DOMESTIC ABUSE

Lived experiences of domestic abuse and support in Wirral.

Qualitative Insight Team – Public Health

May 2026

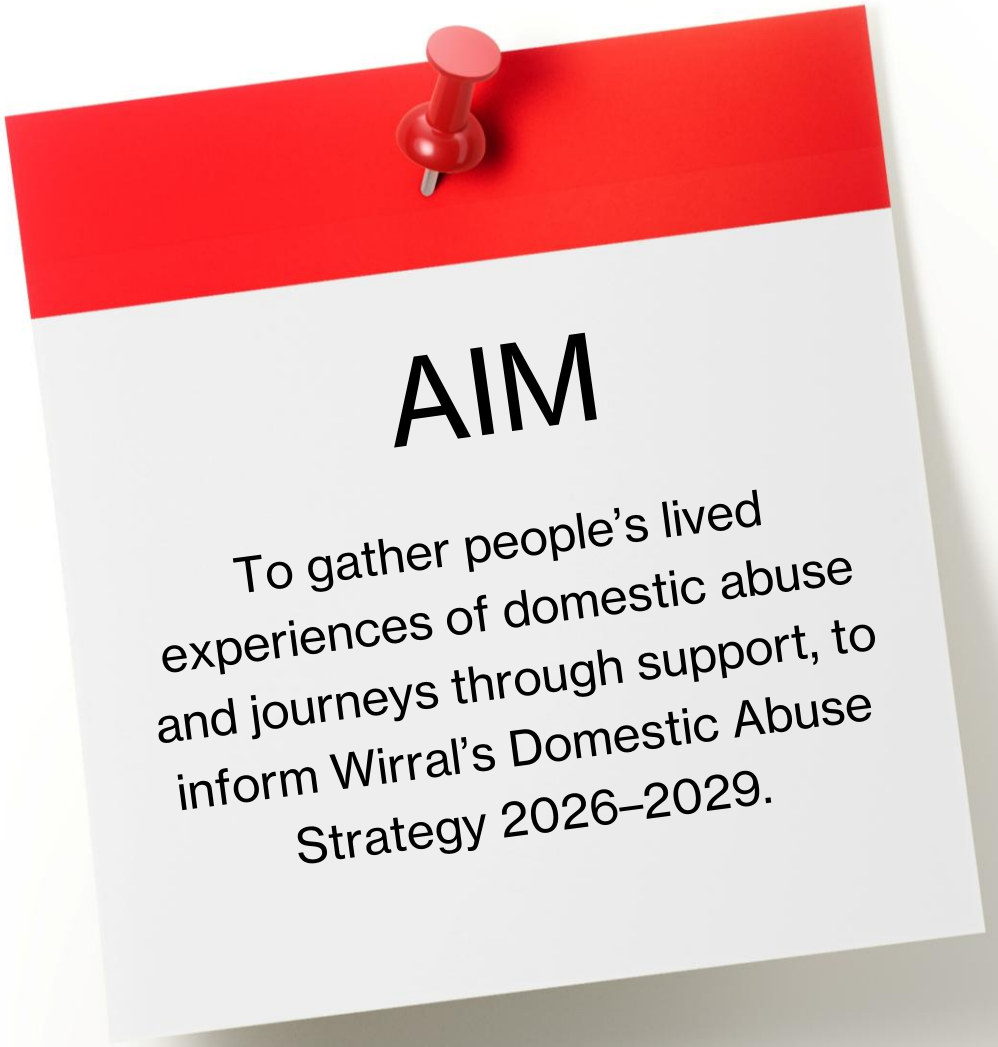
WIRRAL

TERMINOLOGY

The term **'victim'** is used in this document to refer to people with lived experience of domestic abuse. While this may not reflect how people define their own experience, the term is used for clarity and consistency and reflects commonly used language within policy and support services.

The term **'perpetrator'** is used to describe people who have caused harm. However, it is recognised that perpetrators may also have experienced abuse themselves.

The term **'professional'** is used to refer to staff and volunteers who contributed to the research in a professional capacity.



Key areas of the research:

- Experiences leading up to abuse, including risk factors, relationship dynamics, and escalation of harm.
- Motivators and barriers to disclosure and help-seeking.
- Experiences of receiving or delivering support, including gaps and opportunities for improvement.

