Gregory, A. C., Williamson, E., & Feder, G. S. (2016). The impact on informal supporters of domestic violence survivors: A systematic literature review. Trauma, Violence, and Abuse. DOI: 10.1177/1524838016641919

The impact on informal supporters of domestic violence survivors: A systematic literature review

Alison Gregory[1], Emma Williamson[2], Gene Feder[1]

[1]Centre for Academic Primary Care, University of Bristol; Bristol, UK

[2]The Centre for Gender and Violence Research, University of Bristol; Bristol, UK

Funding information: This review was conducted as part of a PhD study which was funded by the National Institute for Health Research (NIHR) School for Primary Care Research and was hosted by the University of Bristol.

Corresponding author details:

Dr Alison Gregory

Centre for Academic Primary Care, University of Bristol,

Canynge Hall, 39 Whatley Rd, Bristol. BS8 2PS. UK

+44 (0) 117 928 7352

alison.gregory@bristol.ac.uk

The impact on informal supporters of domestic violence survivors: A systematic literature review

Abstract

Domestic violence (DV) is experienced by 1 in 4 women in the UK during their lifetime, and most survivors will seek informal support from the people around them, even if they choose not to access help from professionals. Support from these relatives, friends, neighbours and colleagues can provide a buffer against effects on the survivor's physical health, mental health, and quality of life, and has been shown to be protective against future abuse. There has been an absence of research studying members of survivors' networks and, in particular, investigating how the impact of DV might diffuse to affect *them*. A systematic literature review of reported research (either in peer reviewed journals or in grey literature) was undertaken to explore the impacts of DV on survivor networks. Of the articles found, twenty-four had data relating to the topic area, though no study addressed the question directly. Framework analysis and meta-ethnography generated the following themes: physical health impacts, negative impacts on psychological wellbeing, direct impacts from the perpetrator, and beneficial impacts on psychological wellbeing. The studies in this review indicated that informal supporters may be experiencing substantial impact, including vicarious trauma and the risk of physical harm. Currently there is little support available which is directly aimed at informal supporters of domestic violence survivors, thus these findings have practical and policy implications, in order to acknowledge and meet their needs.

Keywords

domestic violence, vicarious trauma, disclosure of domestic violence, perceptions of domestic violence & homicide and domestic violence.

The impact on informal supporters of domestic violence survivors: A systematic literature review

Introduction

Domestic violence (DV) is a problem of epidemic proportions; it is globally widespread (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005), high in prevalence, chronic in nature and far-reaching in consequence. Much research has been carried out to identify the serious and persistent physical, emotional and psychological impacts on women who have experienced such abuse (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008).

In the majority of cases, friends and family members knew about the DV their loved one was experiencing or perpetrating (Klein, 2012; Williamson & Hester, 2009), and most women in abusive relationships do access support from members of these networks (Fanslow & Robinson, 2010; Parker & Lee, 2002; Sylaska & Edwards, 2014). In a study by Parker and Lee, 89% of women who had experienced abuse reported telling their friends and relatives and, whilst only three quarters of intimate partner violence (IPV) survivors in Fanslow and Robinson's research disclosed to anyone, 94% of the women who had told someone, had divulged the abuse to friends and relatives (Fanslow & Robinson, 2010; Parker & Lee, 2002).

Whilst many survivors rely on friends and family alongside formal DV services, there are also many women who rely initially, predominantly or exclusively on this informal support (Fanslow & Robinson, 2010; Latta & Goodman, 2011). Because of the primacy given to friends and family members by survivors, the responses, judgements and behaviours of these people have the potential to significantly improve or worsen the situation of the survivor (Klein, 2012).

Work by Coker and colleagues explored the triad of IPV, health, and the social network, reporting that a higher level of social support acts as a buffer against the effects of abuse on poor perceived physical and mental health (Coker et al., 2002; Coker, Watkins, Smith, &

Brandt, 2003). Additionally, survivors' satisfaction with their support network has been shown to be a predictor of self-esteem, emotional health, level of loneliness, and quality of life (Fry & Barker, 2002; Tan, Basta, Sullivan, & Davidson, 1995). With regards to impact of a positive social network on women's entry into or return to abusive relationships, there is also evidence to suggest that informal support acts as a protective factor against future abuse (Goodman, Dutton, Vankos, & Weinfurt, 2005; Plazaola-Castano, Ruiz-Perez, & Montero-Pinar, 2008).

In the UK, the National Institute for Health and Care Excellence (NICE) has recognised the importance of carers and family members, suggesting that research regarding DV needs to include interventions directly targeting the informal supporters of survivors (*Domestic violence and abuse: How health services, social care and the organisations they work with can respond effectively*, 2014). There is, however, a large piece missing in this picture, because the vast majority of research to date has relied on survivors' reports of interactions between themselves and those they know (Sylaska & Edwards, 2014), and has looked almost exclusively at how these interactions impact on the survivor. The only studies that have considered the network member's perspective have been primarily concerned with the role these people play and their willingness, or not, to be involved in the situation (Beeble, Post, Bybee, & Sullivan, 2008; Latta & Goodman, 2011; Paquin, 1994).

The purpose of this research was to systematically review the literature in order to understand the health and wellbeing impacts on adult friends, relatives, neighbours and colleagues of women experiencing domestic violence.

Method

Literature Search

AG conducted systematic searches of the following databases using the terms outlined in detail in Appendix A: MEDLINE, PsycINFO, Embase, CINAHL, PubMed, the Cochrane library,

Web of Science, Open Sigle, EThOS, DART-Europe E-thesis portal, National Research Register Archive and CSA Illumina. The search form was: [terms for domestic violence and abuse] AND [terms for friends or relatives] AND ([terms for impact] AND (within four words) [terms for health and wellbeing]).

As shown in Figure 1, 4926 articles were initially identified, with 3316 remaining once duplicates had been excluded. The abstracts for these were read and screened for relevance. Criteria developed during the review of the first 30 abstracts were applied to the succeeding 100 in order to check that the principles were sufficiently robust, and further clarifying commentary and examples were added to a developed decision-aid tool.

Sixty-four full text articles were reviewed resulting in 17 articles for inclusion. Seven additional relevant articles were identified by citation tracking and hand searches. A second reviewer independently examined a 5% subsample of the abstracts using the developed decision-aid tool to ensure its reliability. Her decisions about the inclusion and exclusion of articles matched those of the initial reviewer.

Data Extraction

AG extracted data from all 24 of the included full-text articles. A second reviewer examined a subset of the articles, highlighting text relevant to the research question and assigning codes from the original index created by AG, noting if themes arose that she felt unable to classify. For the articles considered, there was general agreement between the reviewers, and where there were differences (concerning the labelling of themes and the exclusion of data relating to DV exposure during childhood), theme descriptors were honed until consensus was reached. This gave confidence in the reliability of the data extraction, and aided the process of refining the theme labels.

Data Synthesis

Studies were included if they reported data pertaining to impact on the health and wellbeing of adults in the social network of a female DV survivor. *Adult* meant that they were 16 years old or above, *social network* included friends, colleagues, neighbours, current non-abusive partners, and any relative including step-family, non-blood relatives and family-in-law, and *DV* was defined in accordance with the fullest meaning of the British Home Office definition:

> *Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial & emotional. ("Domestic violence and abuse: New definition," 2013)*

No exclusions of articles were made on the basis of: research design, setting, language, type of publication, or date of publication.

Dixon-Woods and colleagues suggest meta-ethnography (Noblit & Hare, 1988) as an approach which can be used with qualitative data alongside quantitative data, and demonstrate the synthesis of both in a review of access to healthcare by vulnerable groups (Dixon-Woods et al., 2005). For the review reported here, framework analysis (Ritchie & Spencer, 1994) was used to initially manage and order the data, and to begin to classify key themes, concepts and emergent categories. Techniques from meta-ethnography were then applied to compare, analyse, interpret and translate findings from individual studies to produce a new level of interpretation.

As part of the deconstruction, following Britten and colleagues' approach, the data were separated according to notions of *orders of constructs*, with *first-order constructs* referring to the *'everyday understandings of ordinary people'*, and *second-order constructs* referring to the *'constructs of the social sciences'* (usually the interpretations, explanations and theories

proposed by the authors of articles). A lines-of-argument synthesis was then used to develop a *third-order interpretation* (Britten et al., 2002).

Quantitative data do not naturally fall into first- and second-order constructs, so we used an innovative approach, aligning descriptive statistics, with first-order qualitative data, and author discussions and commentary with second-order qualitative data. For clarity, authors' interpretations and explanations have been given the label 'author description', whereas summary reports by authors, with no interpretive content, have been labelled 'author summary' when quoted.

Findings

Study Characteristics

Twenty-four articles reporting 23 studies met the inclusion criteria (see Appendix B for study characteristics). The articles, to a greater or lesser extent, touched on the research question, but none addressed it as the central topic. Eighteen were journal articles, two were reports or reviews, three were PhD theses and one was a Masters dissertation. The majority (15) were conducted in the USA, with two studies in Sweden, two in the UK, two in Australia, one in Canada and one in South Africa.

Thirteen of the studies used qualitative methods, nine used quantitative methods, and one was a mixed-methods study. In only six studies were participants the friends or family members of a survivor. In nine studies, survivors had been specifically recruited as participants, and thus all data reported in these articles about the impact on friends and relatives were third-party. A further five studies recruited participants on the basis that they represented members of the general population (rather than explicitly having experience relating to DV). Data from these studies reflected a mixture of first-hand and third-party perspectives.

In the remaining three studies, additional third-party perspectives were given, all of which related to fatal DV, with information from case notes of professionals involved in DV femicide reviews, media and police reports of IPV homicide-suicide, and mental health professionals supporting families post-intimate partner femicide (IPF).

