

Saskia's experience as both a professional and survivor led her to realise that statutory services like social services expect survivors to be less powerful than they are and are hostile if this is challenged. She experienced this first hand when she tried to use her professional knowledge to assert her needs and stand up for herself: *"…you're not approaching us as a professional, you're approaching us as a survivor…you're not allowed to be a professional person and be a survivor."* (Saskia p. 13).

For Kaalo a lack of trust and a related sense of fear was present in some of her interactions and relationships with services. Not feeling in control of the support she was offered and not feeling able to build a safe relationship with a professional felt threatening: *"…meeting her just had an inkling something wasn't quite right."* (Kaalo p. 13). Kaalo also held the belief that some services are to be feared and so shouldn't be criticised, leading to her checking several times during our interview that what she said wouldn't be passed on: *"I don't want to mention any names... I still have children at home, I want to keep it totally anonymous."* (Kaalo p. 11).

For Saskia, the sense that mental health services were linked with others like social services meant that engaging with therapeutic support felt like she was opening herself up to judgement about how good a parent she was*: "…we both had an assessment around our wellbeing because we were discussing the full custody of our son…I feel like at the time I thought all the services were linked."* (Saskia p. 25). Feeling threatened by mental health services, Saskia had to convince her GP that her distress was temporary, she didn't need emotional support, and would be fine soon. The threat that her distress may be used against her was enough to stop her ever accessing therapeutic support: *"…I reassured them that it would be, this is not going to be a long-term thing…I'll be back on my feet, but I just needed a bit of help at the moment in terms of the medication"* (Saskia p. 20).

It is hard to say why Kaalo and Saskia were the only participants who had accounts fitting with this sub-theme. Both were from quite different backgrounds and had very different levels of knowledge about services. One spoke English and the other Sylheti. The only clear similarity in their stories was that they had more contact with social services, courts, and police than other participants did. Most of their experiences described in this sub-theme were with, or linked to, those services.

This chapter first provided details of each participant and their experiences before outlining the main themes that emerged through the individual analysis of each interview. The group analysis of all six interviews was then presented. This resulted in four themes, each with two or three sub-themes which were described in detail with participant quotes to demonstrate how they relate to the original interview data. The themes and sub-themes were presented in the form of a thematic map in Figure 1, demonstrating how they relate to participants' mental health help-seeking journeys. The next chapter will discuss these results in relation to the research questions and the wider literature, before the strengths, limitations, and implications of the research are presented.

Chapter Five: Discussion

Research details clear links between DA and subsequent psychological distress or mental health difficulties (Trevillion et al., 2012). Studies looking at the experiences of WGM and South Asian woman demonstrate the same links, with particular difficulties around intersectional disadvantage and a lack of culturally competent service provision (Rodríguez et al., 2009; Stockman et al., 2014), as well as cultural stigma (Gill, 2004). The very small amount of existing research demonstrates how unclear we are on what mental health help-seeking journeys after DA look like for women in the UK (Eassom, 2018), particularly WGM (Femi-Ajao et al., 2020) and South Asian women (Anitha et al., 2009). To my knowledge, only Anitha et al.'s large-scale study has looked at the DA and overall help-seeking experiences of South Asian women in the UK, providing a starting point for this research.

This study aimed to provide a first in depth and detailed account of the mental health help-seeking experiences of a small sample of UK based South Asian survivors of DA.

The research question was:

How do South Asian women who are survivors of DA experience the process of seeking help for their mental health?

Within this question I aimed to explore:

- *How do South Asian women who are survivors of DA experience gaining access to mental health support?*
- *How does having a South Asian cultural background impact the mental health help-seeking journey of South Asian women who are survivors of DA?*
- *What is the impact of the mental-health help-seeking journey on the emotional wellbeing of South Asian women who are survivors of DA?*

Semi-structured interviews were used to collect data from six participants. This data was then analysed using IPA, producing four Group Experiential Themes (GETs), each with two or three group-level sub-themes.

This chapter will provide a summary of the main research findings in relation to the three sub-sections of the research question and then in the context of the wider literature. The strengths and limitations of the project will then be covered, as well as the implications of the findings for services, professionals, and further research. Finally, a conclusion and my closing reflections will be presented.

5.1 Main Research Findings in Relation to Research Questions and Existing Literature

All three sub-sections of the research question will be covered in this section. Firstly, relevant themes will be used to demonstrate how the questions have been answered by the findings. Subsequently, how these findings relate to existing literature in the evidence base will be detailed. Participant quotes will not be used in this or the following section as these have been presented thoroughly in the results section.

5.1.1 Research Question Sub-section 1: How do South Asian Women who are Survivors of DA Experience Gaining Access to Mental Health Support?

This first research question was focused on how participants experienced reaching or being reached by services and accessing support for their emotional wellbeing. Results suggested that this experience was defined by a struggle to access any or enough support. Participants described a variety of barriers between them and support which were difficult, and at times impossible, to overcome. The lack of support that participants experienced whilst struggling to gain access was described as harmful to their wellbeing, recovery, and futures. There was a strong sense that participants emotional support needs had not been met, continued to go unmet, and at times that their needs were directly disregarded.

The first theme, **'Chronic lack of support'**, and one sub-theme ('***Turned away: needs ignored'***) of the final theme, **'Services causing harm'** seem to best demonstrate the results relevant to this first research question, as is detailed in the following sections.

5.1.1.1 Chronic Lack of Support.

This first theme represented the **chronic lack of support** that all participants experienced throughout, but particularly at the beginning, of their help-seeking journeys. One sub-theme, ***'The struggle to access support',*** detailed several factors that got in the way whilst participants were trying to reach support services. Factors such as being brought to the UK for marriage, not knowing anyone outside their abuser's circle, being unsure that what they were experiencing was DA, being isolated and restricted from going out and speaking to others all created a significant lack of knowledge of available options for support. Participants described that this was made even more difficult by being young, lacking in confidence, and unable to speak or understand English. In their accounts of this struggle, participants spoke exclusively about them trying to reach services, not of services trying to reach them. Others detailed how having young children to care for, facing intersectional disadvantage such as disability, and having restrictions placed on the timings and locations of their movements outside the house made it even more difficult to connect with support services once they had discovered them, particularly if services were inflexible with their meeting times and locations. Some participants anticipated that they would be viewed negatively by professionals if they were to inhabit the status of 'victim' or of someone who needs support, further discouraging them from seeking help.

There was a strong sense from participants here that the support landscape was confusing and difficult to find their way around. They spoke about a wide range of services being involved separately, at different times. Several participants had little or no input to or understanding of their referrals to different services or even which services they were in contact with. Those who were unable to understand English had a particularly confusing experience of gaining access to support. Those who had the resources to spend time and energy researching the support options available found that it took significant effort to gain a clear understanding. Although this will be explored further in section 5.1.2 below, it is worth noting here that several participants were made aware about services by other women in their family or wider community. For some this was the only way they were able to find out what their options were.

The main outcome of this struggle to access support was detailed in the sub-theme, ***'No support: damage caused.***' Participants described the distress caused when much needed support was unreachable, finding that being alone without support was at times worse than the DA itself. Several participants described knowing that things would have turned out differently, for the better, if they had received the support they needed from the start. There was a sense that participants were resigned to the idea that they would not ever have emotional wellness or contentment as they had not been given the emotional support they needed to reach this after such traumatic experiences. Those who were able to gain access to some helpful therapeutic support described a crippling lack of progress and positivity when this support ended prematurely.

5.1.1.2 Turned Away: Needs Ignored.

This sub-theme of the theme, **'Services causing harm'**, detailed participants experiences of approaching therapeutic services, often to refer themselves, and being ***'turned away, their needs ignored'***. Participants described sometimes repeatedly contacting therapeutic services, telling their story, and outlining the emotional support they needed. Rather than this being met with an offer of support, for most participants this resulted in services deeming them unsuitable for support and denying their referral. Services provided the feedback that they appeared to be doing well, didn't need emotional support, needed to agree to unsuitable conditions, or that they were simply not right for the service. This silencing of participants' narratives and expertise was experienced as harmful, leaving them feeling let down in a time of need.

5.1.1.3 Links to Existing Literature: Mental Health and DA Help-seeking.

Existing research details a number of factors that influence help-seeking behaviour in relation to DA and mental health. A belief or view that the problem did not exist or that it would improve by itself have been implicated in an avoidance of seeking help (Andrade et al., 2014). Results from this research detail participants being unaware that they were experiencing DA and in need of help until alerted by others or via the media. This is supported by Moller et al.'s (2016) findings that emphasised the importance of promotion of DA support services in key locations where WGM could be reached.

Liang et al.'s (2005) DA help-seeking framework proposes that individual coping style may predict the type of services women approach for support. As detailed previously, the reality in the UK is less straightforward. The results of this research demonstrate that the support landscape is confusing and difficult to navigate, with participants struggling to know about or understand their options at all stages of their help-seeking journeys. Other research recognises the difficulty survivors of DA, particularly WGM, face in finding their way to adequate support often falling through the gaps between services unwilling or unable to support them (Thiara, 2021; Women's Aid, 2022). A systematic review of research exploring mental health help-seeking within the UK South Asian population reported a widespread lack of awareness of support options, creating a distance between South Asian communities and services (Prajapati & Liebling, 2022).

Liang et al.'s (2005) three step framework identified problem recognition and appraisal, as well as existing experiences of help-seeking and being supported by others as key contributors in deciding to seek help after DA. This current study detailed the experiences of participants living their lives in isolation, separated from their wider family, and restricted from and unused to interacting with others. It is likely that women whose time and contact with others is dominated by their perpetrator may struggle to conceptualise and define their experiences as DA and psychological harm. Similarly, they may be so unused to being supported and relating to others in this way that taking the step to seek emotional help is a daunting one. Indeed, Thiara (2021) reported the social isolation of women who have moved to the UK being an exacerbating factor in the harm caused by DA.

Some participants of the current study also avoided seeking help due to worries that they would be judged or labelled by services. This idea was expanded on by Clement et al. (2015) finding that anticipation of negative responses led to an avoidance of help-seeking, with subsequent experiences of stigmatisation adding to this. This has implications for this research, with all participants reporting negative, even harmful responses from services, including victim blaming and dismissal of their needs. As outlined in the literature review in Chapter Two, the Intimate Partner Violence Stigmatisation model (Overstreet & Quinn, 2013) identifies how knowledge of negative responses from services leads to anxiety and discouragement for women considering seeking help. With results from this research demonstrating that other women often provide knowledge of support options, this has implications for the shared knowledge and appraisal of services within communities of South Asian women.