METHODS

Participants	
Female victims	25
Professionals	22
Male victims	16
Male perpetrators	2
Total	**65**

Gathering methods	
1-1 depth interviews	12
Focus groups	11
Research grids	3

Three cohorts:

Victims of domestic abuse who have received support.

Perpetrators of domestic abuse who have received behaviour change support.

Professionals across health, wellbeing, housing, maternity, social work, legal and behaviour change sectors.

Participants were recruited through community partners.

Conversations took place in community venues.

Ages ranged from early 20s to late 70s.

TARGET GROUPS

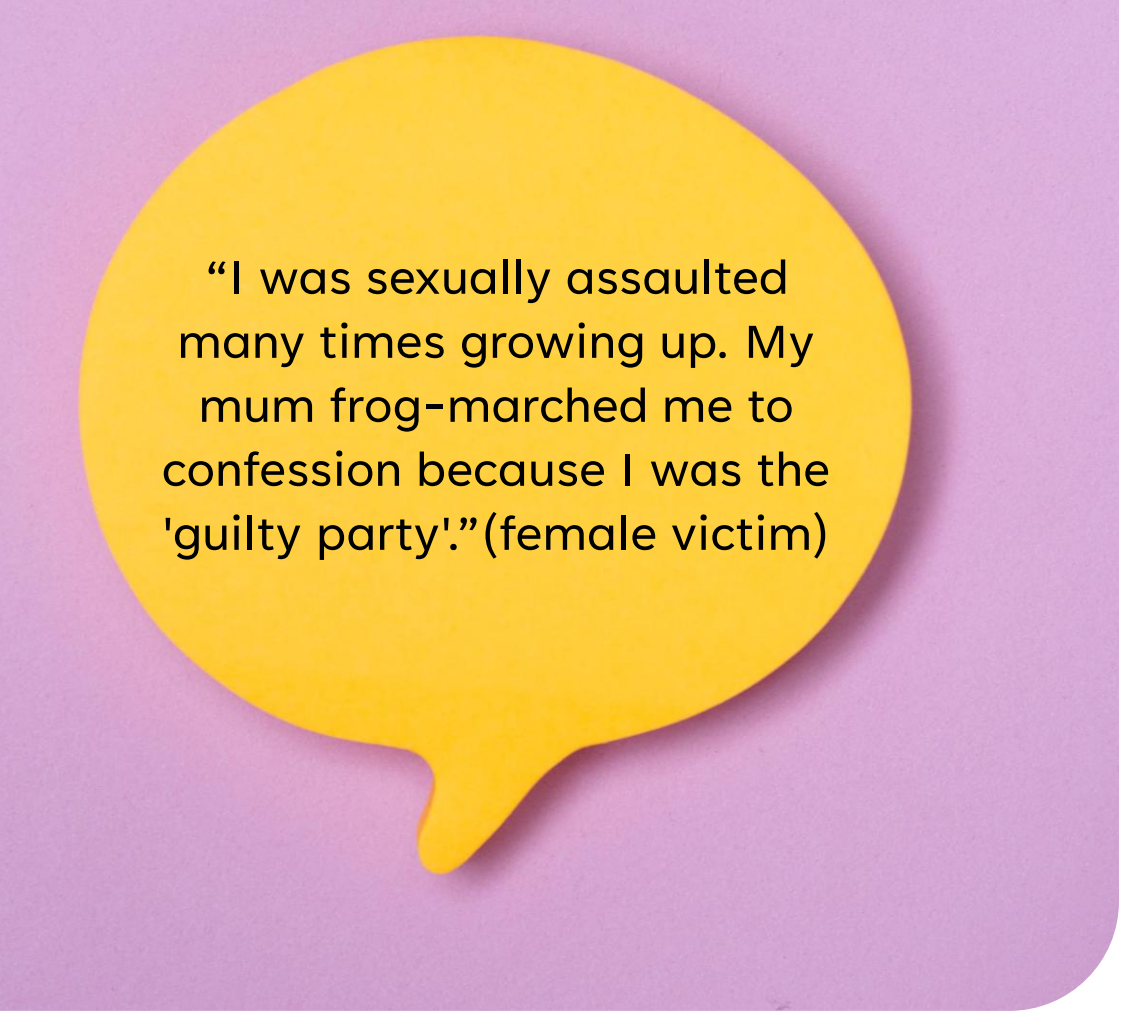
ORIGINAL TARGET EXPERIENCES

- Abuse in pregnancy
- Coercive control
- Family and criminal court
- Financial control
- Impact of domestic abuse on children, particularly aged 10-15
- Honour-based abuse
- LGBTQ+ communities
- Male victims
- Mutual accusations
- People seeking asylum and refugees
- Perpetrators

