Is sleep deprivation used as a means of coercive control?

An examination of the lived experience of sleep deprivation within intimate relationships.

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Abstract.

There is a substantial and growing body of evidence demonstrating the negative consequences of living with coercive control, though very little research has directly examined the use of sleep deprivation as a technique of control. This is surprising given the known, adverse consequences of inadequate, and poor-quality sleep and its recognition as a means of torture. This qualitative study explored the experience of five women survivors, using semi structured interviews to establish how sleep deprivation was being used as a means of coercive control and the subsequent impacts on their health and wellbeing. The findings indicated sleep deprivation was a powerful method of coercion and control which had significant short-term impacts on all the participants' physical and mental health. Some survivors experienced chronic adverse health effects, attributable to poor sleep, years after the abuse ended. Findings also suggested the use of sleep deprivation could be an indicator of higher risk for suicide/ involuntary manslaughter and domestic homicide, as there were notable similarities in the progress of relationships in the study and those observed within the Domestic Homicide Timeline as described by Monkton Smith (2020).

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Diagram -The Coding Wall.

List of Acronyms.

AAFDA	Advocacy After Fatal Domestic Abuse.
CIA	Central Intelligence Agency
CPS	Crown Prosecution Service
GDPR	General Data Protection Regulation
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services.
LGBQT+	Lesbian, Gay, Bisexual, Queer and Transgender
NMC	Nursing and Midwifery Council
ONS	Office of National Statistics
PTSD	Post Traumatic Stress Disorder
UK	United Kingdom
US	United States
WHO	World Health Organisation

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Chapter One - Introduction.

Since the introduction of the Serious Crime Act 2015, which criminalised coercive control in England and Wales and the Domestic Abuse (Scotland) Bill 2018, there has been considerable interest in improving understanding of this phenomenon (Walklate and Fitz-Gibon, 2019). Traditional discourse has depicted domestic abuse as a series of explosive, violent events, usually enacted by a male perpetrator towards his intimate female partner and interspersed by periods of relative calm (Bettinson and Bishop, 2015). Stark (2007) challenged this view extensively and raised the centrality of coercive control as a dominant feature in many abusive relationships. Unlike the visible, irrefutable evidence of a physical assault, coercive control has been described as an invisible thread running through victims' and perpetrators' lives (Hart and Hart, 2018, p.79). Analogies have been made to a cage, suggestive of the controlling and confining impact on victims' lives however, understanding of how coercive control is 'done' continues to grow (Williamson, 2010; Mitchell and Raghavan, 2021; Crossman, Hardesty and Raffaelli, 2016).

Coercive control appears to be a highly gendered phenomenon, overwhelmingly perpetrated by men, against women (Office of National Statistics, 2020) and tends to have its focus within the domestic sphere where traditional, highly gendered roles are reinforced to assert authority and control (Stark, 2007). It is a highly individualised form of abuse, tailored by the perpetrator, in response to their intimate knowledge of the victim, with significant risk of adverse outcomes (Dobash and Dobash, 2015; Monkton Smith, 2020).

Disclosures made during the researcher's work indicated sleep deprivation was being used by perpetrators, as part of a repertoire of techniques to coercively control intimate partners, prompting an interest in undertaking this study. The importance of sleep to human health and well-being cannot be overstated. Maslow (1943) recognised the centrality of sleep for human survival when he placed sleep alongside food and water, at the base of the pyramid used to illustrate the Hierarchy of Needs. Without adequate sleep, we cannot fully engage in life, and sleep deprivation quickly renders us vulnerable and desperate (O'Mara, 2019; Krause et al.,2017). Such is the importance of sleep for human health and well-being that sleep deprivation is recognised as a form of torture (O'Mara and Schiemann, 2019; Denbeaux et al.,2019).