Although there is little research exploring the emotional impact or meaning made of being turned away from services with needs unmet, some existing research provides an idea of how this has been experienced by other women. Anitha et al. (2009) report the majority of women in their sample of 72 not being referred or accepted for therapeutic or emotional support at all. These women described their emotional needs going unacknowledged by a range of services including GPs and mental health teams. Several large-scale reports identify a common theme of women who have experienced DA, particularly WGM, being denied access to services time and time again, highlighting the harm this causes to their wellbeing, safety, and futures (Holly, 2017; Oram et al., 2016; Siddiqui & Patel, 2010; Thiara, 2021; Women's Aid, 2021a, 2022).

5.1.2 Research Question Sub-section 2: How does having a South Asian Cultural Background Impact the Mental Health Help-seeking Journey of South Asian Women who are Survivors of DA?

This research question aimed to explore how participants' South Asian culture and their belonging within a South Asian family and community impacted or interacted with their help-seeking journey. The results suggested that culture and community had a significant influence across all aspects of the help-seeking journey. This included how involved community and family were in the finding and accessing of support, the impact of cultural stigma on help-seeking, and the impact of having or not having a shared language with support services. The second theme, **'Culture and community'** and its three sub-themes directly address this research question, as will be detailed in the following section.

5.1.2.1 Culture and Community.

The first sub-theme of this theme, ***'The whole is bigger than the parts'***, detailed the differing levels of support that family and community provided for each participant. For several participants, their solution for breaking through the barriers and accessing support was in their wider family and community connections. Often other women held the key to support, passing on their own knowledge and experience to others going through similar difficulties with DA. For some, the support of family was essential, providing warmth and containment, as well as practical support with accessing services. Those who had family support throughout their journey were clear that there were limits to what family could do, and that services were needed to fill the gaps. Others gained support and strength from their faith and wider community. For some, along with the support of services, prayer and faith in religion were key to getting through the distress of DA, as well as connecting with other South Asian people at community centres and events.

Some participants had little to no support from their families and communities. Differences in family and community involvement across individual accounts were often due to physical distance from family and community, with some participants being alone in the UK. However, for some participants, unsafety in their community due to the influential position of their perpetrator within it, or experiences of judgement and stigma from community and family members meant that support from these sources were not an option.

The second sub-theme under **'Culture and community'** represented the role of a ***'Shared language'*** in the mental health help-seeking journey. Experiences of this were similar for all participants who had come to the UK unable to speak or understand English. Participants described struggling to access and understand support services without a shared language. Services that were only offered in English were limited in the support they could provide. Conversely, support offered in participants' native languages allowed for them to communicate with ease, understand fully what was being offered, and fostered connection and hope.

Several participants also described the transformative effect of being supported to learn English, allowing them to feel empowered, connecting with their new community and interacting with people around them. There was a sense that this helped participants feel that they were moving forward, away from the restriction and isolation of DA.

A final sub-theme concerned experiences of cultural ***'stigma and judgment'*** and how these interacted with the mental health help-seeking journey. Some participants described that cultural stigma and feelings of shame around DA influenced and restricted how they spoke to support staff and shared their experiences. There was a commonality in participants feeling liberated when they were in support relationships free from stigma, in contrast to relationships they had within their family and community. For some, support from South Asian professionals who inherently understood the impact of cultural stigma was easy and effortless. Others experienced such difficulty with judgment and shame from their own community that they could not feel safe accepting support from South Asian professionals or organisations.

5.1.2.2 Links to Existing Literature: South Asian Community and Culture.

The findings of this research around the value of family and community support relate to a number of areas of existing literature. Existing research identifies the strengths and resiliencies found within many South Asian communities. Support from family and community, faith, prayer, and non-Western appraisals of distress have all been reported as alternatives to professional help-seeking (Anand & Cochrane, 2005; Anitha et al., 2009; Beliappa, 1991; Hussain & Cochrane, 2003). An emphasis in many South Asian communities on collectivism and responsibility for caring for others, as well as family or religious values around self-reliance and emotional wellbeing, have been reported as strong and reliable sources of support, reducing the need for services in some cases (Prajapati & Liebling, 2022). Participants of this research spoke about their faith, family connections, community members, and personal appraisals of their experiences helping to carry them through their distress, alongside the support of services.

Existing research highlights the importance of a shared language in creating positive support experiences. As well as Bowl's (2007) findings that interpreters are often not offered and mental health appointments carried out in English for South Asian people who speak other languages, research in the DA field has reported similar findings. Anitha's (2009) study of South Asian women's experiences of DA and help-seeking identified a lack of shared language as a significant barrier to support, with services offered in participants own languages being experienced as hugely supportive and essential. Others have reported similar findings, highlighting the necessity of language specific support to enable non-English speaking DA survivors to access the support they need and recover their wellbeing (Parmar et al., 2005; Thiara & Hussain, 2005; Thiara, 2005).

Perhaps the most common finding within mental health and DA help-seeking literature in South Asian communities is the impact of cultural stigma and shame, which has repeatedly been identified as a barrier to help-seeking (Decker et al., 2013; Mathur Gaiha et al., 2014; Mukerji et al., 2023; Nine et al., 2022). This research detailed a variety of responses to cultural stigma. Some participants reported that it made opening up and talking to professionals difficult, expecting that they would be judged. Others detailed how professional relationships free from stigma and judgement were revelatory in their contrast to family and community relationships.

A key finding was that some participants found support from South Asian people or services threatening or unsafe due to the threat of cultural stigma and judgement. This is at odds to much of the available UK research which reports specialist 'by and for' services as the most successful and well regarded by survivors (Thiara, 2021). Moller et al.'s (2016) findings mirror those of this study, finding a disparity between South Asian participants who preferred 'culturally matched' counsellors and those who viewed White counsellors as safer and less likely to be judgmental. It is important to note that most participants in this study reported extremely valuable experiences of 'by and for' services, mirroring previous findings of these services providing safety, care, warmth, and the ability to move forward by people who inherently understand how it is to be a WGM (Chantler, 2003; Kalathil et al., 2011; Thiara & Roy, 2020). It is clear that there is a not a uniform response or preference on this issue across the many, diverse South Asian communities and people in the UK. A systematic review of mental health help-seeking in UK South Asian communities outlined a majority of studies reporting participants valuing the cultural understanding of South Asian professionals who shared their experiences of cultural stigma. In contrast, the same review identified a number of studies that reported worries about being judged as dishonourable by South Asian professionals, restricting them from trusting and being open about their needs and experiences (Prajapati & Liebling, 2022).

5.1.3 Research Question Sub-section 3: What is the Impact of the Mental-health Help-seeking Journey on the Emotional Wellbeing of South Asian Women who are Survivors of DA?

The answer to this research question covers a range of experiences on a spectrum from transformatively positive to severely harmful. All participants experienced a variety of responses from services that had differing impacts on their emotional wellbeing at different points of their journeys. Positive support experiences resulted in participants feeling held in mind and cared for and helped them to move forward in their lives, gaining strength, confidence, and empowerment. Negative experiences of services left participants feeling disregarded and looked down upon, resulting in a sense of being stuck, unable to move forward with their lives. Some experiences were likened to the effects of DA, with services perpetuating the harm. The two final themes, **'Flourishing through connection'** and **'Services causing harm'**, best represent the response to this final research question.

5.1.3.1 Flourishing through Connection.

This theme consisted of three sub-themes representing the main aspects of positive emotional support that participants described. The first sub-theme demonstrated the ***'safety and attunement'*** that participants felt within some support relationships. Participants described being welcomed in with warmth, knowing that it was safe for them to open up and share what had happened to them. Being able to speak freely about their experiences and knowing they were being heard, felt like their burden was being shared, lifting some of the weight from their shoulders. Specialist DA support including refuges were described as knowing exactly what participants needed, intuitively providing safe spaces where wellbeing and empowerment could be foregrounded.

Leading on from this, participants described how they felt ***'valued, held and cared for'*** within these safe emotional support relationships. There was a sense in this sub-theme that warm, caring, connected support happened with professionals from a variety of services, not only those who were commissioned to provide emotional support. Participants felt valued when professionals took an interest and truly invested in them, giving them the gift of time, and holding them in mind. Some participants felt emotionally held when professionals centred their emotional needs, encouraging them to care for themselves as well as caring for their children. In describing these relationships there was a strong sense of how impactful and moving they had been for participants with the emotional closeness being likened to connection with friends or family.

In a third sub-theme, participants described how these safe, attuned relationships where they felt held, valued and cared for helped them in ***'moving forwards'***. Being given choice, agency, and control over their own support was instrumental in helping participants to move away from the effects of DA, towards a more positive future. There was a sense of movement being created through positive support relationships, from a place of restriction and control under DA, towards freedom and openness. For some participants, being believed and validated in their experiences empowered them to move forwards in defiance of what they had been through.

5.1.3.2 Services Causing Harm.

As well as the above-described positive relationships, all six participants described negative and harmful experiences of support services. One sub-theme of **'Services causing harm'**, ***'Turned away: needs ignored,'*** relates more to the first research question and is covered in section 5.1.1.2. The second two sub-themes describe experiences that relate to this research question about the impact of the help-seeking process on participants' emotional wellbeing.

Participants spoke about instances of services ***'Getting it wrong'***, taking actions that were detrimental to their wellbeing. Some participants described services focusing on procedure and box-ticking rather than on listening to participants' stories and hearing and attending to their needs. Others identified a lack of cultural competence in services, leading to culture related elements of their lives being mis-judged and labelled negatively. When participants were unable to develop safe and trusting relationships with services, the responses of professionals fostered self-doubt and blame around what had happened to them. A number of different services being involved but working separately was experienced as adding to the existing confusion around the support system, leaving participants unsure about what they had been offered.

Leading on from this, a final sub-theme described experiences of services ***'perpetuating the abuse'***. Participants reported responses from services lacking in compassion, that damaged their self-worth, leaving them feeling dismissed and looked down upon. There was a sense that some services were dangerous and threatening and that criticising or standing up for yourself to these services should be avoided. Participants described feeling judged and appraised, discouraging them from seeking therapeutic support. The impact of these experiences was similar to, and at times worse than, the impact of the DA itself, with participants experiencing them as abusive and harmful to their emotional wellbeing.

5.1.3.3 Links to Existing Literature: Role of Services.

Research detailing women's experiences of emotional support seeking in the UK after experiencing DA largely mirrors the findings of this study. As existing research tends to be located within and about particular types of services, this section will address findings from specific service types and how they relate to the findings.

5.1.3.3.1 Health and Statutory Services.

Previous research has identified shortcomings and difficulty in accessing positive therapeutic support from mental health services that lacked understanding of DA and minimised women's support needs (Anitha et al., 2009; Trevillion et al., 2016; Trevillion et al., 2014). The results of the current study highlight a lack of access to therapeutic support, with participants who had experienced significant trauma being turned away or deemed unsuitable for any or enough support. Research exploring the role of general health services, particularly GPs, in the help-seeking journey identified the key role GPs often play in having contact with women who might otherwise be unknown to services (Dunn, 2000). Similarly, the current research found GPs to consistently be a key source of advice, warmth, support, and signposting. Almost all participants named their GP as of key importance in their help-seeking journeys. Previous research details comparatively more negative experiences of GPs responding with little empathy and focusing on medication over emotional needs (Anitha et al., 2009; Bacchus et al., 2003; Evans & Feder, 2016).