ADDITIONAL EXPERIENCES CAPTURED

- Abuse among care givers and in care settings
- Abuse via technology and social media
- Adult victims of child abuse or domestic abuse in childhood
- Child-to-parent abuse
- False accusations
- Parent alienation
- People with physical and learning disabilities
- Physical and sexual abuse
- Post-separation abuse
- Stalking and harassment

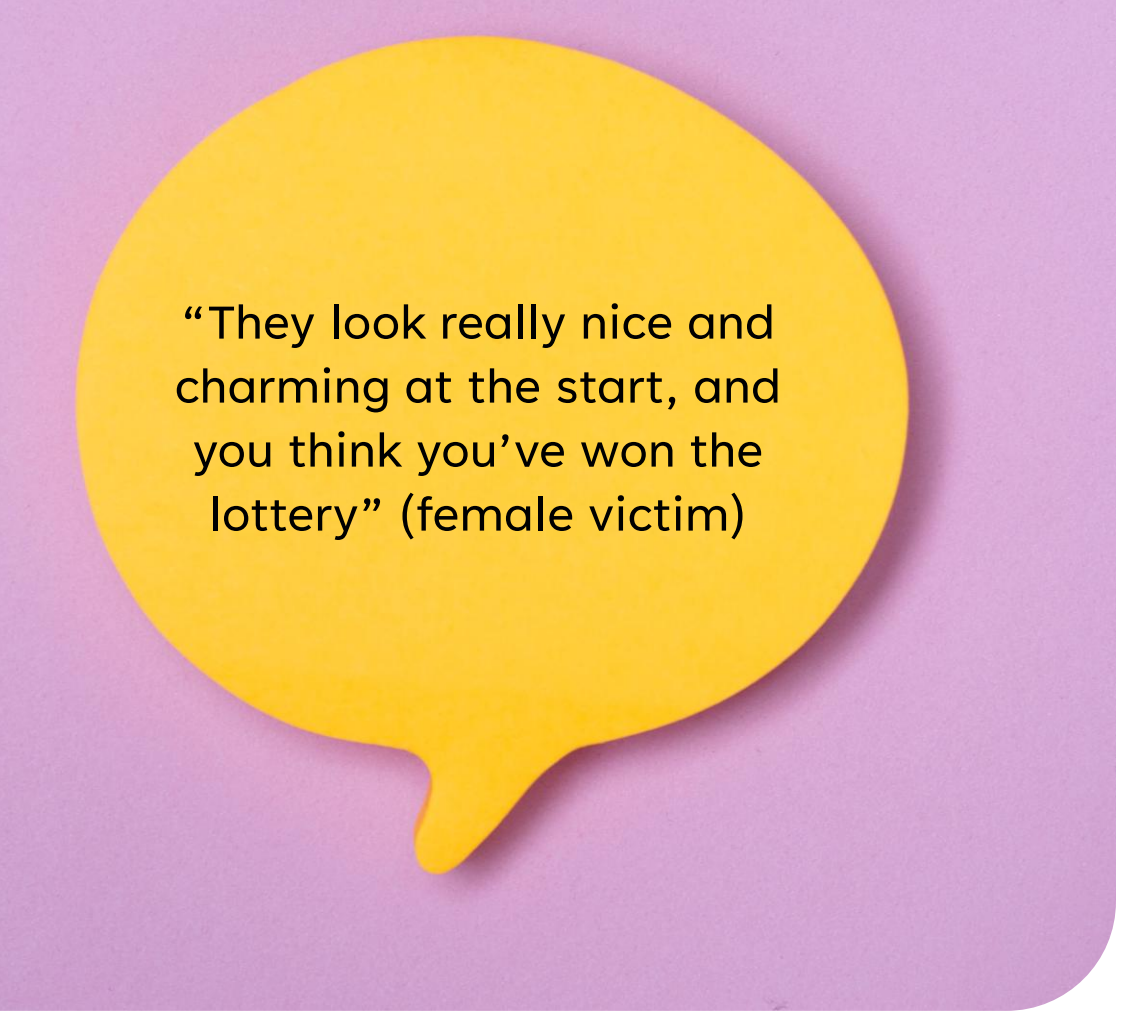
EXPERIENCES LEADING TO DOMESTIC ABUSE



RISK FACTORS

- Family history of abuse, childhood trauma, and early intimate relationships shaped what felt ‘normal’.