Synthesis Findings

Physical health impacts. The physical health of people in survivors' networks was occasionally mentioned, and was particular to three contexts: post-intimate partner femicide for family caregivers, where witnessing of events had occurred, and where people were long-term supporters of a survivor.

The post-intimate partner femicide caregiver scenario is perhaps the most difficult to unpick because failing health of family members may be due to wide ranging factors, not singularly the DV. The picture is clouded by tragedy, grief, previous health of family members (for whom ill-health is more likely due to these people being predominantly of grandparent age), and the complex stress of caring for distraught children (Hardesty, Campbell, McFarlane, & Lewandowski, 2008; Spencer-Carver, 2008). A quote from a mental health professional illustrates this:

> *You would know that the caregiver needed to go to the doctor and you would follow up; did she go to the doctor? "Well, no, I did not go to the doctor, but I took the kids to the doctor."...I think that those healthcare things continue to get put off... People took longer to respond to their own needs... Part of that is due to the recent trauma and part is that they have a lot of new responsibilities and might not be taking time to observe how their body is doing...We attribute a lot to the grief which might be true...Their fatigue and headaches fit what they are going through now but may also mask things that also need help* (A mental health professional, interviewed by Spencer-Carver, 2008, p.63)

Physical fatigue was also mentioned where network members felt *'drained'* and *'exhausted'* by the process of trying to define their function and responsibility in the situation (Latta, 2008). The process of providing long-term support, particularly when the extrication from an abusive

relationship is complex and drawn out, could have a secondary effect of frustration which can lead to physical exhaustion. Network members choosing to make themselves available to the survivor, may experience a sponge effect, with little or no control to influence the situation, leaving them feeling drained.

This would echo findings from studies with informal carers of relatives with physical health conditions, who describe a combination of frustration and tiredness as part of the caring burden (Bucki, Spitz, & Baumann, 2012; Nahm, Resnick, Orwig, Magaziner, & Degrezia, 2010).

In situations where incidents of DV are *witnessed*, it is possible that a form of post-traumatic stress disorder (PTSD) may result, and this has been shown to have association with poor self-reported health and increased utilisation of medical services (Schnurr & Jankowski, 1999).

Negative impacts on psychological wellbeing. The concept of negative impacts on psychological well-being had two subgroups: those that could be considered *acute* impacts, occurring immediately after exposure to DV events, and those that could be considered *chronic* in terms of longevity and relentlessness. They are described separately, although people often experienced a trajectory, with acute impacts resulting in chronic impacts over time.

Acute psychological impact. Trauma, shock and fear were mentioned by study participants and by authors of articles. Some participants talked specifically about the trauma which followed fatal DV, and others about exposure to scenarios that connected with participants' own histories of victimisation. Hardesty and colleagues described trauma in relation to grief following intimate partner femicide (IPF), and connected this with the physical and mental health of relatives:

Adult family members who suddenly become caregivers after IPF must manage their

> *trauma and grief reactions in addition to the needs of the traumatized children. Doing so likely compounds levels of stress and heightens the caregivers' risk for negative physical and mental health effects* (Author description by Hardesty et al., 2008, p.103)

In this same study, by Hardesty and colleagues, one participant described the destruction of the family unit following her daughter's murder as traumatic, whilst another spoke of both the immediate impact and the longevity of traumatic impact from having witnessed her friend's death:

> *I feel so very bad for [the victim]. She was breathing when I got to her. Her face was swollen. He had beaten her. He claimed self-defence. Everyone thinks about immediate family effects. I mean the last 2 years have been hell for me. I've had nightmares. I suffered so much* (A friend to a survivor, interviewed by Hardesty et al., 2008, p.119)

In Spencer-Carver's study, reporting post-intimate partner femicide impacts on relatives, trauma is also mentioned by the authors, alongside the caregiving responsibilities that resulted from the death:

> *The weight of that "catastrophic trauma" falls on the shoulders of the caregivers who choose to care for these children and do so with little community support...* (Author description by Spencer-Carver, 2008, p.62)

Likewise, Salari discussed trauma in relation to scenarios where domestic violence resulted in the woman being killed, describing intimate partner homicide-suicide as having *'far reaching effects on public health as events traumatize families, friends, neighbourhoods and entire communities'* (Salari, 2007, p.441). Examples of trauma given in media reports in this study include a son whose father killed his mother and left him an answerphone message saying that he was about to kill himself, and neighbours in a retirement village who witnessed a couple jumping to their deaths from an upper storey window (Salari, 2007). Salari suggests that symptoms of post-traumatic stress disorder are a possible impact for people living in close proximity to homicide-suicide events (Salari, 2007).

Erlingsson and colleagues also mentioned the possibility of trauma, citing research which indicated the traumatic nature of abusive situations for witnesses, and highlighting the support their findings leant to the possibility of *'traumatic psychological and emotional stress'* for those around an abusive relationship (Erlingsson, Carlson, Astrom, & Saveman, 2009). For Ron, a friend in Latta's study, the trauma of being around the survivor and the perpetrator was related less to what Ron was witnessing, and more to the feelings it brought up about his own past history of physical abuse by his father (Latta, 2008).

Shock at the situation was mentioned by participants in two studies. In Latta's research participants described their shock as they understood the behaviour the perpetrator was capable of (Latta, 2008), and in Salari's study, third-party media reports indicated the shock neighbours experienced following intimate partner homicide-suicide (Salari, 2007). In summarising some of the findings, Salari suggests that lack of warning contributed to these feelings:

> *One close friend stated "The murder suicide came as a total surprise...I was with him every weekend and you talk about that sort of thing to your best friend."...Neighbors in another case said "You couldn't ask for better neighbors...They never fought...I'm close to being in shock over this..."... "There was not even a hint that there was a problem...they seemed so happy...devoted to one another...the victim was happy about the upcoming visit from her brother...I was shocked - I can understand wanting to kill yourself , but why take someone else's life?"* (Author summary of media reports by Salari, 2007, p.447)

A third acute psychological impact was fear. Following the intimate partner murder of her neighbour, a participant in Hardesty and colleagues' research talked about her fear that the perpetrator, or his relatives, would kill her because the victim had fled to her home:

> *I feared for my own life. I thought he would come back and kill me. I moved out in 2 weeks. I went to the trial. I testified. I had my boyfriend go to the trial with me every day. I was afraid his family would kill me. I was so afraid* (A friend and neighbour to a victim, interviewed by Hardesty et al., 2008, p.119)

For a group of women in McNamara's study, their friend's death left them with a more generalised fear of others' behaviour towards themselves and towards their loved ones

(McNamara, 2008). In particular, they mentioned how verbal aggression had become frightening, for example one participant mentioned the change in her experience of her husband's family:

> *When we go over there my nerves can't handle it. There is a lot of shouting. In his family there is physical threatening using hands. It's verbal aggression, not bad language or anything but loud! I just thought beforehand "that's just them; they have their anger management issues"...Since this has happened to Kate it's terrifying* (A friend to a victim, interviewed by McNamara, 2008, p.208)

Even in situations of non-fatal domestic violence, a strong sense of fear could result:

> *When he banged her head with a log, I was scared for my own safety. I guess all the times that I actually saw it [a violent incident]...He didn't care who was around at that time. If something triggered him-it could be anything-he would just go off. He just lost it...I was fearful for my life* (A friend to a survivor, interviewed by Latta, 2008, p.182)

In this same study by Latta, others spoke about their fear in relation to potential outcomes for the survivor, the perpetrator, or for both parties. For example:

> *I've seen him kick the crap out of her and stuff like that. I'd be like, never again, never again [will I get involved]. But then the call would come and I'm not going to leave the kid. Because honestly, my biggest fear was that she's going to put a knife in him in the middle of the night. Or he's going to lose control and punch her lights out and really hurt her and go to jail for twenty years* (A friend to a survivor, interviewed by Latta, 2008, p.176)

While the survivor remained in the abusive relationship, two types of fear were described: fear that the survivor would be harmed, and fear of damaging or losing the relationship with the survivor. Latta makes a connection between her participants' fear, their heightened awareness of the seriousness of the situation, and their willingness to help. In particular, she highlights that *'when network members were afraid that the violence might end [the survivor's] life, they felt a strong motivation to engage' (Latta, 2008, p.178)*, but also that fear could lead to disengagement if people felt they might experience harm themselves by remaining in touch with the couple.

Additional studies provided second-order data regarding fear in relation to third-party report. Riger and colleagues mentioned that *'interviews with women with abusive partners revealed that some extended families may fear for their own safety'* (Riger, Raja, & Camacho, 2002, p.186), whilst Goodkind and colleagues made the connection between direct threats to network members, fear, and increased likelihood of negative response towards the survivor, asserting that *'family and friends may be least likely to show support to survivors when they fear for their own safety'* (Goodkind, Gillum, Bybee, & Sullivan, 2003, p.366).

In Hobart's case review, the actions that friends, family and neighbours might *not* take because of fear are mentioned by the author:

> *People are often afraid that an abuser will know they called the police and will retaliate against them...When friends, family or neighbors fear that an abuser has a gun, it becomes very difficult for anyone other than law enforcement to intervene, but it also may be very frightening to even consider calling law enforcement.'* (Author description by Hobart, 2002, p.46)

The acute impacts of feeling traumatised, shocked or fearful, are established symptoms of post-traumatic stress disorder (PTSD) and acute stress disorder (ASD) ("Acute stress disorder," 2007; *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR)*, 2000; "Post-Traumatic Stress Disorder (PTSD)," n.d.). Both of these conditions can result in those who have directly experienced traumatic events that involve threat, and recently attention has been given to second-hand exposure to events, with *witnessing* being shown to similarly trigger symptoms (Allenou et al., 2010; *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR)*, 2000; Espié et al., 2009; "Post-Traumatic Stress Disorder (PTSD)," n.d.).