The disclosures made to the researcher exposed a particularly hidden form of coercive control which had significant impacts on victims and prompted this study. Contextualising these individual incidences of coercive control, by examining the scale and impact of this global phenomenon (World Health Organisation, 2021), highlights the importance of studies which increase understanding of the complex ways coercive control is enacted, as well as improving understanding of the impact on victims.

The scale of Domestic Abuse.

Domestic violence is recognised globally as a major public health issue, with one in three women experiencing physical or sexual violence in their lifetime (WHO, 2021). It disproportionately affects women and girls; 27% of fifteen to forty-nine-year-old women who have been in an intimate relationship, have been subject to some form of domestic abuse (WHO, 2021). This pattern is reflected in England

and Wales, with figures indicating 74% of victims of domestic abuse and 77% of victims of domestic homicide were women (ONS, 2020). A Home Office report examining the economic and social impacts, estimated the cost of domestic abuse to the annual economy of the United Kingdom (UK) was in the region of £66 billion (Home Office, 2019). A study undertaken by WHO (2021) found significant and wide-ranging consequences for health, including high rates of physical injuries, depression, anxiety, post-traumatic stress disorder (PTSD), (Romito, Turan and De Marchi, 2005, p.1721) and a higher risk of miscarriage and premature birth (WHO,2021).

Defining Domestic Abuse

Domestic abuse is one of several terms used to describe a range of behaviours which include ‘physical aggression, sexual coercion, psychological abuse and controlling behaviours’ (United Nations, 1993) and is also referred to as domestic abuse, intimate partner abuse/ violence and battering.

Definitions vary globally and since the establishment of the first Refuges for ‘battered’ women in the 1970’s, there has been an evolution in understanding of the experience and impact of domestic abuse and, growing recognition of coercive control as a significant feature in many abusive relationships (Stark, 2007).

The Domestic Abuse Bill 2021 introduced a new definition within England and Wales, which saw the age limit of victims and perpetrators limited to sixteen years and over, whilst individuals who are ‘personally connected’ are recognised

as potential victims and perpetrators, regardless of gender or sexuality. (Domestic Abuse Bill 2021).

The gendering of Abuse.

Notwithstanding these figures, debate continues around the gendered nature of Domestic abuse (Donovan and Barnes, 2019). Straus (2009) argued there is extensive evidence of gender symmetry in what is described as situational couple violence, with women using violence to coerce, and as an expression of anger and to punish misbehaviour (Straus, 2011, p.285) rather than a means of asserting power based on gender inequality. However, exploration of the underlying reasons for women's use of violence in intimate relationships, indicates a proportion of women may be acting in self-defence, a position disputed by Straus (2011), as a response to their own victimisation from previous abuse and violence (Houry et al., 2008).

Further, the impact of women's violence against men is often significantly less harmful than men's against women (Dobash and Dobash, 2004, p328), a view supported by the evidence from domestic homicide figures where 77% of victims are women and 96% of suspects are men (ONS, 2020).

Stark (2007, p.92) agrees that whilst some inter-couple violence is perpetrated by women against male partners, there is clear evidence women are more likely to be victims than men, particularly where violence is present alongside coercive and controlling behaviour. He argues coercive control directly exploits traditional, gendered roles, for example within the performance of domestic tasks and involves the micro regulation of everyday, gendered activities (Stark, 2007, p

271). This reinforcement of a version of femininity is facilitated by men's enablement in society where 'the performance of masculinity involves controlling others, whereas the performance of femininity involves deference to men's control' (Anderson, 2009 p. 1448).

Distinguishing the different typologies of abuse within intimate relationships is therefore imperative, given the outcomes are often significantly different (Donovan and Branes, 2019; Myhill, 2015). Relationships characterised by coercion and control, sometimes referred to as 'intimate partner terrorism' can be deeply corrosive to both the mental and physical wellbeing of victims (Roberts et al.; Polletta, 2009). Significantly, studies have found evidence of greater frequency of physical injury, damage to physical wellbeing (Myhill, 2015, p.365) and more extreme violence and domestic homicide (New South Wales Government, 2015, p.11; Monkton-Smith, 2020, p.1268).