- Relationships often involved familiar or trusted individuals, reducing recognition of risk.
- Low self-esteem, people-pleasing, and oversharing were perceived to increase vulnerability to control.
- Cultural and societal norms (e.g. gender roles, misogyny, and victim-blaming) reinforced or hid abuse.
- For women who migrated to the UK, isolation, financial control, language barriers and honour-based threats greatly increased risk.

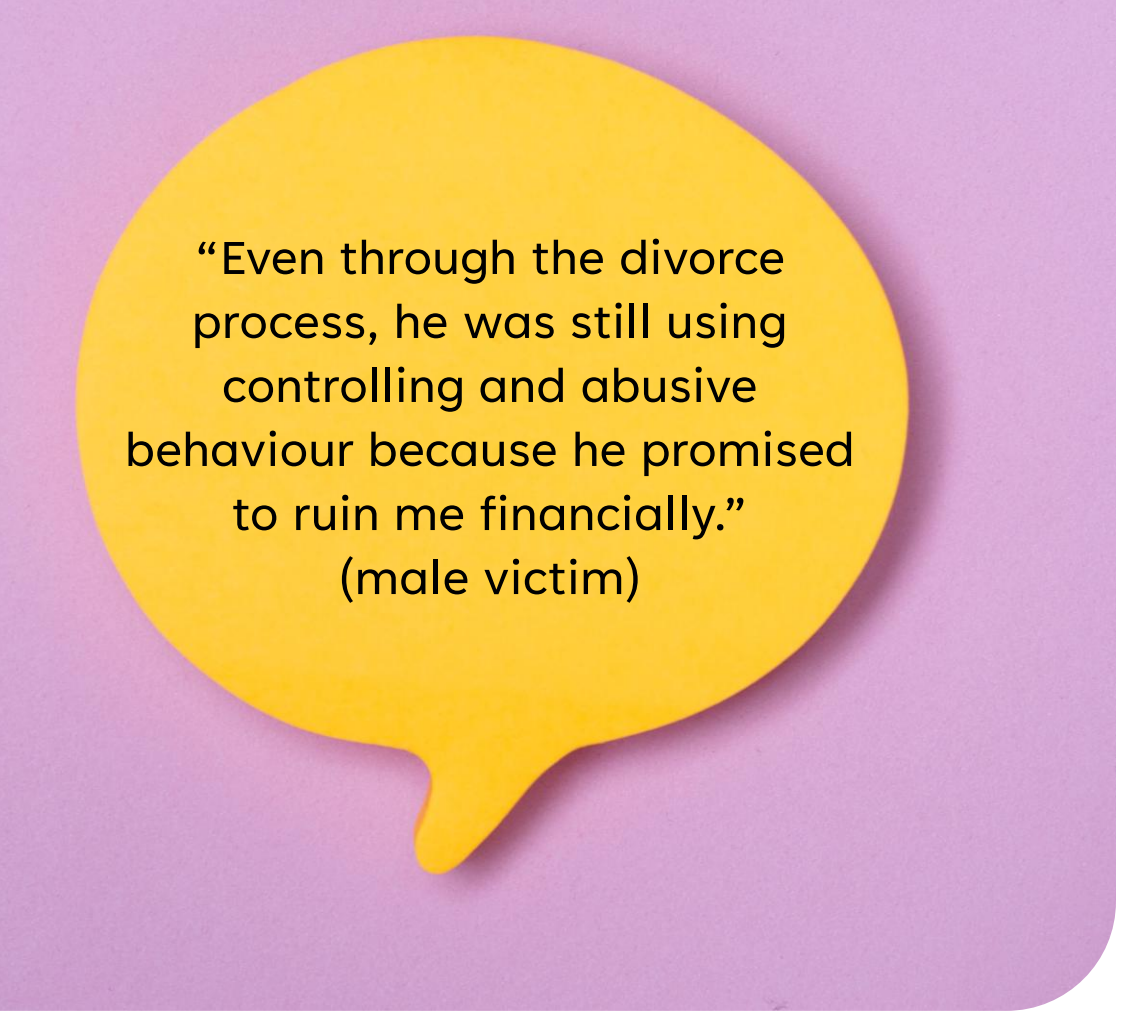
“The reason I always had the implication that certain things were okay is because of the way my dad was with me. I used to get battered by my dad [...]. He hit my mum”. (perpetrator)