In this review, the contexts in which these acute psychological impacts were mentioned were where DV had ended in the tragic death of the woman, where friends or relatives had witnessed extreme physical violence first-hand, or where network members themselves had

been a prior victim of abuse. This fits with the idea that the closer people are to the situation, either by relationship with the survivor, by visually witnessing incidents, or by closely identifying with the survivor's experiences, the more they will be impacted.

Chronic psychological impact. A number of chronic psychological impacts were apparent, including: grief, guilt, shame, sadness, hopelessness, powerlessness, worry, isolation, reduced confidence, anger and frustration.

Given that several studies mentioned contexts in which women had not survived domestic violence, it was perhaps unsurprising that grief and loss were mentioned. McNamara described the *'especially profound sorrowing'* of the group of women she interviewed, and mentioned the persistence of this grief (McNamara, 2008). Hardesty and colleagues discussed the double impact for carers, managing their own grief after intimate partner femicide alongside providing support to grief-stricken children (Hardesty et al., 2008). They also mentioned how difficult it was for families to recover from such devastating losses, even after many years.

Similarly, mental health professionals in Spencer-Carver's study spoke about grief as a *'never ending process of adjusting to loss'*, and additionally touched on a separate idea of loss, not of life, but of life-plans and future ideals:

> *Taking on the care of a young child means that you have 18 years ahead of you. Some of these people were tired and that wasn't what they had envisioned. Even people who had been a primary caretaker [before the murder] for these children had been living with the illusion that the mother would step up to the plate and take this job over. There is loss of that vision for their future. And then there is the grief and loss for the actual person who was ripped from their life* (A mental health professional, interviewed by Spencer-Carver, 2008, p.62)

Spencer-Carver also alluded to the possibility of high social isolation resulting alongside grief, because of the stigmatised nature of the loss (Spencer-Carver, 2008).

Some participants spoke about loss regarding relationships (Bennett, 2006; Latta, 2008). Bennett linked work by other authors, suggesting that feelings of loss when friendships cultivated in refuges ended were *'similar to those associated with bereavement',* and reported an incident, relayed by a refuge worker, about the impact on others when a survivor unexpectedly decided to return home:

> *It really hit the others hard - they were all getting on great and they felt very let down, they kept asking me what they had done wrong and why she hadn't trusted them enough to talk about it. It made them question their friendship - they felt like she had 'thrown it back in their faces' I tried to reassure them that it was nothing to do with them, but it left them feeling very confused and hurt* (A refuge worker, Bennett, 2006, p.46)

Participants in several studies mentioned the guilt, shame or regret they experienced. For example, Jessica spoke of the guilt she felt about *managing* her interactions with the survivor:

> *Sometimes I just wouldn't answer the phone. If it was like a 3 a.m. call, I would because I was concerned it would be an emergency. But at 9 p.m., I'd be like, "I can't do this right now, I've gotta get up for work and I don't, I can't get into that place"...it was like when do I draw the line trying to get myself out of this hole?...I don't want to be dragged down...So that was definitely challenging. I definitely struggled with it. I was like, "Oh I'm a horrible person, I should be there more readily," so I did struggle with it. I had a guilt trip about it* (A friend to a survivor, interviewed by Latta, 2008, p.174)

More generally, for Latta's participants, they looked back on the situation with regret, with network members wishing they had intervened before the violence began (Latta, 2008). Likewise, in McNamara's study post-intimate partner murder, there were repeated expressions of regret about not having realised the danger their friend was in; about the '*signals misread and opportunities lost, in respect to Kate's acute vulnerability'* (McNamara, 2008, p.211).

Guilt and regret were also mentioned by mental health professionals in Spencer-Carver's study, and Hardesty and colleagues pointed out that whilst their participants did not explicitly mention self-blame, they were clearly wrestling with having had an awareness of the abuse prior to the murder, but not having been able to prevent it (Hardesty et al., 2008).

For the niece of a survivor and perpetrator in Erlingsson and colleagues' study, the impact described is shame rather than guilt, shame of not having spoken out about the abuse (Erlingsson et al., 2009). Erlingsson and colleagues described the origin of this shame in the tension the participant felt between her own ideals that urged her to expose the DV, and the loyalty she felt towards her family, compelling her to remain silent. In her thesis (Erlingsson, 2007), Erlingsson describes how this was compounded by the participant feeling that having a blood relative who was committing abuse, was shameful in itself:

> *The family member witness described how she would not be able to look herself in the mirror if she intentionally harmed anyone, gave offence, or violated personal rights. She repeatedly described how she knew what she ought to do and how she felt she was not living up to her ethical ideals about how she should act; as a niece, nurse, or human being...She had been trapped by her loyalty to family, her desire to protect family, and a deep shame that this was her family* (Author description by Erlingsson, 2007, p.35)

Participants also mentioned their sadness or feelings of hopelessness. In situations where a woman had been killed by a DV perpetrator, McNamara described the *'profound sadness'* of the group of friends she interviewed (McNamara, 2008), and Hardesty and colleagues' reported that participants had struggled with depression and low mood, sometimes over a period of years (Hardesty et al., 2008). The hopelessness spoken about by friends and family members was due to the perceived impossibility of effective intervention in the situation, and authors suggested hopelessness as an explanation for a reduced level of offered emotional support; that members of the social network feel their efforts are in vain and begin to distance themselves (Goodkind et al., 2003; Latta, 2008). For example:

> *In part, the hopelessness reflected the emotional pain and difficulty of watching someone you love and care about remain in an abusive situation. Add to this the frustration of feeling like there was nothing you could do to help them and you end up with feelings of hopelessness and resignation* (Author description by Latta, 2008, p.209)

Connected with hopelessness was a sense of powerlessness or helplessness. For example, Lisa, the niece of a survivor and perpetrator, felt helpless as a result of wanting to protect her family:

> *Lisa described feeling powerless and immobilized; fearing that any action would be positive for one family member in the abusive dyad but negative for the other* (Author summary by Erlingsson, 2007, p.35)

Lisa lamented that whilst as a professional she knew what was right and ethical, when faced with abuse in her own family, she felt powerless to challenge her uncle. Erlingsson and colleagues described how loyalty to family created the *'torment'* of being caught between an impetus to disclose and confront, and a sense of helplessness and passivity (Erlingsson et al., 2009). Following an intimate partner murder, some people described a retrospective sense of helplessness, of feeling that they had somehow *'failed in their duty to protect'*, in spite of having been previously unaware of the situation (McNamara, 2008).

Where friends or family members knew about the DV, they spoke about their worry and concern particularly regarding the survivor's safety (Hardesty et al., 2008; Latta, 2008). Some participants also described the concerns they had, prior to a certainty that abuse was happening, and mentioned a specific cause of worry at the point where the perpetrator was threatening to kill himself (Latta, 2008). Latta proposed that network members' concerns were extended and complicated by there being children as part of the picture (Latta, 2008).

Participants also talked about feeling isolated. For many network members it was being the only one who knew about the DV that had an isolating effect. Lisa, a participant in Erlingsson and colleagues' research felt unable to trust others so remained silent whilst yearning for someone to confer with. The authors summarise this experience:

> *Lisa longed for external support in addressing the abuse situation; someone who would provide support in a way Lisa could accept and who would allow her to maintain relationships in the family. Lisa thought no one had seen (or wanted to see) the abuse or Lisa's own need for support. She perceived herself as disregarded and invisible* (Author summary by Erlingsson et al., 2009, p.10)

Latta suggested a link between this isolation and a heightened sense of responsibility; that being a lone supporter of a survivor was both solitary and entailed a heavy burden of responsibility

(Latta, 2008). In the aftermath of intimate partner femicide, mental health professionals in Spencer-Carver's research also talked about the isolation of victims' relatives, but as part of the complicated picture around grief (Spencer-Carver, 2008), and the author described the isolating dual stigma of having had DV in the family, and having had a relative murdered.

Anger and frustration were also spoken about; the niece of a survivor in Erlingsson and colleagues' research talked about her anger towards the perpetrator, which surfaced once she got past the shame that silenced her (Erlingsson et al., 2009). Similarly, participants in Latta's research spoke of anger towards perpetrators and of the consequent difficulty of being near them, and having to act as if they knew nothing (Latta, 2008).

Authors of articles relating to post-intimate partner femicide studies described anger in relation to other emotions such as sadness, frustration and helplessness that formed part of the grief process for people who had lost a loved one (McNamara, 2008; Spencer-Carver, 2008). At a level lower than anger, participants also talked about their frustration. In particular, they linked frustration with their engagement with survivors who seemed to disregard advice or suggestions offered, as a friend to a survivor described:

> *After a while you, it seems you become a little bit callous about this sometimes because you try to help, you offer your advice, you offer suggestions, you spend hours on the phone helping a person out, but they never take it or they always go back to the same situation* (A friend to a survivor, interviewed by Latta, 2008, p.147)

Latta went on to describe the lengthy process from disclosure to the end of the abusive relationship as exhausting, and mentioned the frustration of participants in relation to the seeming lack of results from all that they had invested to support the survivor (Latta, 2008). Frustration seemed to occur regardless of people's knowledge, understanding and prior experience of DV; one participant with extensive professional experience of working with survivors, spoke of her frustration in trying to support her sister-in-law, whilst participants in

Bennett's research spoke of their frustration with fellow-survivors, when women who had described their partners as highly abusive, decided to returned home:

> *...[A]nd by dinner time she was talking about going home - I was gob-smacked coz she hadn't a good word to say about him - we all tried to get her to stay but by teatime she had gone! - nobody could get their heads round it* (A friend to a survivor, Bennett, 2006, p.46)

Moreover, mental health professionals, in Spencer-Carver's study, spoke of a very specific frustration for families and neighbours post-intimate partner femicide, which concerned being excluded and ignored when it came to seeking justice and a voice in court proceedings (Spencer-Carver, 2008).