Stark (2007, p.257) viewed domestic abuse through a feminist lens and propelled the concept of coercive control into the discourse around domestic abuse, arguing it was more of a pattern crime, an extreme display of gendered roles, wherein the perpetrator would exercise control through micro regulation of the minutiae of daily living. This contrasted with the view of domestic violence as a series of unrelated, explosive acts of violence, interspersed with periods of relative calm, likening the experience of coercive control to one of living with intimate terrorism. Polletta (2009, p.1491) reiterates this point and suggests that 'viewing each incidence of abuse separately, places it below the threshold of criminality, whilst simultaneously minimising and ignoring their cumulative impact, which though invisible, is pervasive and highly damaging'.

The discourse around how coercive control presents within intimate partner relationships and the impact upon those subjected to it, has evolved significantly over the last two decades (Dutton and Goodman, 2005) particularly since it was criminalised in England and Wales under the Serious Crime Act 2015 and in Scotland, under the Domestic Abuse (Scotland) Bill 2018.

Figures published by the ONS (2020) overwhelmingly corroborate claims that coercive control is a gendered crime, with men representing 97 % of those prosecuted and 99.5% of those convicted (ONS, 2020). This position was acknowledged by the Scottish Executive (2000) who embedded the significance of gender within their legal definition of domestic abuse. The UK government took a different approach, arguing they wanted a 'gender neutral definition to ensure all victims and all types of domestic abuse are sufficiently captured' (Home Office, 2021, p.16) whilst the Crown Prosecution Service (CPS) guidance on controlling and coercive behaviour, highlights the importance of recognising that 'the gendered patterns and dynamics involved in these cases need to be understood in order to provide an appropriate and effective response' (CPS, 2017).

These nuanced differences in definitions appear reflective of broader discussions within society regarding the gendering of domestic abuse and are likely to evolve as understanding of this complex phenomenon changes.

Legal change.

Interweaving the discourse around the gendered nature of domestic abuse is the impact of legislative changes on the position of women over the last 150

years, for any discussion around coercive control cannot ignore the impact of the expanding legal empowerment of women. Common Law dominated the lives of women for nearly a thousand years when marriage led to the state of ‘femme couverte’ (covered woman) with the loss of some legal control particularly over finances, property, and children. Legislative changes under the Married Women’s Property Act 1882 enabled women to control and retain their earnings and inheritance as their own, rather than being subsumed under the control of their husbands. The act of ‘giving away’ in marriage is a powerful reminder of the vestiges of women’s legal subjugation.

Conclusion

This chapter has demonstrated both the scale and far-reaching impacts of domestic abuse globally and examined the debate and evidence of the gendered nature of this epidemic, particularly in the commissioning of coercive control by male perpetrators. Domestic abuse is a significant threat to public health with far reaching costs for society and as such, studies addressing more hidden aspects of coercive control are important in illuminating this poorly understood, but deeply deleterious form of abuse.

Chapter Two - Literature Review.

Introduction.

This study was undertaken following disclosures during the researcher's work, that sleep deprivation was being used by male partners within intimate partnerships, with subsequent adverse impacts on health and wellbeing and capacity to work and parent.

A narrative literature review was undertaken to establish current knowledge of the use of sleep deprivation as a means of coercive control within intimate relationships and, the impact of sleep deprivation and coercive control on health and well-being. Literature searches were completed using the following search terms to broadly capture studies relating to the impacts of sleep deprivation in intimate relationships and in other circumstances where sleep deprivation may occur, such as torture. Searches were undertaken via the University of Worcester online library and via the PsycINFO and MEDLINE databases. Search terms included 'sleep deprivation', 'sleep', 'sleep control', *and* 'health', 'impacts', 'domestic abuse', 'intimate partner violence', 'domestic violence', 'intimate partner terrorism', 'coercive control', 'torture'.