EARLY RELATIONSHIP DYNAMICS

- Relationships often began as positive and aspirational, with abuse emerging gradually.
- ‘Love bombing’ created early commitment, fast-moving relationships, and emotional dependency.
- Perpetrator’s charm masked abuse, making it harder for victims and those around them to recognise harm.
- Victims described how perpetrators targeted their vulnerabilities, often presenting as the ‘rescuer’.
- Dependency could also work in reverse, with victims providing care and support to the perpetrator.

“They can be so loving, and then you hold out for those times, and you become dependent on those positive times” (male victim)

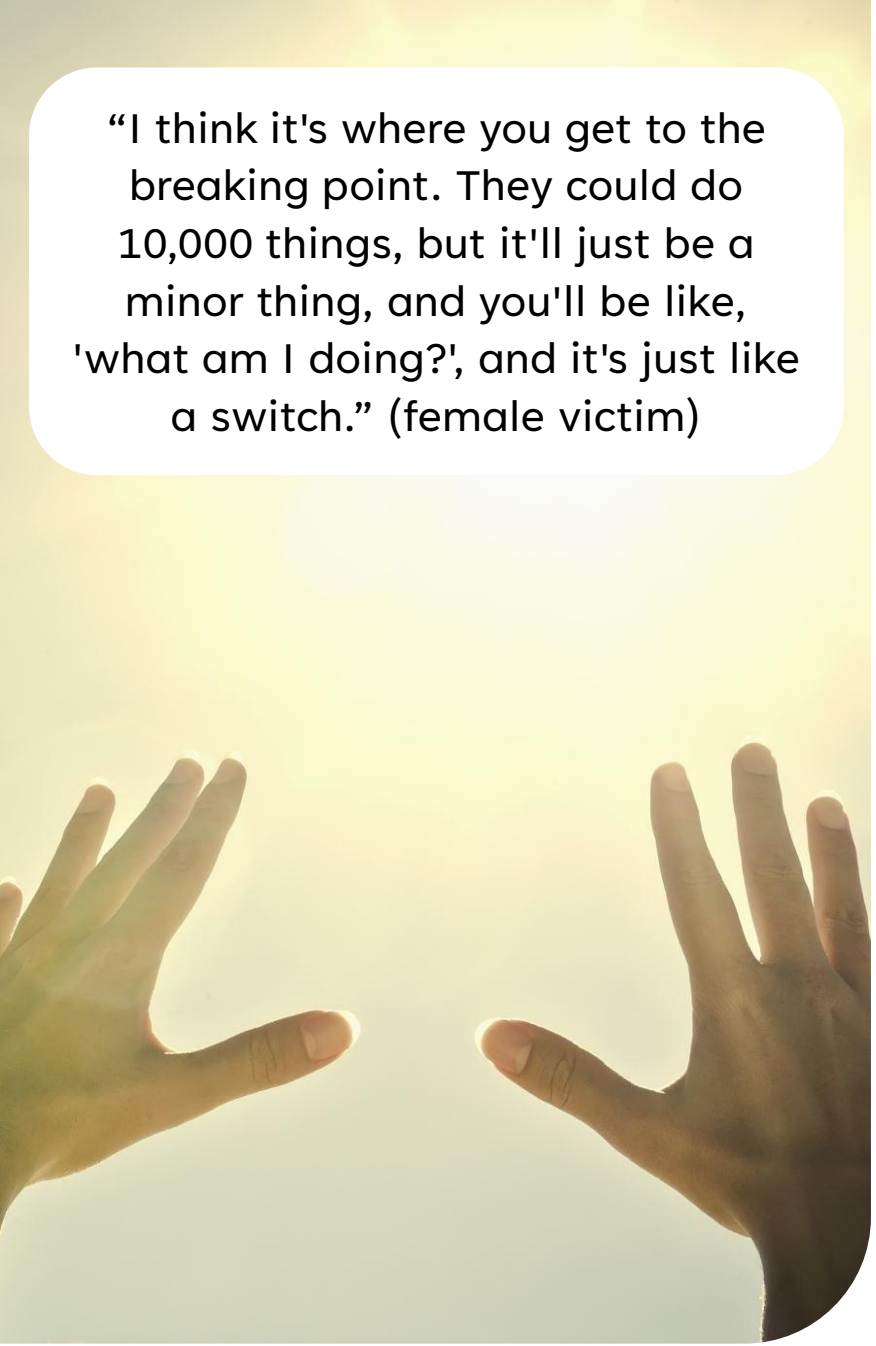


ESCALATION OF ABUSE