With regards to the chronic psychological and emotional impacts mentioned, there seemed to be different trajectories depending on whether or not the domestic violence had ended tragically. For friends and family members post-intimate partner femicide, much of what was described related to bereavement, with network members feeling a combination of sadness, regret and anger, as models of grief predict (Kubler-Ross & Kessler, 2005). However, there were a number of factors that made their grief more complex than usual: their loved one had been murdered rather than having died naturally, and the murder had been committed by someone they knew. There is also stigma attached to violent deaths which may lead to isolation.

Along with these complexities related to loss, many people may have been suffering from PTSD, which is known to impact on bereavement, inhibiting the normal mourning process, and can result in people being at higher risk of developing complicated grief (Nakajima, Ito, Shirai, & Konishi, 2012) - where symptoms last longer, and are more intense and painful compared to the majority of bereavements (Rosner, Lumbeck, & Geissner, 2011). Complicated grief has been shown to be associated with further physical and mental health sequelae (Rosner et al., 2011).

For network members whose loved one survived the abuse, the picture was somewhat different, often with powerlessness feeding into frustration, leading to anger and emotional exhaustion, which could prompt the friend or relative to disengage from the survivor. Their sense of helplessness mirrors that of the survivor, with both feeling the entrapment of the situation. Even those who worked with DV survivors or who were survivors themselves, described their frustration. There was something very difficult about supporting someone they knew and cared for who was making choices they did not agree with.

Frustration towards survivors who remained in the relationship could lead to emotional fatigue in network members, and witnessing incidents, or hearing disclosures of incidents over time, led to anger towards the perpetrator, which remained unexpressed. Shame, worry and isolation acted as compounding features, producing a melange of distress, with friends and relatives lacking voice and outlet for what they were experiencing.

The psychological impacts described are not unique to those supporting a friend or relative through DV; findings from research with carers of patients with cancer, dementia, substance abuse and eating disorders likewise describe the fear, stress, helplessness, worry and depression that those providing support experience (Ellis, 2012; Figueiredo, Gabriel, Jácome, Cruz, & Marques, 2014; Guillevin et al., 2013).

Direct impacts from the perpetrator. More than half of the papers revealed, either through research with network members or with third parties, a level of direct perpetration against friends, relatives and co-workers. Participants not only described physical violence, threatening behaviour and harassment from the main perpetrator, but also in some cases, from the perpetrator's network, or even their own partner, as a result of living in a community environment where DV was endemic. In articles describing fatal DV, authors highlighted the increased risk to friends and relatives and, even where the outcome of the DV was less extreme,

authors drew attention to the potential for harm spilling over into the lives of those closest to the survivor (Hobart, 2002; Salari, 2007).

Several participants described being in danger of physical harm, or even death, themselves. One friend to a survivor expressed how at risk she felt when the survivor's boyfriend was angry (Latta, 2008), and a neighbour and friend of a victim of fatal DV discussed her ongoing concerns that the perpetrator or his family might try to murder her (Hardesty et al., 2008). In response to feeling unsafe, friends and family members avoided perpetrators and, in some cases, excluded them from their networks, rather than risking potential violence.

Third-party report, in the Washington State domestic violence fatality review and in Salari's media review, highlighted the extent of the danger by mentioning secondary victims in cases of intimate partner femicide (Hobart, 2002; Salari, 2007). The murders of friends and relatives mentioned in these articles took place during the same incident as the intimate partner murder and, in Hobart's review, ten adult friends and family members, three new boyfriends, and one work colleague of the primary victim were killed (Hobart, 2002). Salari's review of homicide-suicides found that sixteen secondary victims were also injured or killed, and she highlighted that in cases perpetrated by an intimate terrorist there tended to be a protracted period of terror for secondary victims before they were murdered (Salari, 2007). Two cases from this review illustrate the danger to those connected with the primary murder victim:

> *...[T]he couple was recently estranged after a 38 year marriage, the husband (60) had calmly played golf in the morning and later that day chased his screaming wife (57) down street and shot her in the back of the head. When police arrived, he shot himself. These events took place in front of the neighbours, who were severely endangered and traumatized by the incident* (Author summary by Salari, 2007, p.448)

> *In a Pennsylvania case, the former husband (78) (divorced 30 years ago) stalked and found his ex-wife (75) and her current husband (71) and killed them in their own basement, before he killed himself at the scene* (Author summary by Salari, 2007, p.448)

In addition, authors gave examples of women who had been murdered by their sisters' estranged partners, and mentioned two men who dated a survivor after her divorce and were consequently assaulted and threatened themselves; with one man having his nose broken by the perpetrator and another receiving death threats (Hardesty et al., 2008; Hobart, 2002). Wolf and colleagues also reported risk of harm to friends and family; showing that whilst women who sought protection orders were less likely to be physically assaulted or injured themselves, that their family members or friends were actually *more* likely to be physically assaulted as a result (Wolf, Holt, Kernic, & Rivara, 2000).

Furthermore, survivors' co-workers were not exempt from danger. Data from Swanberg and colleagues showed that the risk of physical harm to this group was very real because it was part of a repertoire of interference tactics that perpetrators frequently employed in survivors' workplaces (Swanberg & Logan, 2005; Swanberg, Macke, & Logan, 2007).

Taking a step towards a broader picture of perpetration, Raghavan and colleagues considered associations among community factors and partner violence, and demonstrated a relationship between network IPV and personal experience of IPV (Raghavan, Mennerich, Sexton, & James, 2006). Similarly, Salari described the potential contagion effect in homicide-suicide DV cases, noting that events often did not exist in isolation but as a cluster in the local geographic vicinity (Salari, 2007).

Several authors proposed that the potential for harm, or actual harm, had an influence on the decision-making of survivors, particularly whether or not they disclosed to family and asked them for support, whether or not they sought help from professionals, and whether or not they left the relationship (Davis, Taylor, & Furniss, 2001; Riger, Raja, & Camacho, 2002; Wolf et al., 2000). There was also a suggestion that fear for their own safety would affect the reactions and assistance offered by family and friends (Latta, 2008; Riger et al., 2002).

In addition to the potential for direct physical harm, some studies highlighted a number of people in the survivor's network who had experienced threats, terrorisation, intimidation or harassment by the perpetrator. In research by Wolf and colleagues, survivors reported not only an increased risk of actual violence to their network members, as they sought a protection order, but also of threats being made (Wolf et al., 2000). In work-place settings, survivors described perpetrators making direct threats against co-workers, with work by Swanberg and colleagues demonstrating that this tactic was often used repeatedly (Swanberg & Logan, 2005; Swanberg, Macke, & Logan, 2006; Swanberg et al., 2007). In addition, a friend to a survivor described the threats the perpetrator was making to harm her, his menacing behaviour, and how he had begun stalking her (Latta, 2008).

Third-party report in Hobart's fatality review revealed the extent of threatening behaviour from perpetrators which was directed towards family and friends, and the potential for its escalation, with almost two-thirds of narratives mentioning the abuser's threats to kill someone other than the woman herself (Hobart, 2002). One perpetrator made threats to *'blow (the) head off'* his girlfriend's mother, and then a month later, threatened to kill the family of his subsequent girlfriend. A short while after, this assailant broke into the home of his estranged girlfriend where he shot both her and her sister (Hobart, 2002).

Harassment by the perpetrator was also not uncommon and the review conducted by Hobart highlighted the extent to which harassment could encompass those surrounding the survivor:

> *...[T]hree stalkers each engaged in one or more of these behaviors:...calling family members, harassing friends for information... In another case, the abuser stalked his ex-wife, learned she was dating another man, and then began stalking the new boyfriend as well* (Author summary by Hobart, 2002, p.57)

In a health impact assessment on DV, carried out by Hoile, findings indicated that all of the survivors' families were *'to a various degree, intimidated, harassed or bullied'* (Hoile, 2001).

Five further studies showed that perpetrators often called the woman's friends and co-workers in an attempt to find her, sometimes with high frequency (Latta, 2008; Riger et al., 2002; Swanberg & Logan, 2005; Swanberg et al., 2006; Swanberg et al., 2007). The colleagues of women who had chosen to make a disclosure in the work place were more likely to have been on the receiving end of this harassment (Swanberg et al., 2006). Several authors noted the strength of influence that behaviours directed towards relatives or friends may have had on their ensuing perceptions and responses (Goodkind, Gillum, Bybee, & Sullivan, 2003; Latta, 2008; Riger et al., 2002).

It was clear that threat to safety was potentially an issue for anyone who was part of the social network of a survivor; that family members, friends, neighbours, subsequent partners and co-workers all need to be considered in terms of risk. Fear and threat were mentioned in conjunction with possibility of actual physical harm, and it may be that these influence the behaviour of network members in determining whether to distance themselves from the survivor or not.

Certainly, where violence had reached life-threatening levels, the research indicated a not insubstantial risk of physical harm to those associated with the survivor, although it is noteworthy that in all the murder cases reported, the killing of a friend or family member took place concurrently with the intimate partner femicide. It is possible that physical proximity is a key part of the picture around fatal impact.

Threats by a perpetrator against friends, family and co-workers appeared to have a number of functions. At their most transparent, they were communications of intended harm, but being threatened also created a sense of fear that impacted on the survivor and on her network, with the perceptions and responses of friends and family towards the survivor being affected. Likewise with harassment, because it creates a barrier so that people feel less inclined to remain involved in the situation.

Both the directly threatening behaviour and the harassment experienced by individuals in the survivor's social network have the potential to impact on wellbeing (Kamphuis & Emmelkamp, 2001). Psychologically, we know that depression, anxiety and PTSD can result, and physically, that sleep can be affected for people on the receiving end of these kinds of behaviour (Lewis, Coursol, & Herting Wahl, 2002; Pathe & Mullen, 1997).