Peer reviewed, qualitative, and quantitative studies were identified and the Critical Appraisal Skills Programme Checklist for qualitative research (CASP,2021) was used as a guide to assist in critically evaluating the quality of the studies.

Only one quantitative study was found that directly enquired about control of sleep (Silverman et al., 2016) whilst few qualitative studies explored sleep in the

context of domestic abuse and none directly addressed perpetrator's role in sleep deprivation, highlighting a significant gap in knowledge and the relevance of this study. Further searches reviewed Government websites and charities involved in supporting survivors of domestic abuse.

This chapter considers findings from studies looking at sleep deprivation and the impacts of sleep deprivation within the context of intimate relationships, to understand current knowledge and to inform the design of this study.

The literature search also highlighted the debate around the role of sleep deprivation as a mode of torture and the early work of Biderman (1957). His work documented the links between non-violent coercion, using techniques such as sleep deprivation, and the weakening of resistance of victims undergoing interrogation, establishing a link with behaviours seen in coercively controlling relationships.

The Origins of 'Coercive Control.'

Prior to its use in domestic abuse discourse, the term coercion was employed by Biderman (1957) who studied the experiences of torture and interrogation of American service personnel returning from the Korean war. He described eight, distinct, non-violent methods used to induce prisoner's compliance and subsequently developed Biderman's chart of coercion (See Appendix one). A study analysing the interactions between human traffickers and their victims, found evidence that Biderman's techniques were used by the traffickers to assert control and reinforce the submission of their victims, resulting in significant adverse outcomes 'even in the absence of physical force or restraints, (Baldwin,

Fehrenbacker and Eisenman, 2015, p1171). The study highlighted the transferability of the techniques across a range of human interactions to achieve control.

Biderman's methods were also employed to weaken the resistance of victims of torture (Amnesty International, 1975) and formed part of the theoretical justification for enhanced interrogation techniques, including sleep deprivation, employed by the Central Intelligence Agency (CIA) in Abu Graid and Guantanamo Bay detention facilities, post 9/11 (Senate Select Committee, 2014, p.4). The CIA admitted sleep deprivation was used on individual detainees 'to reduce the ability to think on his feet and, through the discomfort associated with lack of sleep, to manipulate him to cooperate' (Denbeaux et al, 2019, p.25). O'Mara (2015) argued Biderman's techniques were never designed to elicit confessions, particularly as prolonged sleep deprivation has been shown to adversely affect memory retrieval but was 'about imposing suffering to 'break' human beings (O'Mara and Schiemann, 2019, p.180). In one account, a detainee explained 'my words and behaviour became all confused' (Denbeaux et al., 2019, p.25) following prolonged periods of sleep deprivation.

The US Senate Enquiry Report on the CIA Detention Interrogation Program (2014) looked at the treatment of detainees and found at least five detainees experienced disturbing hallucinations during prolonged sleep deprivation' (US Senate Report, 2014, p.10). The Report found the use of enhanced interrogation techniques, which included sleep deprivation, were not an effective way of acquiring intelligence, and furthermore *constituted torture.*

The scenarios of enhanced interrogation and human trafficking appear quite disparate however, the techniques used, including sleep deprivation and the subsequent feelings of disorientation, exhaustion and compliance are also recognised as techniques used within abusive intimate relationships, thus resonating with Stark's (2007) description of coercive control as 'intimate partner terrorism'.

The impacts of coercive control.

Coercive control was used in the above scenarios of torture and trafficking to create an atmosphere of terror and compliance. Furthermore, studies have demonstrated living with coercive control can be systemically deleterious to an individual's wellbeing with significant, negative impacts on mental health including, depression, PTSD, lowered self-esteem, and anxiety (Blasco-Ros et al., 2010) and increased risk of suicide and femicide (Walby, 2004; WHO, 2021; Munro and Aitken, 2019; Johnson et al 2019).