Existing evidence highlights the prevalence of the medicalisation and pathologisation of trauma and distress responses in WGM and South Asian women who have experienced DA, with women being given psychiatric diagnoses and prescribed psychoactive medication rather than offered therapeutic support (Anitha et al., 2009; Oram et al., 2013; Siddiqui & Patel, 2010). Participants of this research did not report these experiences, and in their accounts of positive support, described their unique stories being listened to and validated. Within the UK health system, the non-medical model of understanding psychological difficulties, adopted by the field of clinical psychology in the UK (BPS, 2013; Johnstone & Boyle, 2018), is perhaps well placed to approach the support of women who have experienced DA. A focus on what has happened to people to cause their psychological distress, allows for the recognition of the impact of DA itself, as well as the wider social and political context of gender inequality.

Prajapati and Liebling's (2022) UK based systematic review of mental health help-seeking in South Asian people found widespread reports of service users feeling 'disempowered and dehumanised' (p. 15) by service responses that did not take their wishes, views, and cultural and support needs into account. Results also demonstrated that many services did not place value on the importance of family involvement, going against the views and wishes of South Asian service users who felt they would benefit from family input. This mirrors the experience of several participants of the current research who reported similar instances of services making decisions that were experienced as negative, harmful, or not fitting with their needs and wishes.

5.1.3.3.2 Multiple Service Involvement.

As detailed previously, the National Institute for Health Care Excellence (NICE) guidance names multi-agency partnership working as the most effective form of DA intervention (NICE, 2014) but does not provide further detail on what this should look like. These current results point to a joined up and cohesive response from services being valued and helpful for recovery, with disjointed input from a variety of services being experienced as confusing and unsettling. Existing research has previously called for the inclusion of detailed NICE guidance on the specific actions services should take in the support of WGM who have experienced DA and are in need of mental health intervention (Siddiqui & Patel, 2010). Previous examples of joint working across professions have yielded positive results with more women accessing emotional support and safety and experiencing this as instrumental in their wellbeing and recovery (BEH-MHT, 2018; Siddiqui & Patel, 2010; Trevillion et al., 2011).

This research identified a variety of responses from services that participants found unhelpful, at times even harmful. This mirrors existing research that reports services responding inadequately due to their lack of understanding of the impacts of DA on the wellbeing and lives of WGM (Kelly et al., 2014; Women's Aid, 2022). The Women's Mental Health Taskforce made calls for mental health services to be 'trauma and gender informed' (Department of Health and Social Care, 2018). A trauma informed approach is one which actively pays attention to the impacts of trauma on an individual's psychological, interpersonal, and biological development and functioning (Sweeney et al., 2016). Trauma informed services use this understanding to provide care which focuses on creating safety and avoiding practices which exacerbate trauma responses (Sweeney et al., 2018).

Comprehensive research addressing the barriers women face in accessing mental health support after DA (Women's Aid, 2022) has provided a number of recommendations for services that mirror the accounts of participants in this study. An empathic response from professionals who understand the dynamics and impact of DA was recommended as essential, with both factors also strongly identified by participants of this study as instrumental for positive support. Participants named having space and time to openly talk and share their burden as an element of support that helped them process their experiences and move forward. Women's Aid's (2022) report similarly identified this as a key pillar to successful support, emphasising the importance of women having access to therapy.

5.1.3.3.3 DA Services.

Existing research points to DA services as providing overall the most positive experiences of support for survivors. An understanding of the dynamics and impact of DA, an empathic and empowering approach, and flexibility in providing long-term support have all been identified as valuable (Anitha et al., 2009; Brooks & Burman, 2017; Madoc-Jones & Roscoe, 2010). Participants of this research detailed an attuned, safe, and trusting response from DA services who understood and met their needs, continuing to support them long term. Research also aligns with several participants' accounts of South Asian 'by and for' services providing attuned and culturally competent support, inherently understanding the impacts of experiences like cultural stigma and racism. The literature largely supports the substantial importance and value in 'by and for' services that hold significant expertise in working with their own communities (Siddiqui & Patel, 2010; Thiara, 2021). Women's Aid's (2022) recommendations for good mental health support for DA survivors identifies the need for women's only spaces and services led by women who share the background of those they support. They also call for services to recognise the need for timely and long-term support, mirroring participants' descriptions of feeling stuck and abandoned when offered short term support for in a long-term journey to recovery.

5.2 Strengths and Limitations

5.2.1 Strengths

A key strength of this research has been in its position of inclusion of women who are normally excluded from research. Disrupting the pattern of silencing exclusion that South Asian women experience in service and research provision, it has documented the voices and detailed stories of six South Asian women who have survived domestic abuse and sought help for their mental health, something which, to my knowledge, has not been done before. Similarly, the active inclusion of women who speak languages other than English in dialogue-based, qualitative research, and the consideration of the impact of language differences on the project as a whole, are key strengths.

The collaborative approach taken, with input from interpreter Anowara, service user consultant Sara, and the South Asian women's host organisation, is another strength. This has ensured that South Asian women, including those who have experienced mental health help-seeking after DA, have played a key role in designing, carrying out, and analysing this research. Their input also contributed to creating a safe and containing process for participants.

5.2.2 Quality Measures

In their guidance on carrying out IPA, Smith et al. (2021) recommend the use of frameworks by Elliot et al. (1999) and Yardley (2000) to consider measurements of quality in IPA studies. How the recommendations of these frameworks apply to this research is detailed in Table 3.

Table 3 *Table of recommended quality measurement frameworks and actions taken*

Recommendation	Approach Taken
Owning one's perspective *(Elliott et al., 1999).*	In my reflexive statement I have detailed how my multiple positions and experiences will influence my carrying out of this research. I have referenced this throughout different parts of the write up, particularly in the results section and in detailing my decision to go forward with a project on South Asian women's experiences, as a White researcher. As recommended by Engward and Goldspink (2020), I have approached attending to reflexivity not as a one-time activity but as a dynamic and active process throughout the entire project.
Situating the sample *(Elliott et al., 1999).*	The demographic information in Table 1, as well as the information provided under the individual analysis section dedicated to each participant situates the sample, providing context to the experiences participants described.
Grounding in examples *(Elliott et al., 1999).*	As well as the inclusion of Table 2, demonstrating where each theme and group-level sub-theme is represented throughout the sample, direct participant quotes are used throughout the results section to evidence the themes as they appear in the original transcripts.
Providing credibility checks *(Elliott et al., 1999).*	My approach to this is covered thoroughly in Section 3.4.6. It included discussing and incorporating feedback from my supervisors, service user consultant, and interpreter in carrying out analysis, as well as ensuring

	shared understanding through member checking during and after interviews, before beginning analysis.
Transparency and coherence *(Elliott et al., 1999 and Yardley, 2000).*	I have provided detailed accounts of all methodological and analytical processes used in this research in order to be as clear as possible about all decisions and actions taken.
Resonating with readers, impact, **and importance** *(Elliott et al., 1999 and Yardley, 2000).*	The dearth of research addressing South Asian women's experiences of mental health help-seeking after DA demonstrates the importance of this project. Particularly within the field of clinical psychology where a very small proportion of research is focused on women who have experienced DA. The impact of the research is detailed in the results and recommendations sections, with the hopes that this will encourage thought, discussion, and even change within services and other research projects. The use of both individual and group analysis, ensuring each woman's story could be told, and the situating of results in the wider literature and service landscape all aimed to enhance the resonance of the material with readers.
Sensitivity to context *(Yardley, 2000).*	As well as providing demographic and more detailed information about participants' contexts for readers, I considered and held these in mind throughout data collection, analysis, and write up. I spent time reflecting on and discussing with supervisors and peers how participants' contexts influenced the themes that were represented in their accounts.
Commitment and rigour *(Yardley, 2000).*	I have evidenced my commitment to, and rigour in, carrying out this research in the thorough consideration and planning of all aspects of the project, as well as the detailed and comprehensive analysis and write up.

5.2.3 Limitations

Smith et al. (2021) recommend a sample size of between six and ten participants for applied doctoral research projects. With six participants, this project was on the low end of this recommendation. Interviewing more participants would have added value to the research in that the unique richness of their experiences could be detailed in individual analysis, and their convergence or divergence from the group themes could have been explored. I spent a significant amount of time and effort, over the course of a year, liaising with DA services about recruitment. Time constraints dictated that I had to stop working on recruitment and move onto analysis once the minimum number of recommended participants had been interviewed.

Although the aim of IPA based research is not generalisability of the results to the wider population, it is across much other research and so should be addressed. Research that attempts to, or succeeds in, producing truly generalisable and representative results is a valuable and essential element of the evidence base (Brocki & Wearden, 2007). Some argue that qualitative research should aim to be as generalisable as possible (Snowden & Martin, 2011) with others reasoning that this privileges the dominant philosophy of positivism, detracting from the meaningful contribution of non-generalisable qualitative studies (Breen & Darlaston-Jones, 2010). The results of this study certainly cannot be generalised to the whole UK population of South Asian women. This could be considered a limitation but was a deliberate choice in the design of this IPA project, focusing on the unique and idiographic depth of a small number of individuals' experiences (Smith et al., 2021).

Smith et al. (2021) also make a recommendation for sample homogeneity in IPA projects in order to recruit a group of people with a somewhat shared experience and relationship to the research questions. The inclusion of Wapis and Saskia can be critiqued as making the sample more heterogeneous due to them both speaking fluent English and being professionals in the helping sector. Additionally, Saskia was the only participant to be born in the UK and not of Muslim religious background. Although nothing in Wapis or Saskia's accounts fell widely outside the shared group themes, the results may have come together differently if these elements of heterogeneity were not present. In the case of this project, it was not possible to recruit anyone else to the research and excluding Wapis and Saskia would have felt unnecessarily exclusionary and risked missing out on their invaluable contributions. Smith et al. (Smith et al., 2021) recognise that the level of sample homogeneity will depend on the research question, sample population, and other project specific factors. They recommend striking a balance between homogeneity and what is pragmatically possible.

5.3 Implications

Although the results of this study cannot be generalised to the wider population, there was enough convergence across individual accounts into themes that implications can be made for service provision across the helping sector. In the following section I will address several points that could be beneficial for service providers and helping sector professionals to consider in their work with South Asian women who have experienced DA. Table 4 provides a summary of the three sub-sections of the research question, and the key findings and implications related to each one.