Beneficial impacts on psychological wellbeing. The suggestion of positive impacts on psychological wellbeing was somewhat surprising, with articles mentioning or alluding to constructive or affirming effects of finding oneself in the position of supporting a survivor. The articles mentioning this included: those where research focussed on the impact of DV (including having a survivor as a friend or relative) on the attitudes and practices of healthcare professionals towards patients, and those which examined the relationships of survivors with one another.

The idea that being a friend to a woman who has experienced DV could validate one's own progress, was introduced in Henderson's study researching peer-provided support in refuges:

> *They felt that they understood what the new women were going through and that they were equipped to help...these women enjoyed the new feelings of confidence as well as the proof that they had made progress from the stage where they felt as needy as the new women* (Author summary by Henderson, 1995, p.122)

Henderson described this validation of progress as a process where *'the ability to offer support was viewed by the "givers" to be evidence of their own recovery'*, and spoke of the reinforcing and long-lasting impacts of this (Henderson, 1995). Linked with this validation, was an increase in self-esteem that survivors spoke about; where participants described feeling good about themselves, experiencing a new sense of confidence and an increased sense of self-respect, as a consequence of being able to offer friendship to others. The interplay between roles of *supporter* and *supported*, within friendships between survivors, was described in a few

articles, and seemed to capture something of the beneficial effect of exchange or *reciprocity* within these relationships (Henderson, 1995; Pennell & Francis, 2005).

The two studies looking at friendships in refuge settings (Bennett, 2006; Henderson, 1995) also made reference to a heightened awareness, with participants describing how sharing their story with other survivors had opened their eyes to their own experiences:

> *And I guess I didn't realize how abusive, until I got to speaking to people in the house and, hearing myself telling the story about how he was before made me think, geeze you know, that's been awful* (Fellow-survivor, interviewed by Henderson, 1995, p.123)

Raghavan and colleagues commented on the *limitations* of reciprocity in community settings where rates of DV are high, noting that even if network members are sympathetic, that being in an abusive relationship themselves, may preclude people from providing tangible assistance (Raghavan et al., 2006).

Some network members, in the aftermath of intimate partner femicide, described their experiences as having given them an impetus and desire to reach out to other abused women (Hardesty et al., 2008; McNamara, 2008). In addition, network members expressed not only an increase in their compassion and understanding for their friend or family member during the journey alongside them, but also a general raising of their awareness about DV (Latta, 2008).

Beyond this sensitisation and sense of altruism in the personal realm, there were also studies which highlighted participants being better able to perform their job, having become more aware of the needs of others as a result of exposure to DV. Authors of papers about research with health workers reported that exposure to DV (including indirect exposure to a friend or family member's relationship) had impacted on their participants' clinical practice with DV survivors (Christofides & Silo, 2005; Moore, Zaccaro, & Parsons, 1998; Stenson & Heimer, 2008). Christofides and Silo demonstrated that those whose exposure to DV pertained to an abusive relationship of a friend or family member, were more likely to have identified

cases of DV and to have shown survivors better care, higher even than those whose exposure had been within their own intimate relationship (Christofides & Silo, 2005).

Stenson and Heimer's study, with Swedish healthcare workers, reported similar findings: that staff who had an awareness of violence, within their own family or among their acquaintances, were more likely to identify abused women (Stenson & Heimer, 2008). The authors of papers reporting studies with healthcare professionals explored a very particular slant on being sensitised to the needs of others, with the benefits not necessarily to network members on a personal level, but rather on a professional level; they were better able to respond to patients in their care.

In scenarios where friends or relatives were themselves DV survivors, there appeared to be a strong pull towards offering support to abused women who crossed their path. From research based in refuge settings, being able to offer assistance to another survivor was experienced as an indication of growth. Moreover, the beneficial impacts of providing friendship to other survivors included opportunities to offer opinions, or do things for others, which increased women's overall sense of competence and self-worth.

When a survivor offered support to a friend or family member who was experiencing violence, it is possible that a sense of reciprocity developed as they banded together, finding solidarity. Whilst the idea of beneficial impacts seemed paradoxical, perhaps it should not be surprising; after all, an underpinning concept of the refuge set-up was that women gained in a variety of ways from interacting with one another in this communal context (Delahay & Turner, 1998; Stark, 2007). Moreover, if we consider the wider literature related to suffering and gain from altruism, it becomes clearer that these beneficial effects are far from unlikely.

Staub and Vollhardt considered the connection between suffering and helping other people, and suggest that there is a promotion of healing for the likewise-victimised helper

(Staub & Vollhardt, 2008). They point to *'survivor mission'*, which refers to a deep commitment by victims of violence to be part of the prevention of future suffering, and propose that genuine post-traumatic growth occurs when cognitive changes are transformed into action, including the activity of supporting others. In addition, Midlarsky's work on altruism proposes several ways in which helping others may benefit the helper: it can provide distraction from one's own troubles, it can enhance the sense of value of one's own life, it has a positive impact on self-evaluation, it increases positive mood, and it facilitates social integration (Midlarsky, 1991).

Overall, the findings from this literature review are consistent with these ideas, however, there was one exception, in communities where general levels of violence were high. Here the potential for reciprocity appeared be constrained by survivor and perpetrator assumptions about the normality and acceptability of DV.

Several network members, who were not themselves survivors, described a need to *do* something to support others, which was also reflected in data from healthcare workers whose clinical responsiveness to abused women was enhanced as a result of DV exposure. People who had supported a survivor and seen positive outcomes to this assistance may have felt edified and inspired to support others, or may simply have been more sensitive and observant generally to distress, and thus more likely to identify survivors of DV around them.

Discussion

Psychological and emotional effects emerged as the primary impact on the wellbeing of members of the survivor's network. Within this theme there was a spectrum of experience. Impacts related to trauma, such as shock and fear often resulted from witnessing events first-hand or from initial survivor disclosure, whereas impacts such as powerlessness, anxiety, loss, low mood, frustration, guilt and self-blame, tended to develop over time and potentially

persisted. This was especially the case when the survivor remained in the abusive relationship, or there were on-going consequences (continued abuse, child access issues or caring responsibilities following the murder of a woman).

These longer term impacts were akin to those that might be experienced by people offering informal support to loved ones in challenging or stigmatised situations, such as those battling with substance abuse or an eating disorder (Highet, Thompson, & King, 2005). In the case of DV, however, the source of harm is another person, which adds a further stigma and risk. With regards to trauma-related impacts, what friends and relatives reported was consistent with symptoms of post-traumatic stress disorder (PTSD), or acute stress disorder (ASD), caused either by direct exposure to abusive events, or by hearing distressing information about incidents (*Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR)*, 2000; "Post-Traumatic Stress Disorder (PTSD)," n.d.).

Not all the impacts on psychological wellbeing were described as negative; the journeying alongside a survivor could have constructive or affirming effects. For some, who were survivors of DV themselves, this was about an increased sense of agency and a validation of the progress they had made, in addition to a powerful sense of reciprocity, mutual support and understanding, which led to growth and depth of relationship between fellow-survivors. This links with the underpinning concepts upon which early refuges were based, and with the idea of reciprocal gains from altruism born of suffering (Delahay & Turner, 1998; Smith, Coleman, Eder, & Hall, 2011). For those who had a professional role which brought them into contact with survivors, there was an indication that personal exposure (through the experiences of a friend or relative) led clinicians to respond better to those in their care.

People also described physical health impacts in the particular scenario where DV was fatal, with relatives who took on caregiver roles being at particular risk of ill-health. This could occur as a consequence of cumulative stress, possible PTSD, and not prioritising their own

healthcare due to time and financial constraints resulting from caring for traumatised children whilst grieving themselves (Cohen, Janicki-Deverts, & Miller, 2007; Schnurr & Jankowski, 1999).

The behaviour of the perpetrator also had direct impact on the survivor's network. Much of what was described looked familiar in terms of behaviours that we know perpetrators use against survivors, and, in the scenario of intimate partner femicide, being in the vicinity put friends, family members, colleagues and neighbours in danger of physical harm or even death. As a result of direct perpetrator behaviours, some people chose to retreat, removing themselves from possible threat but, for others, the exposure added illumination to the situation and made them more willing to be involved in some way.

We know that resilience against the impact of negative events and stressors varies at the individual level, and across time and circumstance (Margolin & Gordis, 2004), but the findings also indicated a mediation of *what* was experienced, depending on the relationship the network member had with the survivor. For example, fear for one's own safety was more often expressed by people who had witnessed or been in close proximity when physically abusive behaviours (including murder) were taking place - usually friends, neighbours and colleagues rather than family members.

Limitations

One limitation of this research is that even though a very broad definition of DV was used to capture experiences relating to as wide a range of survivors as possible, only experiences of informal supporters of survivors of *intimate partner violence* in heterosexual relationships were identified. There are also some limits to the generalisability of findings due to the nature of the primary studies: most were conducted in the USA, no study included participants aged over 50

years, and there was little ethnic diversity in the participants (almost exclusively White or African American).

In addition, because this is a largely unexplored topic, relevant data were scant, disparate, and in a variety of forms due to diverse research designs of the primary studies. Using meta-ethnographic methods, it was feasible to translate findings into one another, and employ some inference, but virtually no refutation was possible.

Conclusion

This is the first systematic review to explore the impact that domestic violence can have on those providing informal support to survivors. Whilst providing some illumination, it has also exposed the gap in extant literature. First-hand experiences of adult members of the survivor's network have rarely been sought, and where they have, the *impact* of these experiences has not previously been the primary focus of any study. The potential impacts on friends, relatives, colleagues and neighbours are diverse, frequently life-changing, and occasionally fatal.