Blasco-Ros et al. (2010) evidenced the insidious impact of living with coercive control in their study looking at mental health recovery after leaving abusive relationships. They identified a significantly longer delay in the recovery of mental health and well-being amongst women who had experienced psychological abuse alone, compared to those who had experienced both physical and psychological abuse, highlighting the deeply deleterious impact of this form of abuse and refuting the notion of a 'hierarchy of harm which privileges physical harm' (Bishop, 2016, p.60).

Walby (2004) proposed up to one third of women who committed suicide had experienced domestic abuse, whilst a more recent study found substantial evidence of a correlation between experiencing domestic abuse and risk of suicidal ideation and attempts (Munro and Aitken, 2020). These findings are reflected in evidence submitted to the UK government by the charity, Advocacy after Fatal Domestic Abuse (AAFDA) at the beginning of the Covid 19 pandemic, highlighting the link between coercive control and suicide. In March 2020, AAFDA called on the UK government to ensure rigorous investigations took place into suicides where there was a history of, or suspected history of domestic abuse, given that restrictions put in place during the Pandemic would increase isolation and likely exacerbate suicide risk (AAFDA, 2020).

Another disturbing feature of these relationships was highlighted in a study analysing domestic homicide records (Monkton Smith, 2020) which showed a significantly higher risk of domestic homicide compared to relationships featuring physical violence alone, particularly when perpetrators perceive they are losing control of the relationship. Dobash and Dobash (2015) suggest, at this point there can be a shift in thinking to ‘change the project’ from one of controlling, to murder. This clearly frames the act of domestic homicide not as a crime of passion but, as an act of calculated and premediated murder (Monkton Smith, 2020).

Prosecuting Coercive control

The studies above demonstrated victims of coercive control are at increased risk of serious harm and highlighted the necessity of ensuring early identification and prosecution however, there remains huge disparity in understanding the offence

of coercive control amongst victims, and practitioners within the Criminal Justice system (Brennan et al., 2018).

A study examining police responses to coercive control showed ‘a spectrum of understanding amongst police officers… failure to recognise…was not uncommon, with profound implications for effective practise’ (Robinson, Myhill and Hume, 2018, p.44). These difficulties are compounded, as evidence indicated police officers prioritized physical violence with injury and were less likely to take positive action in response to incidents where abusive behaviour was less overt, or manifested as harassment (Myhill, 2015). This finding is confirmed by figures showing coercive control is most often combined with physical assault charges and rarely pursued as a stand-alone offence (ONS, 2019).

Further evidence of ongoing difficulties in prosecutions are highlighted by the proportion of coercive control crimes, relative to overall domestic abuse crimes recorded by the police. Of 1,288 018 domestic abuse crimes recorded, only 24,856 were crimes of coercive control (ONS, 2020), representing approximately 1.9%. Of interest, the gendered nature of coercive control is overwhelming, with men representing 97 % of those prosecuted and 99.5% of those convicted (ONS,2020). Embracing coercive control represents a significant challenge to the ‘hierarchy of harm which privileges physical harm’ (Bishop, 2016) and highlights the need to increase understanding of this crime.

Successfully moving away from this hierarchy, requires an examination of the lived experience of coercive control, an understanding of the diverse ways in which it presents and wider dissemination of these insights. However, low conviction rates for coercive control are reflective of wider disquiet within public discourse concerning sexual violence against women, with conviction rates of 1.6% for rape in 2020 (ONS, 2021). Sexual harassment, domestic abuse and sexual violence have been highlighted by the #Metoo movement (Epstein and Goodman, 2019), and the public demonstrations which took place in 2020, in response to the murder of Sarah Everard and the experiences of women, who face a ‘Gaslight style gauntlet of doubt, disbelief and outright dismissal’ (Epstein and Goodman, 2019, p.399) of their lived experience of abuse.