Table 4 *Research questions and key related findings and implications*

Research Question Sub-section	Key Findings	Implications & Recommendations
1: How do South Asian Women who are Survivors of DA Experience Gaining Access to Mental Health Support?	Difficult to access support, many barriers in the way. Confidence and knowledge needed to find way to support. Support landscape is confusing. Lack of shared language, childcare, inflexibility of services makes this more difficult. Harm caused when left alone, without support. Therapeutic services often deemed participants unsuitable for support.	Services reaching out to South Asian communities to increase visibility. Collaboration with community and family to reach survivors. Using the knowledge and expertise of DA and South Asian community services to reach survivors.
2: How does having a South Asian Cultural Background Impact the Mental Health Help-seeking Journey of South Asian Women who are Survivors of DA?	Family and community support important alongside services. Some wanted but did not get support from community and family. Having a shared language improves support, connection, understanding and outcomes. Empowerment to learn English helps with moving forward and wellbeing. Cultural stigma from South Asian community can make it difficult to open up to professionals. Some felt unsafe accessing support from South Asian people due to fear of judgement, others valued their understanding of cultural stigma.	Services and professionals attending to cultural difference, nuance, impact of their own background. Survivors being offered choice, not a one-size fits all approach. Services offered in language survivors can speak or understand or skilled interpreters offered. This facilitating inclusion of women often excluded due to language and other barriers.
3: What is the Impact of the Mental-health Help-seeking Journey on the Emotional Wellbeing of South Asian Women who	Polarised experiences for all participants. Positive experiences included feeling safe, able to trust support staff, leading to validation. Good support relationships made them feel valued, emotionally held, cared for. Services attended to their needs allowing them to move forward with their lives with hope and positivity.	Importance of integrated, trauma informed approach, attending to all needs across services/systems. Ideal opportunity for this through Community Mental Health Transformation Programme. Positive and negative experiences of participants

are Survivors of DA?	Negative experiences were harmful, services made choices that left them feeling unheard, unsupported, blamed. Some services perpetuated the abuse, damaging their self-worth and making them feel threatened and unable to seek support.	provide best practice and what to avoid for services supporting South Asian survivors.

5.3.1 Lack of Support

Across all participant accounts and in previous research there was a commonality of an overwhelming lack of support, with participants struggling to find out about, reach, access, and maintain contact with all types of helping services and emotional support. Therapeutic support was the most difficult type of support for participants to gain access to, with all but one being refused or not feeling able to request this. The lack of knowledge participants had of services, and their recommendations that services make themselves more known to women in similar situations, could be considered by service providers in how they communicate and work within South Asian communities. It may be that services need to be more pro-active in reaching and providing support for women who are being isolated by DA, particularly those who have recently been brought to the UK.

For most participants, other women around them held the key to connecting with services, perhaps something that providers could make use of in reaching women. Similarly, community and family support were instrumental for most participants and those in previous research findings. Services could benefit from the involvement and incorporation of the strength and resilience that is held within the community and family. The easiest to access and most positive, helpful, and consistent support experiences were through DA organisations. It may be that statutory and health services could benefit from joint working or consultation with the women’s sector where significant knowledge and expertise around how to reach women, and general good practice is held.

5.3.2 Integrated Approaches

It is striking that all participants received the majority of their emotional support from third sector services and the majority received very little or no therapeutic support. The damaging impact of this lack of support and a frequent denial of service provision was palpable in participants’ accounts. The third sector is an essential and invaluable resource of emotional support for women who have experienced DA. Although statutory and health services should and could not replace this support, participants described positive experiences when a number of services were involved and working cohesively, and most expressed a need for more therapeutic support. This could be beneficial for mental health providers, policy makers and commissioners to consider, proactively including South Asian survivors of DA in their support provision. Further research with a larger number of women would be required in taking steps towards more inclusive service provision, this will be discussed in more detail in the below section 5.4.

Examples do exist of how beneficial, successful, and transformative integrated, cohesive support can be for DA survivors (BEH-MHT, 2018; G.J. Melendez-Torres, 2021; Trevillion et al., 2011). As well as those discussed in section 2.3.6, as early as 2001, Southall Black Sisters developed a model of intervention aimed at providing support to WGM, mainly of a South Asian background, who were experiencing DA and related mental health difficulties (Siddiqui & Patel, 2010). Their approach aimed to ensure women were safe but also protected from the traumatic effects of DA, particularly around self-harm and suicide. This 'SBS Model' involved support, advocacy, befriending, counselling, and psychotherapy and was evaluated over the course of eight years. Results found high levels of satisfaction about support provided in women who had accessed the intervention, with significant reductions in self-harm, reliance on medication, suicidal thoughts and behaviour, and low mood. Cohesive, varied support, empathy and cultural understanding, non-English-speaking support, and having access to therapeutic intervention were reported as helpful.

The NHS Long Term Plan has committed to pushing forward integrated care, meaning closer collaboration and partnership between health, social care, and voluntary third-sector services. This is based on evidence that this kind of working improves health and wellbeing outcomes, including those related to mental health (NHS, 2019). Despite the fact that an estimated 50% of women who come in contact with health services will have experienced DA (Department of Health, 2002; Trevillion et al., 2012), there is no mention of DA in any form in the full NHS Long Term Plan document. Similarly, the NHS Mental Health Implementation Plan which has explicit aims of reaching groups of people normally underserved by health systems has no mention of DA or the women who may find it hard to reach services because of it (NHS England, 2019b). There is a clear opportunity and need for DA and its impact on women to be further incorporated into plans to work collaboratively across a variety of organisations and services. Following from this, the particular needs of South Asian survivors must be considered.

Many NHS trusts are currently working on changing their ways of working under the Community Mental Health Transformation Programme (NHS England, 2019a). The aims of this transformation in how mental health care operates include working holistically with the person rather than focusing on singular symptoms or diagnoses, creating easily accessible singular points of access for health, social, and community care, using the expertise of community services in reaching those often underserved by health systems, and adopting a trauma informed approach. The results of this and other research discussed would strongly suggest that inclusion of DA in the thinking and planning around this implementation is an ideal opportunity to improve the care and wellbeing of South Asian survivors.

5.3.3 Trauma Informed Approaches

Unfortunately, a common theme in this research was of participants feeling let down, even harmed through their contact with services. The commonality of this experience across these six participants suggests that service providers and professionals should ensure they are aware of practices that could be harmful to women already attempting to recover from the harm caused by DA, operating within a trauma informed approach. The women who contributed to this study were keen to share their negative experiences as examples of what they would like to be different for women coming after them. Services and professionals learning from this will be able to act on these recommendations and create dialogue around how women want to be supported, hopefully avoiding the perpetuation harm after DA.

With trauma informed approaches becoming more common across UK mental health services, it is essential that professionals consider the particular aspects of DA related trauma which increase the likelihood of institutional re-traumatisation. This relates to aspects of care within services; access to female staff members, restraint practices, mixed gender groups and wards; as well as the ability of professionals to work effectively alongside other organisations involved in a woman’s care and support. The impact of trauma linked to systemic racism and wider forms of discrimination against WGM and South Asian women must also be considered if competent care is to be provided to all women.

Alongside their negative experiences, participants described hugely transformative positive relationships with support staff across a range of services. The core of what they valued and benefitted from was being listened to, heard, validated, held in mind, emotionally held, cared for, cared about. Someone standing alongside them in their journey to recovery, carrying some of their burden allowed them to move away from the abuse and towards hope. These experiences provide a compelling example of what is possible when services provide support in a way that meets the emotional needs of women who have been through such horrific experiences. The women in this study all wished that these positive experiences were heard by others so they could be repeated for the women coming after them.

5.3.4 Attending to Culture

The emotional help-seeking journeys of all participants were impacted in some way by their cultural background. Cultural shame and stigma, language, family relationships, connection to and avoidance of community specific support were all key issues that are also recognised in existing research. These are all essential for services to be aware of and attend to when providing support to South Asian women. The difference across experiences emphasises that this should not be a one size fits all approach but that women should be given choice in how and by who they are supported. This is an important implication for professionals in how they attend to cultural nuance, their own cultural background, experiences, and assumptions in working with South Asian survivors of DA. Professionals should explore this with the women they are supporting, remaining open to each individual's preference and the experiences that have led her to it. Choice, control, and agency given to women is likely to enhance their help-seeking journey and what they gain from it.

It is clear that services offered in English, to women who are not able to speak or understand it, are not fit for purpose. Participants in this study and those of previous studies reported that having a shared language with professionals, or access to good interpreting services, were key in them benefitting from support. It is worth services holding in mind the barriers around DA, restriction on movement, control, and childcare that may make it very difficult for South Asian DA survivors to learn English. As was the case in this research, a skilled and experienced interpreter facilitated warm, in depth, meaningful conversations with women who would otherwise have been excluded from participating.

5.4 Future Research

This small-scale project was successful in its aim to explore the experiences of the six women interviewed. As well as demonstrating that further research with more South Asian survivors of DA is recommended, the results help to identify several areas which would benefit from further research. These are detailed below.

- This research focused on the experiences South Asian women have had, with their cultural identity as a focus. Further research looking at intersectionality and how other aspects of identity such as disability, sexuality, religion, and gender interact with race and culture in the mental health help-seeking process would be valuable.

- Several participants had experienced difficulties with immigration and gaining a secure status in the UK, as well as those who were brought to the UK as marriage migrants. The focus of this research did not allow a more thorough exploration of how the immigration or marriage migration process interacts with help-seeking. This is something that further research could address.

- This research took place with women living and seeking help in two neighbouring London boroughs. Although service provision for South Asian survivors of DA is relatively uniform across London, there are significant differences in what is offered across the rest of the UK. Research into the experiences of South Asian survivors in different areas would build a clearer picture and understanding of the journeys of a wider range of women.

- The results of this study highlighted the complexity of participants' experiences of both support and judgment from community and family. Research with an in-depth focus on these experiences could add to our understanding of how family and community interact with, or add to, the help-seeking process.

5.5 Conclusion

This research conducted a qualitative analysis, using IPA, of the accounts of six South Asian women who had experienced DA then sought help for their mental health or emotional wellbeing. The analysis identified four themes, each with two or three sub-themes, with many commonalities and some differences across all participant accounts.

Participants described an overwhelming lack of support throughout their entire emotional help-seeking journeys. This began with a struggle to find out about and access support and continued throughout as they were turned away from services or offered less support than they needed after traumatic experiences of DA. This lack of support was found to cause harm and damage to participants' wellbeing and future. Participants' culture and community were found to influence all other themes and all aspects of their emotional help-seeking journeys. Most participants considered support from family and community members essential alongside support services. The impact of cultural shame and stigma caused a fear of judgement for some participants, leading to them avoiding support from community members and South Asian support staff. Others experienced South Asian specific support as highly beneficial due to the inherent understanding of the impacts of racism and cultural stigma. A lack of shared language was identified as a significant barrier to accessing and benefitting from emotional support, with services provided in native languages being experienced as essential to recovery and wellbeing.