- Abuse gradually escalated in severity and frequency, involving overlapping forms of abuse.
- Life stressors, substance use, and mental health were linked to the escalation and intensification of abuse.
- Post-separation was a high-risk period, with abuse intensifying through stalking, harassment, intimidation, online abuse, technology-facilitated monitoring, financial abuse (e.g. legal costs), parent alienation, and control via child arrangements.
- Pregnancy reinforced dependency, with initial desires for family life shifting into abuse, (e.g. abortion pressure, body shaming and healthcare control).

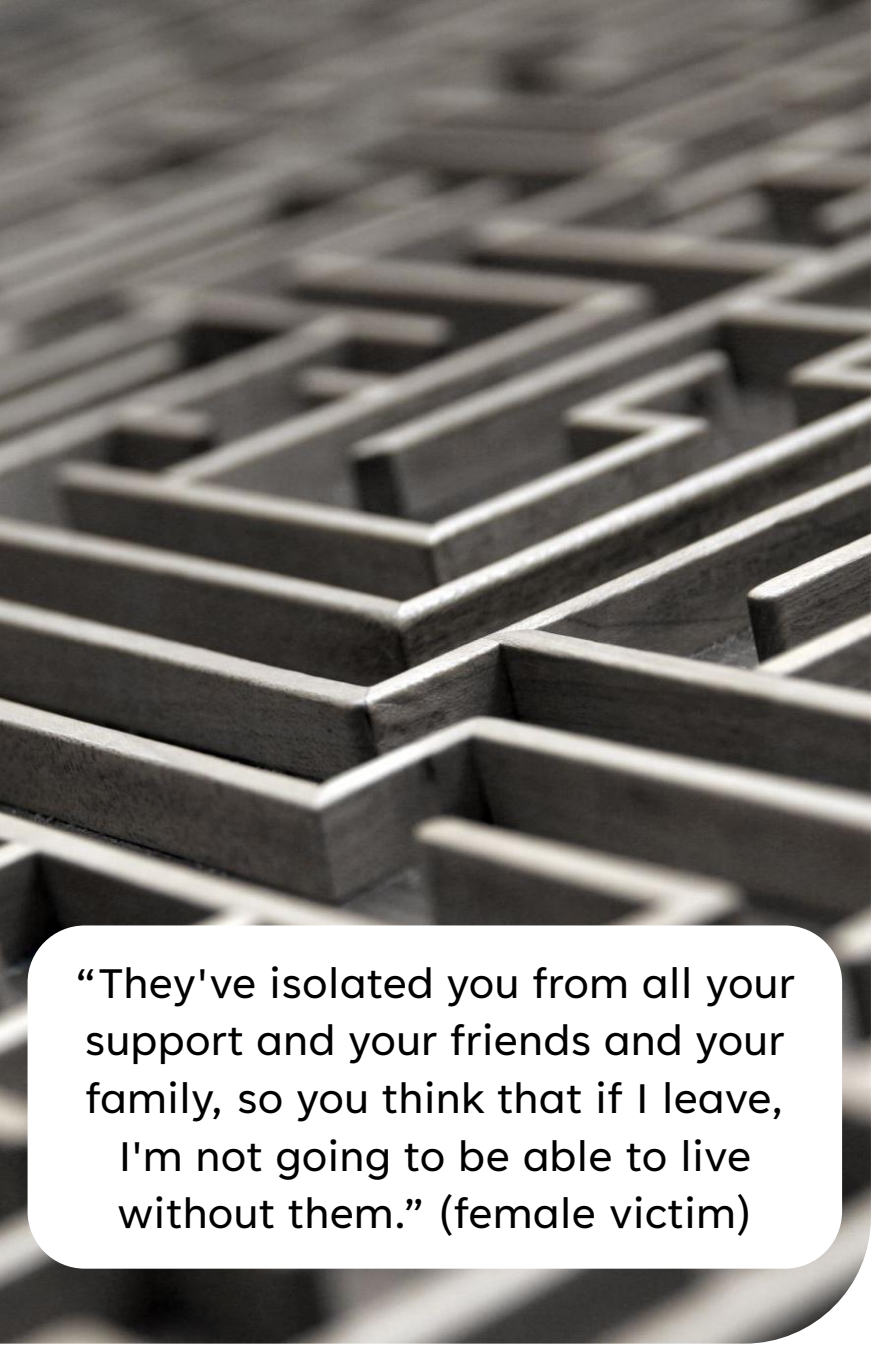
“They’ve got you then. They want you to get pregnant and then punish you for it”
(female victim)