Doubts about the ability of the legal system to successfully prosecute coercive control were raised before and after the introduction of s.76 of the Serious Crime Act 2015. These included concerns around evidencing coercive control in order to meet the threshold for prosecutions (Williamson, E. 2010) and the impact of post-traumatic stress disorder on victims’ abilities to recount experiences , causing them to skip or forget parts of their story with a resultant, disjointed narrative which can be viewed within the criminal justice system as inconsistent (Epstein and Goodman, 2019, p.410) and therefore, not reliable (Bishop and Bettinson, 2018, p.15).

Additionally, several studies indicated a significant number of women who have experienced domestic abuse have experienced traumatic head injury (Jackson et al. 2002) or non-fatal strangulation (Monahan, Purushotham, Biegon, 2019, p.2)

both of which can result in headaches, cognitive impairments and significantly, memory loss and poor recall (Zieman, Bridwell and Cardenas, 2017). Given the adversarial nature of the criminal justice system, these factors may impact on decisions to take prosecutions to court and subsequently the low number of prosecutions for coercive control.

Improving public understanding of the lived experience of coercive control, could facilitate the empowerment of victims through enabling them to recognise their experience as one of coercive control. The CPS published an advisory document for those involved in evidence gathering and prosecution of coercive control, describing how coercive control can be targeted at basic aspects of daily living, for example through controlling ‘when they can sleep’. (CPS, 2017).

The impact of Sleep Deprivation.

Disclosures during the course of the researcher’s work as a Health Visitor, indicated sleep deprivation was being used by intimate partners, with deleterious effects on physical and emotional well-being. Sleep deprivation has been described as ‘the most effective tool for causing chronic and substantial deficits in cognition, mood and memory (Walker, 2008; O’Mara, 2019, p.188) and is commonly used as a method of torture (Denbeaux et al., 2019)

Evidence from studies looking at the impact of sleep deprivation highlighted a wide range of deleterious effects which are thought to be dose related and include reduced task performance and increased attention deficit (Krause et al, 2017), lowered cognitive function, profound problems with memory (O’Mara, 2020), significantly increased risk of road traffic accidents (Connor et al.,2002)

and reduced life expectancy (Capuccio et al, 2010). These effects are experienced irrespective of an individual's level of physical wellbeing and resilience, as evidenced by a study examining the impact of sleep deprivation on a group of elite soldiers, which found function degraded in every area measured, including deficits in declarative memory, reaction time, vigilance, learning and memory (Liebermann et al, 2005).

When these impacts are being felt within the context of living within a coercive and controlling relationship, the reduction in functional capacity induced by sleep deprivation has serious implications for decision making and risks increasing the financial, physical, and emotional vulnerability of victims and their dependents.

Investigating sleep.

The CPS (2017) and Tetlow (2015, p.12) highlight sleep deprivation as a technique of coercive control whilst Stark refers to, 'clients who have been made to sleep standing up' (Stark, 2007, p.242). A search of the research literature indicated very little work had been undertaken to directly investigate the nature, impact, or frequency of sleep deprivation within intimate relationships thus overlooking an area of control with potentially far-reaching impacts on victim's lives.

Lowe, Humphreys and Williams (2007) were inspired to undertake their study after reading descriptions of sleep deprivation experienced by prisoners released from Guantanamo Bay, as the authors recognised parallels in the techniques used for establishing regimes of power and control (2007, p.558) within domestic abuse. They asked female survivors about the challenges they had faced around