All participants described both positive and negative experiences of support services. These occurred at different times, with different services, across help-seeking journeys. Positive emotional support relationships were characterised by professionals taking an interest, showing they truly cared, listening, giving participants' choice, control, and agency. Participants felt able to trust and rely on these relationships, feeling valued and emotionally held, leading to them gaining the empowerment to move forward, away from the impacts of DA, with hope and positivity. Negative experiences ranged from being denied support, deemed unsuitable for therapeutic intervention, to services taking actions not in the best interests of participants, leaving them feeling confused, blamed, dismissed, and not listened to. Some participants described severely negative responses from services that were experienced as a perpetuation of the abuse, damaging their self-worth, and leaving them feeling threatened and harmed.

These results align with the small amount of existing research on how South Asian women generally, and those who have survived DA, experience mental health help-seeking within the UK support system. The findings led to implications for services including the importance of reaching South Asian communities and attending to culture and language, as well as recommendations for services to consider the needs of South Asian survivors of DA, and the use of integrated trauma informed approaches in their planning of service provision.

5.6 Final Reflections

This project has been a challenging one. Reaching out and building relationships with underfunded and chronically busy DA services was not easy, a symptom of how much they are doing with so little. Similarly, it took a significant amount of time to find and connect with six women who were willing and able to participate. This process was a live demonstration of how excluded and pushed out of reach these women are from health and support services. Without the input of language interpreter Anowara, I would not have been able to recruit enough participants to make the project viable. Despite these challenges, I feel immensely privileged to have completed this project alongside the South Asian women of my research team, and the six South Asian women who gave the gift of their time and stories. My Whiteness and lack of shared experience with these women was present for me during every moment. It is only for their involvement, expertise, and lived experience that I was able to decide on and successfully complete this project. In the final stages of this study, I am left holding hope that these women's stories will provide a blueprint for better service provision for other South Asian DA survivors, and that services in the midst of transforming the care they provide will consider and value the valid needs of these women, offering them what they need and deserve.

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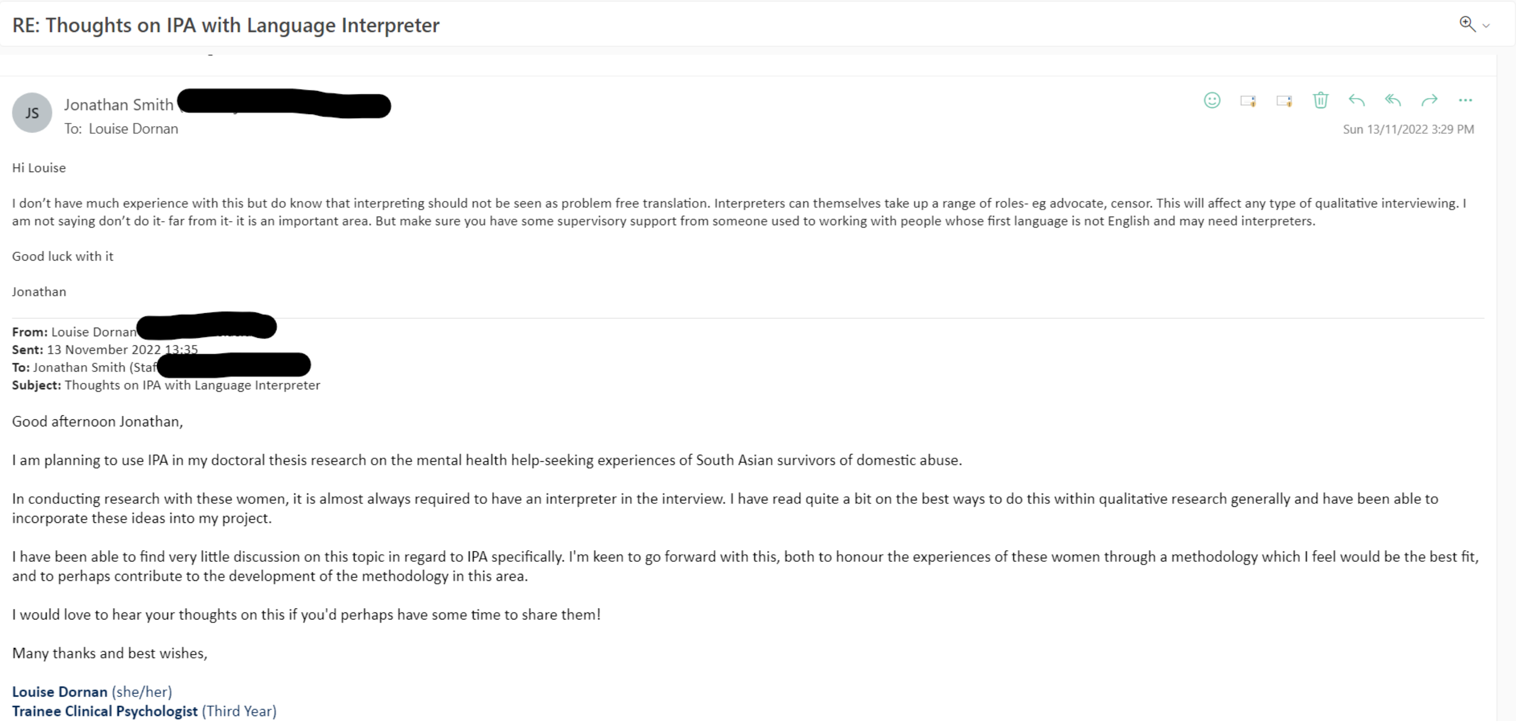
Appendices

Appendix 1 – Email exchange with Jonathan Smith about language interpreting in IPA



RE: Thoughts on IPA with Language Interpreter

Jonathan Smith [redacted]
To: Louise Dornan

Sun 13/11/2022 3:29 PM

Hi Louise

I don’t have much experience with this but do know that interpreting should not be seen as problem free translation. Interpreters can themselves take up a range of roles- eg advocate, censor. This will affect any type of qualitative interviewing. I am not saying don’t do it- far from it- it is an important area. But make sure you have some supervisory support from someone used to working with people whose first language is not English and may need interpreters.

Good luck with it

Jonathan

From: Louise Dornan [redacted]
Sent: 13 November 2022 13:35
To: Jonathan Smith (Staf [redacted]
Subject: Thoughts on IPA with Language Interpreter

Good afternoon Jonathan,

I am planning to use IPA in my doctoral thesis research on the mental health help-seeking experiences of South Asian survivors of domestic abuse.

In conducting research with these women, it is almost always required to have an interpreter in the interview. I have read quite a bit on the best ways to do this within qualitative research generally and have been able to incorporate these ideas into my project.

I have been able to find very little discussion on this topic in regard to IPA specifically. I'm keen to go forward with this, both to honour the experiences of these women through a methodology which I feel would be the best fit, and to perhaps contribute to the development of the methodology in this area.

I would love to hear your thoughts on this if you'd perhaps have some time to share them!

Many thanks and best wishes,

Louise Dornan (she/her)
Trainee Clinical Psychologist (Third Year)

Appendix 2 – Interview Guide, example case study, and example illustrations

Provisional Interview Schedule for research study: Understanding the experiences of South Asian survivors of domestic abuse who have sought help for their mental health.

Ice breaker Questions

How was your journey here / how was it getting onto the zoom chat?

How has your day been so far?

How are you feeling about coming to the interview?

Introduction to Interview

Check if participant has been through the participant info sheet, if they would like to do this again, if they need any help with translation/reading through.

Check through participant consent form together.

As mentioned in the information sheet, I'd like to check if you would agree to me making an audio recording of the interview. *Explain further if needed.*

Next, I am going to talk about an example of the kinds of things the interview will focus on before starting the interview questions.

Is there anything you'd like to check about what we've been through so far?

Example of Mental Health Difficulties and Emotional Support

Saanvi had been living with her husband and mother-in-law for seven years. Her husband was physically and emotionally abusive towards her. Eight months ago, Saanvi called a domestic abuse service for help. They helped her to move safely into a refuge. Even though she was living somewhere safe, Saanvi still felt scared most days that something bad would happen to her. She sometimes had nightmares about the abuse and heard voices saying hurtful things to her. Saanvi felt very sad and cried a lot. She had been through so much and had to leave her family, friends, and routine behind. Saanvi found it hard to stop thinking about what had happened to her and what her future would be like. These thoughts made her worried and gave her an anxious/sick feeling in her stomach. These are all examples of emotional or mental health difficulties.

Saanvi spoke to her support worker at the refuge about how she was feeling. The support worker listened and was kind and reassuring. Saanvi's support worker tried to refer her to the local mental health team, but this referral was rejected. Together they went to Saanvi's GP. She felt reluctant to tell her GP about her feelings, talking to someone outside her family felt scary. Her support worker supported her to talk to the GP, who referred Saanvi for some therapy in the NHS. The waiting list for therapy was long, so while she was waiting for this, Saanvi spoke once a week to a counsellor at a women's centre about what had happened to her. Saanvi also attended a support group at the refuge for women who had similar experiences. These are examples of a journey to get emotional support from services.

**Show below picture examples of emotional difficulties and emotional support. **

Check-in

I want to remind you that nothing you say will be passed on to any organisation you've worked with. Your support will not change because of this interview. Everything will be made anonymous before I include it in my research. This is a safe space where you can share anything you feel like sharing. If you don't want to answer any questions, that is absolutely fine. I'm also a therapist, you can feel safe talking to me.

If you see me taking notes, it's just reminders to myself to come back to something.

Although I have questions, I want to hear what you think is important, so go in the direction you think is most relevant and I'll bring us back to the questions if needed.

How are you feeling now? Would you like to check anything before we begin?

Demographic Questions

I'm going to start by asking some short, general questions about you. This is to help me understand your experiences as much as I can. The questions are based on some of the things which can impact South Asian women who have experienced similar things to Saanvi.

- First of all, what age are you?
- And what country were you born in?

- (If not born in UK) How many years have you lived in the UK?
- (If not born in UK) Some people who were not born in the UK have to go through an immigration process here. Do you know what your immigration status in the UK is?
- Do you have a religion or religious background?
- Do you have any children? How many?
- Other than the HO are there any other services that have supported you since the domestic abuse happened? **Give examples if prompt needed – like NHS mental health services, counsellors, support groups, women's charities, crisis team** ***Don't spend too long on this, get the basics.***
- How long have you/had you been with these services?

Main Part of Interview

The difficulties that Saanvi was experiencing are sometimes called mental health problems or emotional difficulties. **Refer back to images*.* **What words do you use to describe this for yourself?** **Refer back to examples from Saanvi story if needed.**

Prompts: What does that look/feel like for you? How would you describe it if you were feeling like that? If I saw you during that time, what would I see?