The findings from this review indicate the need for existing policies and guidelines for tackling domestic violence and managing its impacts to be extended to include the range of people who may be negatively affected. For professionals there is a need to be mindful of all the potential victims in domestic violence scenarios, to avoid blaming those around survivors for perceived inaction or wrong responses, when they themselves may be traumatised.

Instead, a broader conception of DV is required, which encompasses the diffusion of impacts within communities. Future research must explore the impact on those surrounding the survivor directly and triangulate perspectives so that abusive relationships are considered from multiple viewpoints, broadening our understandings around abuse tactics, disclosure, help seeking, and responses from informal supporters. To improve the support survivors receive

from those around them, we first need to understand what it means to be an informal supporter (Gregory, 2014).

References

Acute stress disorder. (2007). Retrieved from http://www.psychologytoday.com/conditions/acute-stress-disorder (accessed 08_07_2014)

Allenou, C., Olliac, B., Bourdet-Loubère, S., Brunet, A., David, A., Claudet, I., . . . Birmes, P. (2010). Symptoms of traumatic stress in mothers of children victims of a motor vehicle accident. *Depress Anxiety, 27*(7), 652-657.

Beeble, M., Post, L., Bybee, D., & Sullivan, C. (2008). Factors related to willingness to help survivors of intimate partner violence. *J Interpers Violence, 23*(12), 1713-1729.

Bennett, D. (2006). *How do the new friendships women make in a refuge help them cope with refuge life?* (MSc), University of Bristol.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *Journal of Health Services Research & Policy, 7*(4), 209-215.

Bucki, B., Spitz, E., & Baumann, M. (2012). Caring for a stroke victim: the emotional reactions of male and female caregivers. *Sante Publique, 24*(2), 143-156.

Christofides, N., & Silo, Z. (2005). How nurses' experiences of domestic violence influence service provision: Study conducted in North-west Province, South Africa. *Nursing & Health Sciences, 7*(1), 9-14.

Cohen, S., Janicki-Deverts, D., & Miller, G. (2007). Psychological stress and disease. *JAMA, 298*(14), 1685-1687.

Coker, A., Smith, P., Thompson, M., McKeown, R., Bethea, L., & Davis, K. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of women's health & gender-based medicine, 11*(5), 465-476.

Coker, A., Watkins, K., Smith, P., & Brandt, H. (2003). Social support reduces the impact of partner violence on health: Application of structural equation models. *Preventative Medicine, 37*(3), 259-267.

Davis, K., Taylor, B., & Furniss, D. (2001). Narrative accounts of tracking the rural domestic violence survivors' journey: A feminist approach. *Health Care for Women International, 22*(4), 333-347.

Delahay, L., & Turner, A. (1998). *Refuge services: Meeting the needs of women and children?* Retrieved from Bristol:

Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR). (2000). (4th ed.): American Psychiatric Association.

Dixon-Woods, M., Kirk, D., Agarwal, S., Annandale, E., Arthur, T., Harvey, J., . . . Sutton, A. (2005). *Vulnerable groups and access to health care: A critical interpretive review - Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO)*. Retrieved from http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0004/81292/ES-08-1210-025.pdf (accessed 14_04_2014)

Domestic violence and abuse: How health services, social care and the organisations they work with can respond effectively. (2014). Retrieved from London: http://www.nice.org.uk/nicemedia/live/14384/66668/66668.pdf (accessed 29_04_2014)

Domestic violence and abuse: New definition. (2013). Retrieved from https://www.gov.uk/domestic-violence-and-abuse#domestic-violence-and-abuse-new-definition (accessed 19_02_2014)

Ellis, J. (2012). The impact of lung cancer on patients and carers. *Chronic Respiratory Disease, 9*(1), 39-47.

Ellsberg, M., Jansen, H., Heise, L., Watts, C., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet, 371*(9619), 1165-1172.

Erlingsson, C. (2007). *Elder abuse through a prism of perceptions: perspectives of potential witnesses*. (PhD), Umea University, Sweden. Retrieved from http://umu.diva-portal.org/smash/get/diva2:140861/FULLTEXT01.pdf (accessed 18_06_2014)

Erlingsson, C., Carlson, S., Astrom, S., & Saveman, B. (2009). Dilemmas in witnessing elder abuse in caregiving situations: A family member perspective. *Southern Online Journal of Nursing Research, 9*(1). Retrieved from http://www.resourcenter.net/images/snrs/files/sojnr_articles2/Vol09Num01Art12.pdf (accessed 18_06_14)

Espié, E., Gaboulaud, V., Baubet, T., Casas, G., Mouchenik, Y., Yun, O., . . . Moro, M. (2009). Trauma-related psychological disorders among Palestinian children and adults in Gaza and West Bank, 2005-2008. *Int J Ment Health Syst., 3*(21).

Fanslow, J., & Robinson, E. (2010). Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand. *J Interpers Violence, 25*(5), 929-951.

Figueiredo, D., Gabriel, R., Jácome, C., Cruz, J., & Marques, A. (2014). Caring for relatives with chronic obstructive pulmonary disease: how does the disease severity impact on family carers? *Aging & Mental Health, 18*(3), 385–393.

Fry, P., & Barker, L. (2002). Quality of relationships and structural properties of social support networks of female survivors of abuse. *Genet Soc Gen Psychol Monogr, 128*(2), 139-163.

García-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-country study on women's health and domestic violence against women*. Retrieved from Geneva: http://www.who.int/gender/violence/who_multicountry_study/en/ (accessed 04_03_2014)

Goodkind, J., Gillum, T., Bybee, D., & Sullivan, C. (2003). The impact of family and friends' reactions on the well-being of women with abusive partners. *Violence Against Women, 9*(3), 347-373.

Goodman, L., Dutton, M., Vankos, N., & Weinfurt, K. (2005). Women's resources and use of strategies as risk and protective factors for reabuse over time. *Violence Against Women, 11*(3), 311-336.

Gregory, A. (2014). *On the outside looking in: the shared burden of domestic violence.* (PhD), University of Bristol, UK.

Guillevin, L., Armstrong, I., Aldrighetti, R., Howard, L., Ryftenius, H., Fischer, A., . . . Ferrari, P. (2013). Understanding the impact of pulmonary arterial hypertension on patients' and carers' lives. *European Respiratory Review, 22*(130), 535-542.

Hardesty, J., Campbell, J., McFarlane, J., & Lewandowski, L. (2008). How children and their caregivers adjust after intimate partner femicide. *Journal of Family Issues, 29*(1), 100-124.

Henderson, A. (1995). Abused women and peer-provided social support: The nature and dynamics of reciprocity in a crisis setting. *Issues in Mental Health Nursing, 16*(2), 117-128.

Highet, N., Thompson, M., & King, R. (2005). The experience of living with a person with an eating disorder: The impact on the carers. *Eating Disorders, 13*(4), 327-344.

Hobart, M. (2002). *"Tell the world what happened to me." Findings and recommendations from the Washington State domestic violence fatality review 2002*. Retrieved from Washington State:

Hoile, O. (2001). *Health impact assessment of domestic violence. Project report*. Retrieved from

Kamphuis, J., & Emmelkamp, P. (2001). Traumatic distress among support-seeking female victims of stalking. *Am J Psychiatry, 158*(5), 795-798.

Klein, R. (2012). *Responding to intimate violence against women: The role of informal networks*. New York: Cambridge University Press.

Kubler-Ross, E., & Kessler, D. (2005). *On grief and grieving: Finding the meaning of grief through the five stages of loss*. London: Simon & Schuster.

Latta, R. (2008). *Struggling to define my role: The experience of network members who intervened in intimate partner violence.* (PhD), Boston College, US.

Latta, R., & Goodman, L. (2011). Intervening in partner violence against women: Grounded Theory exploration of informal network members' experiences. *The Counselling Psychologist, 39*(7), 973-1023.

Lewis, J., Coursol, D., & Herting Wahl, K. (2002). Addressing issues of workplace harassment: Counseling the targets. *Journal of Employment Counseling, 39*(3), 109-116.

Margolin, G., & Gordis, E. (2004). Children's exposure to violence in the family and community. *Current Directions in Psychological Science, 13*(4), 152-155.

McNamara, P. (2008). Changed forever: Friends reflect on the impact of a woman's death through intimate partner violence. *Journal of Family Studies, 14*(2-3), 198-216.

Midlarsky, E. (1991). Helping as coping. In M. Clark (Ed.), *Prosocial behavior: Review of personality and social psychology* (pp. 238-264). CA: SAGE.

Moore, M., Zaccaro, D., & Parsons, L. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 27*(2), 175-182.

Nahm, E., Resnick, B., Orwig, D., Magaziner, J., & Degrezia, M. (2010). Exploration of informal caregiving following hip fracture. *Geriatric Nursing, 31*(4), 254-262.

Nakajima, S., Ito, M., Shirai, A., & Konishi, T. (2012). Complicated grief in those bereaved by violent death: The effects of post-traumatic stress disorder on complicated grief. *Dialogues Clin Neurosci., 14*(2), 210-214.

Noblit, G., & Hare, R. (1988). *Meta-ethnography: Synthesising qualitative studies*. Newbury Park, California: SAGE.

Paquin, G. (1994). A statewide survey of reactions to neighbors' domestic violence. *Journal of Interpersonal Violence, 9*, 493-502.

Parker, G., & Lee, C. (2002). Violence and abuse: An assessment of mid-aged Australian women's experiences. *Australian Psychologist, 37*(2), 142-148.

Pathe, M., & Mullen, P. (1997). The impact of stalkers on their victims. *Br J Psychiatry, 170*, 12-17.