MOTIVATORS AND BARRIERS TO HELP SEEKING



MOTIVATORS

- **Reaching 'breaking point'/ crisis,** including severe or life-threatening abuse, or mental health crisis.
- **A 'lightbulb moment'** where victims recognised patterns of coercion, prioritising others, or ‘self-sabotaging’.
- **Concern for children,** particularly recognising the impact of abuse on them.
- **Family intervention** or disclosure by others, prompting contact with services.
- **Temporary disruption of routine**, creating a safe opportunity to seek help.
- **Professionals identifying signs** of domestic abuse.



"They've isolated you from all your support and your friends and your family, so you think that if I leave, I'm not going to be able to live without them." (female victim)

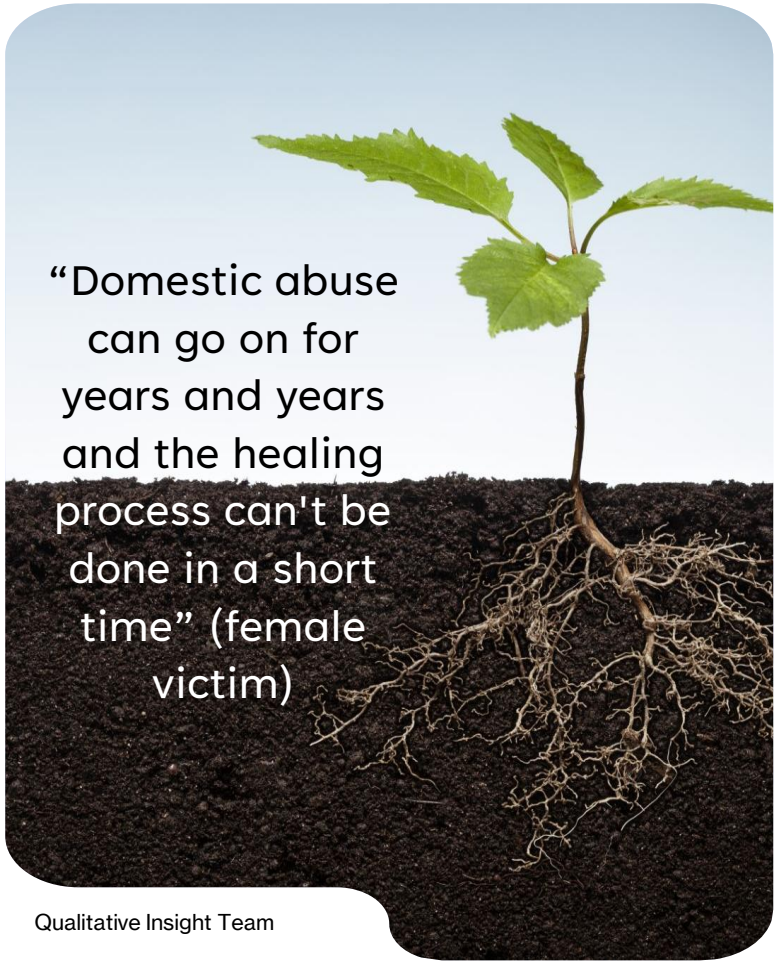
BARRIERS

- **Lack of recognition** and awareness of domestic abuse, including not having the language to describe experiences.
- **Dependency and isolation,** limiting ability to leave or seek help.
- **Fear of consequences,** including retaliation, losing children, financial insecurity, honour-based harm, or immigration status.
- **Protecting the family unit** for children's wellbeing and stability.
- **Family and community complicity,** including minimisation, victim blaming or protecting the perpetrator.
- **Negative perceptions** or past experiences of services, reducing confidence in help-seeking
- **Shame and stigma** linked to relationship failure, parenting, or cultural expectations prevented help-seeking.
- **Emotional, practical and system barriers**, including trauma, accessibility needs, or limited service provision.