If you were to draw your journey of getting support as a line. This is the beginning, and this is the end, you can add ticks for when a service supported you, x for when it didn't work out, ups and downs, how would yours look? **show example from Saanvi and draw theirs out, asking questions about it as we go* Adapt how best to do this, map all out and come back to each or ask as going along?*

Can you tell me what it was like to go through this journey? **Refer to drawing just completed**

Prompts: How did you come to get support from that service? Did you ask any other services for support? **How would you describe it? What first comes to mind when you think about it? How does it feel to think about the journey?**

Can you tell me about a time during this journey when you feel you were getting good emotional support?

Prompts: What made it feel supportive? How did you feel when that happened? How do you think it impacted your *use their chosen term for mental health from first question*? **What did your days look like during that time? Were they different to your days before or after?**

Can you tell me about a time during this journey when you feel the emotional support could have been better? Remember this won't be passed on to anyone.

Prompts: How does it feel to think back and talk about it now? What would you have liked to be different? How do you think it could have been better? How did it make you feel at the time?

If you could wave a magic wand and make this journey **refer back to drawing** **perfect for other South Asian women going through it in the future, what would it look like?**

Prompts: What would be good about that? What do you think is the most important thing? Why do you think that would be important/good/helpful?

If you think about your **their term for mental health, can use images for references** **before this journey and your** **their term for mental health** **now, how has the journey impacted or changed your** **their term for mental health**?

Prompts: How would you describe it? How did that feel? Can you tell me a bit more about that? Has that changed? How has it changed? What does it feel like to think about that process*? *Explore this in relation to different parts of the journey detailed in drawing*.*

If not covered in previous answer:

If you hadn't had that experience **relate to different experiences participant has described so far**, **what do you think your mental health would be like now?**

Prompts: What impact would that have had on your life?

Ending the Interview

I want to ask you to choose a different name I can use for you in the research. It can be something that means something to you, or something random and unrelated. It is important that it's not a name that anyone knows you by or would link to you. Some people use the names of flowers or animals or human names they like. It can be anything as long as it won't identify you to anyone.

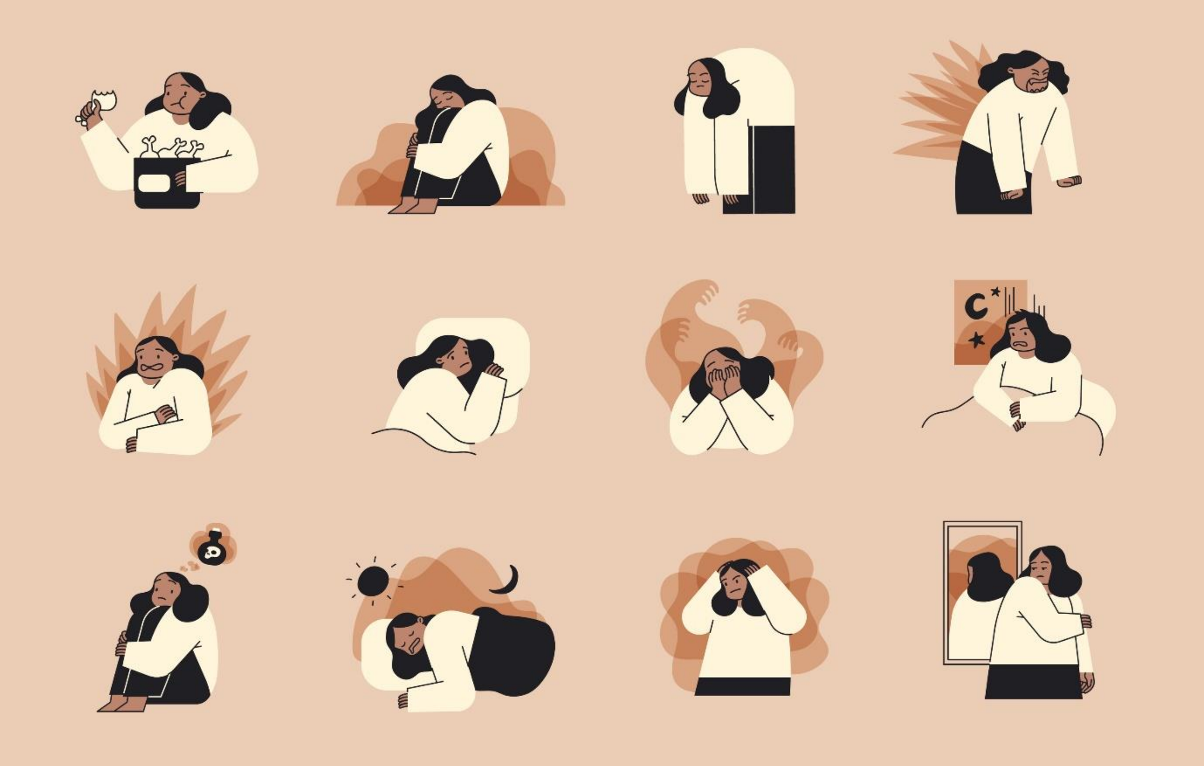
That's all of my questions finished. Is there anything else you'd like to add, anything you feel is important?

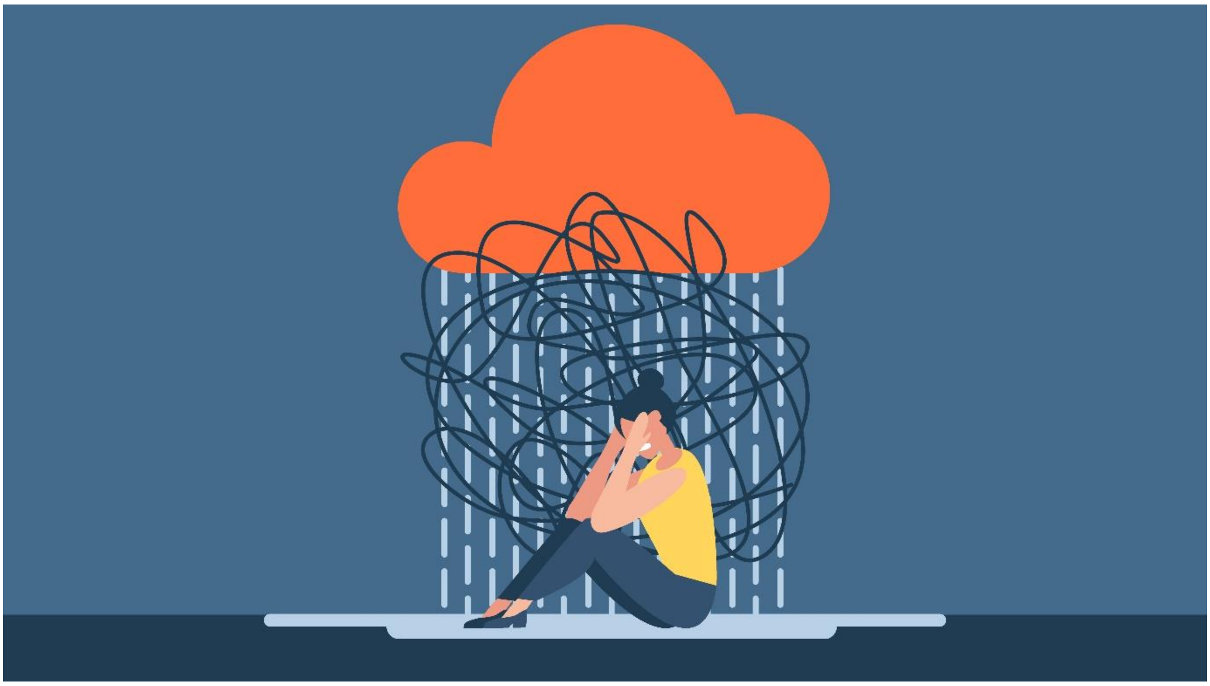
I want to thank you so much for sitting with me and answering all of these questions. I really appreciate it.

I will be in touch when I have written up the research and can send you the final write up if you like.

I want to remind you that within the next two weeks you can change your mind and ask me not to include your interview in the research. **Give participant my email address again.** Your support worker can help with emailing me if needed.

<u>Images used to demonstrate emotional distress (chosen in collaboration with service user consultant)</u>





Images used to demonstrate emotional support services (chosen in collaboration with service user consultant)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Appendix 3 – Recruitment poster in English

UNIVERSITY OF LEEDS

Are you a South Asian woman* who has:

- experienced domestic abuse

and

- asked service(s) for emotional support or help with your mental health**

Would you like to have your voice heard and take part in a research study?

THIS WOULD INVOLVE AN INTERVIEW ABOUT YOUR EXPERIENCES OF SEEKING EMOTIONAL SUPPORT AFTER DOMESTIC ABUSE. YOUR ANSWERS WILL BE KEPT ANONYMOUS.

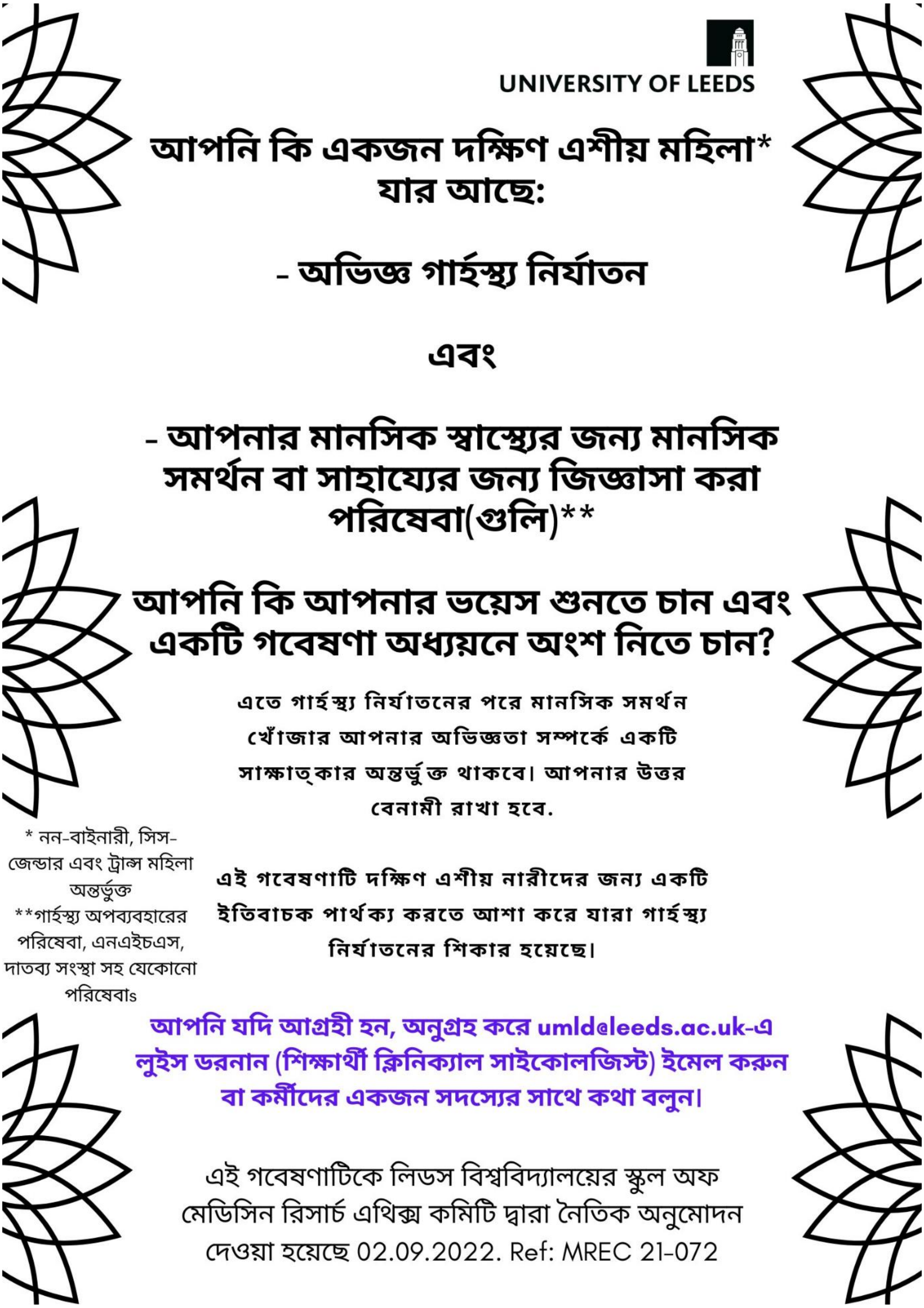
THIS RESEARCH HOPES TO MAKE A POSITIVE DIFFERENCE FOR SOUTH ASIAN WOMEN WHO HAVE EXPERIENCED DOMESTIC ABUSE.