Pennell, J., & Francis, S. (2005). Safety conferencing: Toward a coordinated and inclusive response to safeguard women and children. *Violence Against Women, 11*(5), 666-692.

Plazaola-Castano, J., Ruiz-Perez, I., & Montero-Pinar, M. (2008). The protective role of social support and intimate partner violence. *Gaceta Sanitaria, 22*(6), 527-533.

Post-Traumatic Stress Disorder (PTSD). (n.d.). Retrieved from http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml (accessed 09_07_2014)

Raghavan, C., Mennerich, A., Sexton, E., & James, S. (2006). Community violence and its direct, indirect, and mediating effects on intimate partner violence. *Violence Against Women, 12*(12), 1132-1149.

Riger, S., Raja, S., & Camacho, J. (2002). The radiating impact of intimate partner violence. *Journal of Interpersonal Violence, 17*(2), 184-205.

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. Burgess (Eds.), *Analyzing qualitative data* (pp. 173-194): Routledge.

Rosner, R., Lumbeck, G., & Geissner, E. (2011). Effectiveness of an inpatient group therapy for comorbid complicated grief disorder. *Psychotherapy research, 21*(2), 210-218.

Salari, S. (2007). Patterns of intimate partner homicide suicide in later life: Strategies for prevention. *Clin Interv Aging, 2*(3), 441–452.

Schnurr, P., & Jankowski, M. (1999). Physical health and post-traumatic stress disorder: Review and synthesis. *Seminars in clinical neuropsychiatry, 4*(4), 295-304.

Smith, K., Coleman, K., Eder, S., & Hall, P. (2011). *Home Office statistical bulletin: Homicides, firearm offences and intimate violence 2009/10: Supplementary volume 2 to 'Crime in England and Wales 2009/10' (2nd Edition)*. Retrieved from London: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb0111/hosb0111?view=Binary (accessed 05_03_2014)

Spencer-Carver, E. (2008). Social support for children who had a parent killed by intimate partner violence: Interviews with mental health workers. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 69*(6-A), 2456.

Stark, E. (2007). *Coercive control*. Oxford: Oxford University Press.

Staub, E., & Vollhardt, J. (2008). Altruism born of suffering: The roots of caring and helping after victimization and other trauma. *American Journal of Orthopsychiatry, 78*(3), 267-280.

Stenson, K., & Heimer, G. (2008). Prevalence of experiences of partner violence among female health staff. *Women's Health Issues, 18*, 141-149.

Swanberg, J., & Logan, T. (2005). Domestic violence and employment: A qualitative study. *Journal of Occupational Health Psychology, 10*(1), 3-17.

Swanberg, J., Macke, C., & Logan, T. (2006). Intimate partner violence, women, and work: Coping on the job. *Violence and Victims, 21*(5), 561-578.

Swanberg, J., Macke, C., & Logan, T. (2007). Working women making it work: Intimate partner violence, employment, and workplace support. *Journal of Interpersonal Violence, 22*(3), 292-311.

Sylaska, K., & Edwards, K. (2014). Disclosure of intimate partner violence to informal social support network members: A review of the literature. *Trauma, Violence & Abuse, 15*(1), 3-21.

Tan, C., Basta, J., Sullivan, C., & Davidson, W. (1995). The role of social support in the lives of women exiting domestic violence shelters: An experimental study. *Journal of Interpersonal Violence, 10*(4), 437-451.

Williamson, E., & Hester, M. (2009). *Evaluation of the South Tyneside Domestic Abuse Perpetrator Programme (STDAPP) 2006-2008*. Retrieved from http://www.bristol.ac.uk/sps/research/projects/completed/2009/rl6866/finalreport.pdf (accessed 29_04_2014)

Wolf, M., Holt, V., Kernic, M., & Rivara, F. (2000). Who gets protection orders for intimate partner violence? *Am J Prev Med, 19*(4), 286-291.

Summary Tables

- This is the first systematic literature review to consider how domestic violence impacts those informally supporting survivors (friends, relatives, colleagues and neighbours).
- None of the studies identified directly addressed the question of impact on informal supporters.
- The review highlights the potential for informal supporters to experience substantial impact to health and wellbeing, including the risk of vicarious trauma and direct physical harm.

Table 1: Critical Findings

- Primary research is needed to directly explore the impacts on informal supporters of DV survivors.
- Policies regarding domestic violence should highlight the full range of people who may be impacted by DV.
- Professionals working in the field of domestic violence need to be mindful of all the potential victims.
- A broader conception of DV is necessary to encompass the diffusion of impacts within communities.

Table 2: Implications for Research, Policy & Practice

Figures

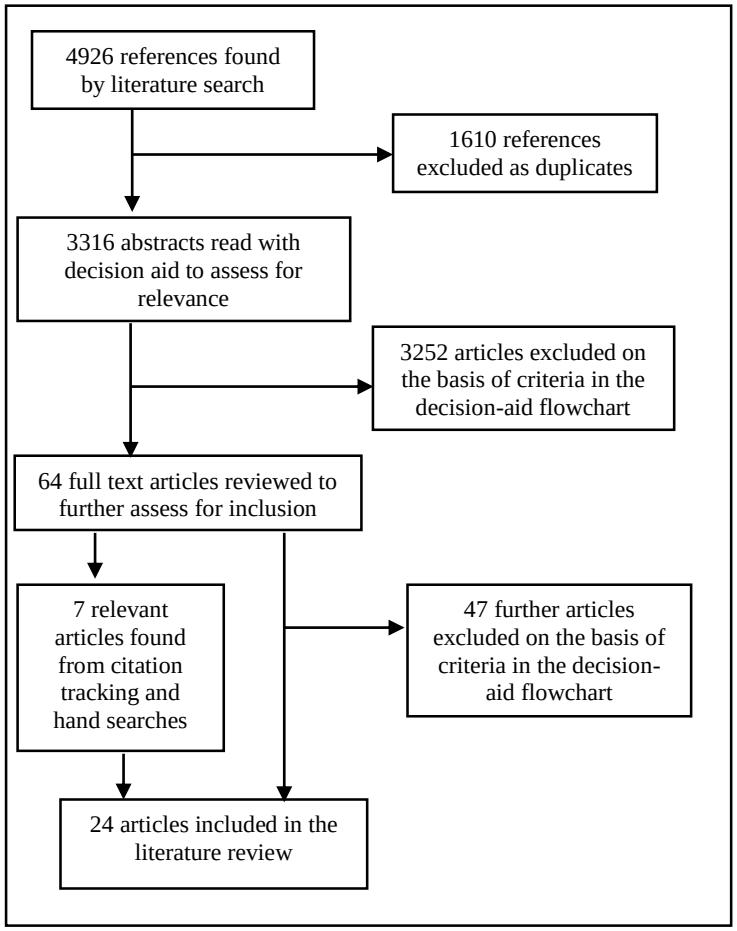

Figure 1: Summary of Search and Selection Process

Appendix A - List of Search Terms

Domestic violence terms	Who? (Population of interest)	What? (Impact on health)	
Domestic Violence (M)	Family (M)	Impact* (KW)	Health (M)
Domestic Violence (KW)	Family (KW)	Implication* (KW)	Well Being (M)
Domestic Abuse (KW)	Families (KW)	Effect* (KW)	Health* (KW)
Spous* Abuse (KW)	Family Members (M)	Consequence* (KW)	Wellbeing (KW)
Spous* Violence (KW)	Family Member* (KW)	Influence* (KW)	Well Being (KW)
Battered Woman (KW)	Friendship (M)	Repercussion* (KW)	Disease* (KW)
Battered Women (KW)	Friendship* (KW)	Outcome* (KW)	Illness* (KW)
Battered Females (M)	Friend (KW)	Reaction* (KW)	Sick* (KW)
Battered Female* (KW)	Friends (KW)	Response* (KW)	Infirm* (KW)
Battered Wife (KW)	Support Network* (KW)	Sequel* (KW)	Disorder* (KW)
Battered Wives (KW)	Social Support (M)	Ramification* (KW)	
Battered Partner* (KW)	Social Support (KW)	Aftermath (KW)	
Wife Abuse (KW)	Social Networks (M)	Result* (KW)	
Abused Wife (KW)	Social Network* (KW)		
Wife Violence (KW)	Social Groups (M)		
Wife Beating (KW)	Social Group* (KW)		
Intimate Partner Violence (M)	Peers (M)		
Intimate Partner Violence (KW)	Peer* (KW)		
IPV (KW)	Significant Others (M)		
Intimate Partner Abuse (KW)	Significant Other* (KW)		
Partner Abuse (M)	Acquaintance* (KW)		
Partner Abuse (KW)	Third Party (KW)		
Partner Violence (KW)	Third Parties (KW)		
Conjugal Abuse (KW)	3rd Party (KW)		
Conjugal Violence (KW)	3rd Parties (KW)		
Marital Abuse (KW)	Informal Support* (KW)		
Marital Violence (KW)	Informal Help* (KW)		
Woman Abuse (KW)	Community Support (KW)		
Abused Woman (KW)	Bystander (KW)		
Women Abuse (KW)	Relatives (KW)		
Abused Women (KW)			
Family Abuse (KW)			
Family Violence (KW)			
Elder Abuse (M)			
Elder Abuse (KW)			
Elder Violence (KW)			
Marital Aggression (KW)			
Relational Aggression (KW)			
Relationship Aggression (KW)			
Partner Aggression (KW)			
Interpersonal Violence (KW)			
Intimate Terrorism (KW)			

Key:

KW - Key word search terms

M – MeSH search terms

Appendix B – Study Characteristics

	Source article (N=24)			Type of article	Country setting	Sample N (age & gender)	Ethnicity	Design & method of data collection	Aim
	Author (s)	Year	Title						
1	Henderson	1995	Abused women and peer-provided social support: The nature and dynamics of reciprocity in a crisis setting	Journal article	Canada	Study 1 N= 8 (all women) Study 2 N=9 (all women) Survivors in refuge setting	Not stated	Secondary analysis from 2 studies - both using in-depth semi-structured interviews (Qualitative)	To explore the use of social support by abused women during their stay in a transition house, in particular the special role of reciprocal help-giving
2	Moore, Zaccaro, Parsons	1998	Attitudes and Practices of Registered Nurses Toward Women Who Have Experienced Abuse/ Domestic Violence	Journal article	USA	N=275 nurses in perinatal practice (all women - 71.4% aged 30 to 50)	94.3% White 5.4% Black 0.3% Other	Questionnaire administered to: 1) convenience sample and 2) mailed to nurses working in private offices (Quantitative)	To compare the education, attitudes and practices related to DVA of perinatal nurses, (including effect of personal/family history of DV on nursing attitudes and behaviours)
3	Wolf, Holt, Kernic, Rivara	2000	Who Gets Protection Orders for Intimate Partner Violence?	Journal article	USA	N=448 survivors in Seattle with police or court contact for IPV (all women - 90%aged 18-44)	Not stated	81.2% structured telephone interview, 18.8% self-administered paper copy of survey (Quantitative)	To compare the characteristics of victims of IPV with and without protection orders
4	Hoile	2001	Health Impact Assessment of Domestic Violence: Multi-Agency Pilot Research Project, Tendring District, Essex, UK	Health Impact Assessment report	UK	N=10 with experiences associated with IPA (all women)	All White	Semi-structured in-depth interviews (Qualitative)	To examine the impact of intimate partner abuse on victims, their families, and local service providers
5	Hobart	2002	"Tell the world what happened to me." Findings and Recommendations from the Washington State Domestic Violence Fatality Review	Review Paper	USA	N=308 cases of domestic violence fatality (women and men victims - aged between 12 and 81)	70% White 10% Black 10% Hispanic	In depth review of cases by fatality review panel since 1997 (Quantitative)	A summary of DVA fatality cases tracked and reviewed in depth, highlighting recommendations
6	Riger, Raja, Camacho	2002	The Radiating Impact of Intimate Partner Violence	Journal article	USA	N=15 survivors a year after being in a DV shelter (all women – aged 19- 38)	75% African-American	Life narrative interviews on 2 occasions (Qualitative)	To explore the impact of violence including a wide variety of aspects of the victim's life as well as the lives of those in her social world
7	Goodkind, Gillum, Bybee, Sullivan	2003	The Impact of Family and Friends' Reactions on the Well-Being of Women With Abusive Partners	Journal article	USA	N=137 survivors exiting a shelter (all women - ave age 29, 81% younger than 35)	47% African American 39% Non-Hispanic White 6% Hispanic 2% Asian/Asian American	Interview - battery of questionnaires (Quantitative)	To examine the degree to which battered women talked with family and friends about abuse, and how the family and friends responded
8	Christofides, Silo	2005	How nurses' experiences of domestic violence influence service provision: Study conducted in North-west province, South Africa	Journal article	South Africa	N=212 nurses working in primary and secondary care (all women - mean age 39.5, range 23-60)	Not stated	Face-to-face interviews using standardised questionnaire (Quantitative)	To determine whether nurses' experiences of domestic violence and abuse influence their management of DVA and rape cases

9	Pennell, Francis	2005	Safety Conferencing: Toward a Coordinated and Inclusive Response to Safeguard Women and Children	Journal article	USA	N=6 DVA survivors, staff, and supporters (all women)	Varied cultural and ethnic backgrounds (no further description)	Two focus groups (Qualitative)	To explores views of DVA survivors, staff and supporters on the creation of a decision-making forum called 'Safety Conferencing'
10	Swanberg, Logan	2005	Domestic Violence and Employment: A Qualitative Study	Journal article	USA	N=32 survivors employed during the past 2 years while experiencing DVA (all women - mean age 38, range 22-54)	69% White 22% Black 3% Native American 6% Other	13 individual interviews and 7 focus groups (+ brief demographic Q'aire and modified Conflict Tactics Scale) (Qualitative)	To explore how domestic violence and abuse affects women's employment, and specifically to identify types of job interference tactics used by abusers and the impact these have
11	Raghavan, Mennerich, Sexton, James	2006	Community Violence and Its Direct, Indirect, and Mediating Effects on Intimate Partner Violence	Journal article	USA	N=50 participants receiving 'Temporary Assistance to Needy Families' on a welfare-to-work program and with an admitted drug problem (all women - aged 20-45)	44% African American 44% European American 12% Native American, Hispanic, or biracial	Interview - battery of questionnaires (Quantitative)	To examine neighborhood-level factors as possible predictors of IPV
12	Swanberg, Macke, Logan	2006	Intimate Partner Violence, Women and Work: Coping on the Job	Journal article	USA	N=518 survivors with DVA orders who had been employed during the past year (all women – mean age 31, range 17-64)	78% White 17% Black 5% Other	Face-to-face interviews using standardised and created questionnaires (Quantitative)	To examine the types and frequency of behaviours used by violent partners to interfere with women's work, the overspill into the workplace, and workplace disclosure and response
13	Bennett	2006	How do the new friendships women make in a refuge help them cope with refuge life?	Masters Dissertation	UK	N=6 women residing in a DVA refuge over a 4-week period (all women)	Not stated	52 hrs participant observation and interaction on 13 occasions (Qualitative)	To explore the formation of friendships between women in refuge
14	Erlingsson	2007	Elder abuse explored through a prism of perceptions: Perspectives of potential witnesses	PhD Thesis	Sweden	N=1 niece witnessing abuse involving her elderly uncle and aunt (woman -mid-life)	Not stated	Individual narrative interviews at 2 time points (Qualitative)	To deepen understanding of elder abuse by exploring and comparing perceptions held by experts, older persons, representatives of support organizations, and family members.
15	Salari	2007	Patterns of intimate partner homicide suicide in later life: Strategies for prevention	Journal article	USA	N= 225 murder suicide events (women and men - at least one member of dyad aged 60+)	Not stated	Content analysis of IPHS news reports between 1999 and 2005 (Mixed Methods)	To explore patterns of IP homicide among dyads with at least one member aged 60+
16	Swanberg, Macke, Logan	2007	Working Women Making It Work: Intimate Partner Violence, Employment and Workplace Support	Journal article	USA	N=485 partner victimized women who were employed during the past year (all women – ave age 32 for employed women and 29 for unemployed women)	83% White 17% Black	Interview - battery of questionnaires (Quantitative)	To investigate whether there is an association between workplace DVA disclosure, receiving support and current employment status

17	Hardesty, Campbell, McFarlane, Lewandowski	2008	How Children and Their Caregivers Adjust After Intimate Partner Femicide	Journal article	USA	N=10 informants – 9 family members and 1 friend (women and men)	6 African American 3 White 1 Mixed (White/Latino)	Semi-structured in-depth interviews (Qualitative)	To explore children's and caregivers' adjustment after IPF using family stress theory
18	Latta	2008	Struggling to define my role: the experience of network members who intervened in intimate partner violence	PhD Thesis	USA	N=18 network members (16 women and 2 men – aged 22-60)	11 White 3 African American 2 Haitian American 1 Puerto Rican 1 Asian American	Semi-structured interviews (Qualitative)	To explore the experiences of informal network members in relation to their experience of intervening in intimate partner violence
19	McNamara	2008	Changed forever: Friends reflect on the impact of a woman's death through intimate partner homicide	Journal article	Australia	N= 5 friends of a female victim of intimate partner homicide (all women – aged in their forties)	Not stated	A single focus group (Qualitative)	To explore with a small group of female friends of a victim of intimate partner homicide how that woman's death has impacted upon them and their families
20	Spencer-Carver	2008	Social support for children who had a parent killed by intimate partner violence: Interviews with mental health workers	PhD Thesis	USA	N=6 mental health professionals who worked with children who had a parent killed by IPV (all women)	5 White 1 African American	Detailed open-ended face-to-face interviews (Qualitative)	To explore the social support that children and their families have had after the death of a parent from intimate partner violence
21	Stenson, Heimer	2008	Prevalence of experiences of partner violence among female health staff: Relevance to Awareness and Action When Meeting Abused Women Patients	Journal article	Sweden	N=588 hospital-based health workers (all women, aged 20-67)	Not stated	Anonymous self-completed questionnaires (Quantitative)	To examine prevalence and awareness of partner violence among female health staff and any associations with practice and knowledge
22	Erlingsson, Carlson, Astrom, Saveman	2009	Dilemmas in Witnessing Elder Abuse in Caregiving Situations: A Family Member Perspective	Journal article	Sweden	N=1 niece witnessing abuse involving her elderly uncle and aunt (woman -mid-life)	Not stated	Individual narrative interviews at 2 time points (Qualitative)	To explore an adult family member's experiences of witnessing family situations of elder abuse
23	Amar, Bess, Stockbridge	2010	Lessons from families and communities about interpersonal violence, victimization, and seeking help	Journal article	USA	N=64 college students (all women - aged 18-25)	31% African American, non-Hispanic 23% Caucasian, non-Hispanic 16% Hispanic 13% Other 11% Mixed race/multiracial 6% Asian/Pacific Islander	8 focus groups using a semi-structured interview guide (Qualitative)	To understand socially and culturally relevant factors associated with violence help seeking in college women
24	Davis, Taylor, Furniss	2010	Narrative accounts of tracking the rural domestic violence survivors' journey: a feminist approach	Journal article	Australia	N=9 survivors of heterosexual DVA living in rural Australia (all women, aged 18+)	Not stated	Semi-structured interviews (Qualitative)	First stage of project to determine the level of use and effectiveness of informal support networks of Australian rural women.