OPPORTUNITIES FOR IMPROVEMENT

SUSTAINING GOOD PRACTICE THROUGH LONG-TERM FUNDING

Build on current strengths and good practice to deliver a sustainable domestic abuse support offer, increasing capacity and continuity.



Examples of effective support:

- Victims valued community groups that provide peer support, reduce isolation and build confidence.
- Person-centred support was valued over standardised courses.
- Perpetrators valued 1:1, non-judgemental support that improves understanding of harm and emotion/conflict management.
- Professionals who identify domestic abuse with discreet approaches (e.g. trained housing association staff and midwives).
- Multi-agency working, such as the increased frequency of MARAC.
- Innovative responses, such as joint working with police to reduce fear among refugee and asylum seeker children.
- Impactful refuge support for women, but desire for more capacity (particularly for men) and culturally appropriate provision.

AWARENESS, TRAINING, AND UNDERSTANDING OF DOMESTIC ABUSE

Increase public awareness and professional training to improve recognition and response to all domestic abuse types, across sectors.

- Participants said education in schools and communities is key to helping people recognise early ‘red flags’.
- Public messaging and support do not reflect the full range of abuse experiences, contributing to stigma and dismissal.
- Domestic abuse training needs to be embedded across services to improve early help and understanding of risk factors.
- Training should aim to reduce victim blaming and improve understanding of complex abuse dynamics, so victims are not misidentified or penalised.
- Improve screening for domestic abuse, ensuring mental health and substance misuse are not treated in isolation.
- System-wide focus on post-separation as a high-risk period.

CONSISTENCY AND QUALITY OF RESPONSES

Improve consistency and communication across services to streamline support, reduce dismissal, and minimise the need for victims to repeat themselves.

- Victims described inconsistent responses across police, legal and social services, making outcomes feel unpredictable.
- Being dismissed, or ‘come down hard on’ by police and social care contributed to severe emotional harm and suicide attempts.
- Participants called for improved trauma-informed practice and safeguarding to reduce dismissive or harmful interactions.
- Safeguarding considerations should apply equally, whether or not someone has children.
- Responses should prioritise victim safety, avoiding actions that could increase risk (e.g. informing perpetrators of police reports).
- Clear and consistent guidance is needed on accessing Claire’s Law, with robust risk assessment and timely responses.
- Stronger communication across services was desired, including wider representation of services at MARAC.

PERPETRATOR ACCOUNTABILITY AND SUPPORT

Stronger accountability and system-wide responsibility for perpetrators, alongside increased engagement and behaviour-change support.

"So many of our perpetrators have been victims, and if we don't start understanding that and working proactively with them, then we're never going to change". (professional)

- Improve coordination and responsibility for managing perpetrators, including safe approaches for high-risk individuals.
- Strengthen accountability for false allegations, with clearer resolution and support for victims.
- Limit opportunities for perpetrators to manipulate legal and safeguarding systems.
- Increase and broaden Wirral's behaviour-change offer.
- Ensure referrals to the programme are appropriate, and end-of-assessment reports are used with caution in courts.
- Increase therapeutic support for adults affected by abuse in childhood to prevent cycles of harm.

IMPROVING OUTCOMES FOR CHILDREN AND YOUNG PEOPLE

Recognise children and young people as victims, hear their voices, strengthen support, and prioritise their safety in all decision making.

- Recognise children and young people as victims in their own right.
- Improve understanding of the impacts on children. Participants highlighted anxiety, withdrawal, poor school attendance, self-harm, and behavioural challenges.
- Increase specialist support, including safe spaces, counselling and therapeutic support.
- Increase representation of children's services in MARAC.
- Ensure safeguarding information can be shared safely without placing children at risk (e.g. alerts on medical records).
- Ensure decisions about unsupervised contact prioritise children's safety and wellbeing.

THANK YOU.

Public Health, Wirral Council

Contact: qualitativeinsightteam@wirral.gov.uk

Quotes are used with consent from participants.

WIRRAL