*includes non-binary, cis-gender and trans women
**any service including domestic abuse services, NHS, charitable organisatons

If you are interested, please email Louise Dornan (Trainee Clinical Psychologist) on umld@leeds.ac.uk or speak to a member of staff.

This research has been given ethical approval by the School of Medicine Research Ethics Committee at the University of Leeds on 02.09.2022. Ref: MREC 21-072

Appendix 4 – Recruitment poster in Bengali



UNIVERSITY OF LEEDS

আপনি কি একজন দক্ষিণ এশীয় মহিলা* যার আছে:

- অভিজ্ঞ গার্হস্থ্য নির্যাতন

এবং

- আপনার মানসিক স্বাস্থ্যের জন্য মানসিক সমর্থন বা সাহায্যের জন্য জিজ্ঞাসা করা পরিষেবা(গুলি)**

আপনি কি আপনার ভয়েস শুনতে চান এবং একটি গবেষণা অধ্যয়নে অংশ নিতে চান?

এতে গার্হস্থ্য নির্যাতনের পরে মানসিক সমর্থন খোঁজার আপনার অভিজ্ঞতা সম্পর্কে একটি সাক্ষাত্কার অন্তর্ভুক্ত থাকবে। আপনার উত্তর বেনামী রাখা হবে.

এই গবেষণাটি দক্ষিণ এশীয় নারীদের জন্য একটি ইতিবাচক পার্থক্য করতে আশা করে যারা গার্হস্থ্য নির্যাতনের শিকার হয়েছে।

আপনি যদি আগ্রহী হন, অনুগ্রহ করে umld@leeds.ac.uk-এ লুইস ডরনান (শিক্ষার্থী ক্লিনিক্যাল সাইকোলজিস্ট) ইমেল করুন বা কর্মীদের একজন সদস্যের সাথে কথা বলুন।

এই গবেষণাটিকে লিডস বিশ্ববিদ্যালয়ের স্কুল অফ মেডিসিন রিসার্চ এথিক্স কমিটি দ্বারা নৈতিক অনুমোদন দেওয়া হয়েছে 02.09.2022. Ref: MREC 21-072

* নন-বাইনারী, সিস-জেন্ডার এবং ট্রান্স মহিলা অন্তর্ভুক্ত

**গার্হস্থ্য অপব্যবহারের পরিষেবা, এনএইচএস, দাতব্য সংস্থা সহ যেকোনো পরিষেবাs

Appendix 5 – Participant information sheet

Participant Information Sheet

An exploration of the experiences of South Asian survivors of domestic abuse who have sought help for their mental health.

*You are being **invited** to take part in a **research project**. Before you decide, it is important for you to **understand why** the research is being done and **what it will involve**. Please take time to read the following information carefully and discuss it with others if you wish. **Ask me** if there is anything that is not clear or if you would like more information. **Take time to decide** whether or not you want to take part.*

Why is the project being done?

I want to **explore** the journeys that **South Asian women** take through different services when they **reach out for help with their mental health**, after experiencing **domestic abuse.** Lots of women have to ask many different types of services to try and receive help and support. This journey can feel different for each person who experiences it.

I **want to hear directly from the women** who have gone through this process. I will interview around 6-10 women and then examine what was said, to get an understanding of their experiences. I will then **write up the results into a report** which will be published around May-July 2023.

Why have I been chosen?

I am working with XXX on this project. You have been chosen because you are using their services and are a South Asian Woman who has experienced domestic abuse and asked services for emotional help and support.

Do I have to take part?

It is **up to you** to decide whether or not to take part, you **do not have to**. If you do decide to take part, you will be given this information sheet to keep, and be asked to sign a consent form. You **can withdraw** from the research until two weeks after the interview. After two weeks from the interview date, it will not be possible to withdraw your data as I will have started analysing the interview results. You do not have to give a reason for withdrawing and there will be no negative consequences. If you would like to withdraw, please email me on umld@leeds.ac.uk to let me know.

What will I have to do?

You will take part in **one interview** with me asking questions. This will **be at X headquarters** and will last **45-120 minutes**. If you prefer to have your interview via video call, this will be done. If you consent, the interview will be audio recorded on an encrypted Dictaphone (further information below).

I will ask questions in a **sensitive way**, taking into account that they might cover topics that are difficult for you to talk about. I will ask open questions so **you can choose** what to focus on. We will have time to chat before the interview so we can get to know each other, and you can ask me any questions you might have.

The interview questions will focus on your experience of asking for or receiving emotional support from services, after experiencing domestic abuse. I will **not ask about your experiences of domestic**

abuse. I **will ask** you to explain any **mental health/emotional difficulties** you have experienced in **your own words**.

I will then ask you to meet with me online or in person, one more time, along with any other women from **X service** who took part. I will read through my general conclusions from the research and ask if you think I have understood your experiences. You will not have to talk about anything personal. If you would prefer to speak to me alone about this, just let me know. This will take no longer than 60 minutes.

Could there be disadvantages and risks in taking part?

I do not anticipate that taking part in the interview will cause you any distress but there is a potential that you might find it **emotionally difficult to speak about** your experiences of asking for and receiving/not receiving emotional support after domestic abuse. A reminder that I **will not ask about** your experiences of **domestic abuse** and that members of support staff from **X will be available if you need them.**

Could there be benefits in taking part?

There are **no direct benefits** for people taking part in the project, but I hope that this work will make a positive difference in how **services understand the needs of South Asian women**. The research will be used to make recommendations to services about how they can better support the mental health of South Asian survivors of domestic abuse.

What will happen to my information and interview responses?

All the contact information that I collect about you during the research will be kept **strictly confidential** and will be stored separately from your interview responses so they can't be linked to each other.

If you agree, the **interview will be recorded** and kept secure and private. If you don't want to be recorded, I will take notes which will be stored securely. All the answers you provide will be **anonymised and stored securely**. You will be invited to **choose a pseudonym** (different name) to be used in the write up.

When direct quotes are used, I will **make sure as much as possible** that these do **not identify** you. There is the **possibility** that those **very familiar** with your circumstances, like X staff, may be able to identify you through the experiences included in the write up.

If you were to tell me that you or someone else is at **risk of serious harm**, I may have to breach confidentiality and **speak to a member of X staff**. I **would speak to you** about this first.

Please find more information here on the University Research Participant Privacy Notice.

What will happen to the results of the research project?

I will write up the results into a thesis document which will be finished around May-August 2023. A shorter version will be **published publicly** in a research journal afterwards.

I will also write up and present **a shorter report for service users and staff at X (including you)**. If you would like copies of any of these reports, I will provide them.

Who is organising/ funding the research?

This research is funded by the University of Leeds, Doctorate in Clinical Psychology course.

Ethical Approval has been sought from the School of Medicine Research Ethics Committee Application reference number: (MREC21-072).

Contact for further information

Researcher:

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Dr Mahua Das
Programme Director
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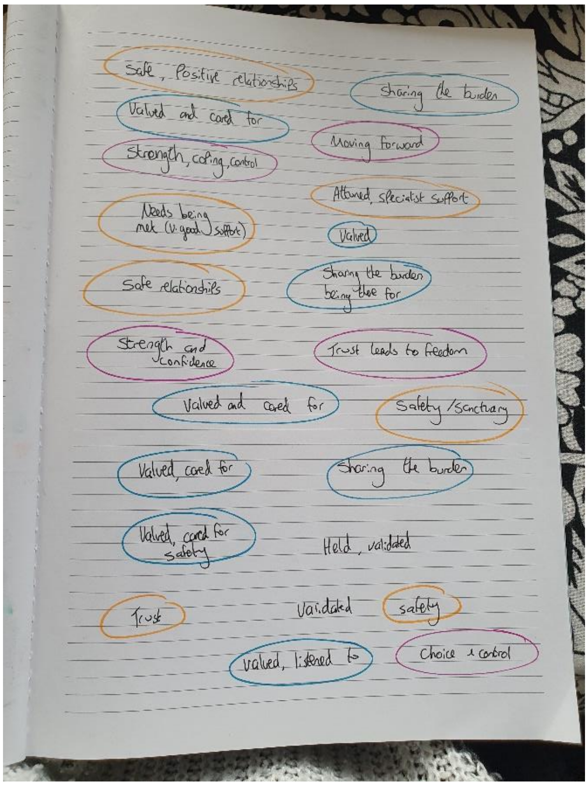
0113 343 4867

Appendix 6 – Examples of analytic process

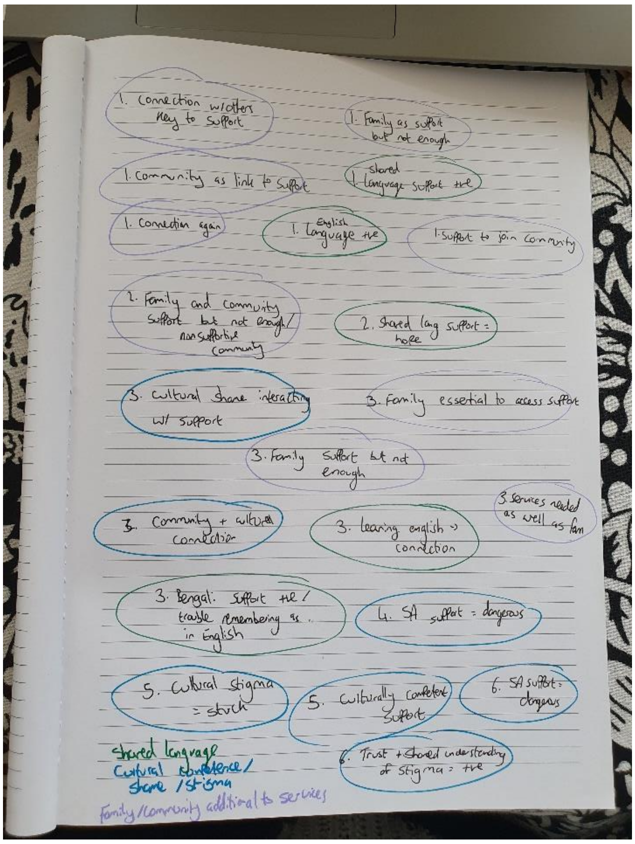
Transcript		Exploratory Notes	Experiential Statements 1.0	Experiential Statements 2.0
L: It was physical, the physical side of things and also I had some bad news, my mum passed away. *Crying*. I'm the only daughter, I feel like I came to this country and lost everything. I've got no one else, I feel like I've got no one to go back to now.		Feels like the therapy helped bring some positivity but really difficult circumstances continued to impact negatively. A sense of loss from coming here, "I'm the only daughter" what impact does this have? Feeling of being alone, "no one to go back to", "got no one else". Isolation again and again. How can services help with this isolation and understand it?	Being brought to the UK, away from her family led to her isolation and left her feeling lost and alone.	Brought to the UK alone, without family, she feels isolated, lost, and lonely.
M: I'm really sorry to hear that. It must have been a really hard time.				
L: It's been 13 years, but I feel like I'm not progressing.		Impact of the "13 years", long passing of time without progress. Being pulled/held back in the starting position.	A long time has passed without her feeling progress/change.	
M: So when you think back about this sort of time, *pointing at beginning of journey* do things feel similar now to how they felt then?				
L: I feel it's still the same. Nothing seems to be improving, it just seems to be getting worse. I feel like I don't	Stuckness again. Going out freely, before she had to take people with her to access services, now the feeling of fear keeps her from going out alone. The impact of this on accessing services.	She continues to feel stuck, restricted, not free - things are not getting better.	Being held back and stuck without progress reduces the value of life.	

have anything going for me, I can’t go out, I can’t do anything freely.	Don’t have anything going for me – linked to the isolation? Thoughts about her self-worth. In comparison to what/who?		

Unable to reach help	Needing support but not getting it ?	Struggling without support ?	Barriers between her and support	How identity shapes help-seeking	Struggling to reach support
Community as a bridge to support	The struggle to reach support	Value of family and community	Disruptors of support	Breaking down the barriers to support	Services exerting negative power
What good support can achieve	Practical support as emotional support	Knowledge and language	Positive relationships and safety	Harmed through help-seeking	Impact of cultural stigma
Connection and community are fundamental	The good support can do	When services get it right	Using her strengths	Threatening and dangerous services	What good support can achieve
Reversal of progress	When services get it wrong	Support at its best	Rejection and a taste of what could have been	Becoming fierce and strong	● Trying to reach support 7 ● Damage / struggle w/out support 4 ● Culture + community 5 ● Strength + empowerment 3 ● Positive support 8 ● Negative/damaging support 7
Damage done by lack of support					



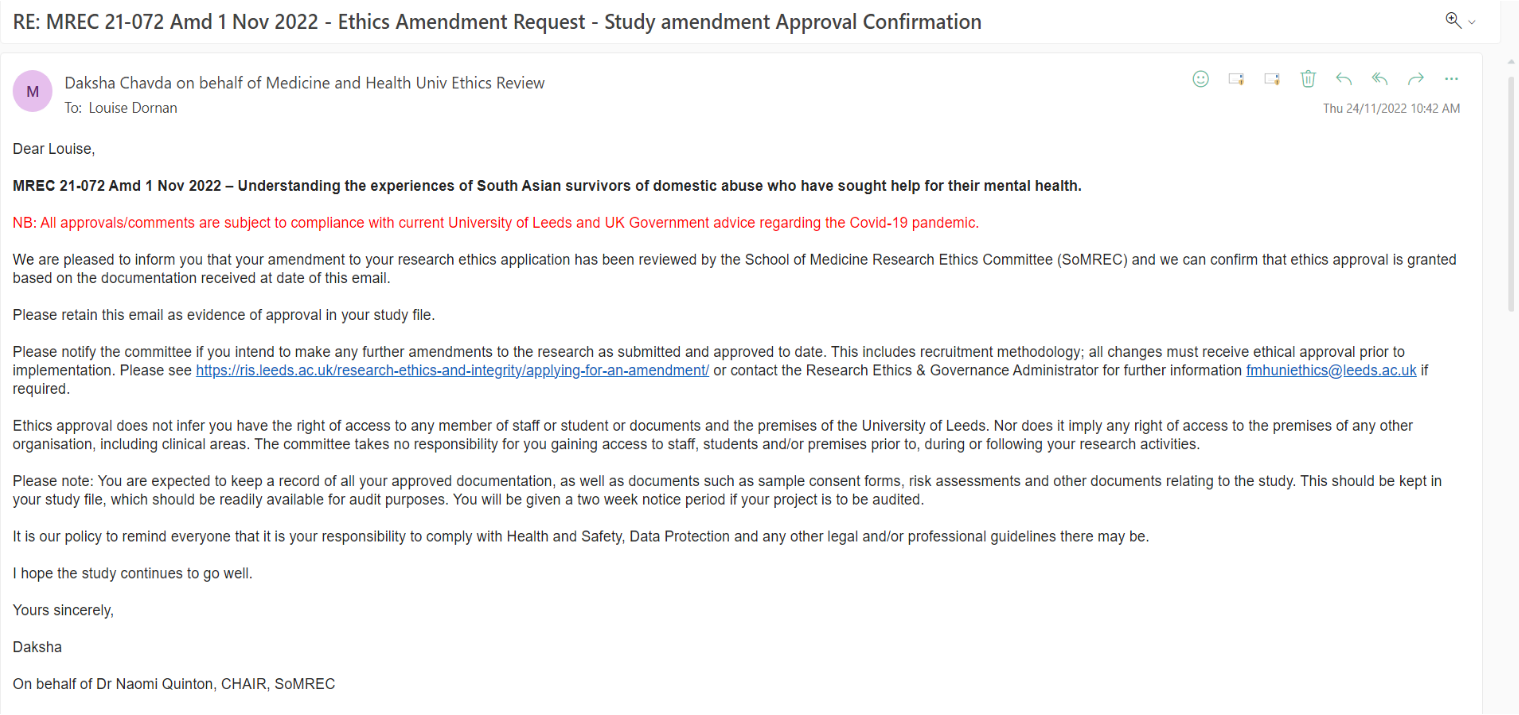
Safe, Positive relationships
Sharing the burden
Valued and cared for
Moving forward
Strength, coping, control
Attuned, specialist support
Needs being met (v. good support)
Valued
Safe relationships
Sharing the burden being there for
Strength and confidence
Trust leads to freedom
Valued and cared for
Safety / Sanctuary
Valued, cared for
Sharing the burden
Valued, cared for safety
Held, validated
Trust
Validated
safety
valued, listened to
Choice & control



1. Connection w/others key to support
1. Family as support but not enough
1. Community as link to support
1. shared language support +ve
1. Connection again
1. English language +ve
1. Support to join community
2. Family and community support but not enough / non supportive community
2. Shared lang support = hope
3. Cultural shame interacting w/ support
3. Family essential to access support
3. Family support but not enough
3. Services needed as well as fam
3. Community + cultural connection
3. learning english → connection
3. Bengali support +ve / trouble remembering ... in English
4. SA support = dangerous
5. Cultural stigma = stuck
5. Culturally competent support
6. SA support = dangerous
6. Trust + shared understanding of stigma = +ve

shared language
Cultural competence / shame / stigma
Family / community additional to services

Appendix 7 – Ethical Approval



RE: MREC 21-072 Amd 1 Nov 2022 - Ethics Amendment Request - Study amendment Approval Confirmation

Daksha Chavda on behalf of Medicine and Health Univ Ethics Review
To: Louise Dornan

Thu 24/11/2022 10:42 AM

Dear Louise,

MREC 21-072 Amd 1 Nov 2022 – Understanding the experiences of South Asian survivors of domestic abuse who have sought help for their mental health.

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

We are pleased to inform you that your amendment to your research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any further amendments to the research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see https://ris.leeds.ac.uk/research-ethics-and-integrity/applying-for-an-amendment/ or contact the Research Ethics & Governance Administrator for further information fmhuniethics@leeds.ac.uk if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study continues to go well.

Yours sincerely,

Daksha

On behalf of Dr Naomi Quinton, CHAIR, SoMREC

Appendix 8 – Participant consent form

Understanding the experiences of South Asian survivors of domestic abuse who have sought help for their mental health.	Add your initials next to the statement if you agree
I confirm that I have read and understood the information sheet dated [insert date] explaining the above research project and I have been able to ask questions about the project.	
I understand that I do not have to take part if I do not want to and that I am free to withdraw until two weeks after the interview date, without giving any reason and without any negative consequences. I understand that after two weeks from the interview date, it will not be possible to withdraw my data as the researcher will have started analysing the interview results. If I would prefer to not answer any particular question or questions, I can say no. To withdraw from the study, I should contact Louise Dornan – umld@leeds.ac.uk. I understand that if I withdraw from the study, any data collected from/about me will be permanently deleted/destroyed.	
I understand that people on the research team (e.g., Louise's supervisors) may be able to see my anonymised interview responses. I understand that my name will not be linked with the research, and I will not be identified or identifiable in the reports that Louise creates from the research. I understand that any quotations used will be anonymised (i.e., my name will not be used).	
I understand that the data I provide will be stored in the University of Leeds secure cloud storage for three years after my interview.	
I understand that data collected during the study (including my interview responses), might be looked at by individuals from the University of Leeds or from regulatory authorities (e.g., people marking Louise's thesis project).	
I agree to take part in the above research project and will inform Louise if my contact details change.	

Name of participant	
Participant's signature	
Date	

Name of lead researcher	
Signature	
Date*	

*To be signed and dated in the presence of the participant.

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.