sleep, particularly the risks and safety issues that arose around sleep. Several participants had experienced being woken by physical and sexual violence whilst others described their efforts to be awake at crucial times, by taking a shorter sleep or not taking medication that would have rendered them less responsive, particularly when perpetrators were returning from work or coming to bed, as 'being asleep while the perpetrator was awake was seen as extremely risky course of action' (Lowe et al., 2007, p.552). The study illustrated sleep quality was adversely affected both during the relationship and subsequently remained a problem, sometimes years after the relationship ended, with one woman reporting 'sleeping tightly, resulting in symptoms of aching limbs and teeth grinding' (Lowe et al.,2007, p.556). Many of the women experienced long term health problems which they attributed to their experience of poor sleep, including headaches, acute fatigue syndrome and for one participant, a diagnosis of fibromyalgia (Lowe et al., 2007, p.557). The role of perpetrators in proactively controlling sleep was, however, largely unexplored. Although the authors stated that enforcing sleep deprivation was another 'method of control' (Lowe et al., 2007, p.553), it was not clear from the narratives if perpetrators were viewed as making a conscious decision to manipulate or control sleep or, was sleep deprivation an unlooked-for consequence of their violent and controlling behaviour? Proving the *intention* to deprive or control sleep is important; it signals a conscious decision to inflict a recognised form of torture on ones' intimate partner, resonating with Tetlow's allusion to homes as 'torture chambers' (Tetlow, 2015, p.4) and is indicative of behaviour which falls within the definition of coercive control (CPS, 2017).

In two studies there was evidence that women survivors of domestic abuse experienced higher levels of sleep disruption, attributable to the trauma they have suffered (Saunders, 1994; Lowe et al. 2007). Furthermore, the symptoms persisted after the women had left their relationships however, there was no exploration of any direct link between loss of sleep and the interventions of the perpetrator, hence not addressing questions being explored in this study.

Several studies considered the links between sleep quality and domestic abuse and found correlations between experiencing domestic abuse and stress-related sleep disorders (Sanchez et al,2016, p.8). In a large study of 609 female participants, researchers found an association between ‘sleep disturbances and victimisation’ (Walker, Shannon and Logan, 2011, p.2017) whilst another found a positive association with intimate partner violence and poor sleep quality (Woods, Kozachik and Hall, 2010, p.143). Discussion in the papers focused on the women’s mental health as a causative factor of their poor sleep but surprisingly, none examined the role of the perpetrator as the direct cause of sleep disruption.

A more focused enquiry into the use of sleep deprivation was undertaken in a quantitative study looking at family violence and maltreatment (Silverman et al., 2016, p.152) which demonstrated participants rest and sleep were being limited and /or controlled by 4.1% of partners, with subsequent links to adverse outcomes in infant morbidity. Though this finding (controlling sleep and rest) wasn’t explored further, it did confirm access to rest and adequate sleep were being used as currency in a wider regimen of control.

Conclusion

The literature review has examined current knowledge regarding the frequency, nature and impact of sleep deprivation and coercive control. There was significant evidence highlighting the deleterious effects of coercive control on victims, particularly the adverse impacts on mental health and well-being, and extensive studies exploring the impact of sleep deprivation on humans. These included adverse impacts on cognition, memory and response times, and its application as a method of torture. However, there were no qualitative studies exploring the experience of sleep deprivation as a direct result of interventions by an intimate partner, revealing a significant gap in current knowledge.

Investigating sleep deprivation may facilitate greater awareness of a hitherto, largely overlooked means of coercive control and provide victims, the Criminal Justice system and domestic abuse support agencies with insights to facilitate earlier recognition of exposure to coercive control as well as evidence of criminal activity. Given that a defining feature of coercive control is victim's reduced capacity for action (Coy and Kelly, 2010), work which illuminates the experience of coercive control is vital.

Chapter Three - Methodology.

Introduction.

This chapter explains the rationale for using a Feminist methodology, the underpinning ontological and epistemological stance and how this influenced the research method and informed the ethical approach to research. It considers the challenges posed to the data collection method, including the impact of the Covid Pandemic. This necessitated a modification and resubmission of the research proposal, integrating an adaptation of the interview process to enable remote interviewing methods whilst ensuring participant safety and wellbeing remained paramount. The rationale and application of Thematic Analysis as a method of data analysis is discussed and finally, limitations are explored.

A Feminist Methodology.

The evidence outlined above indicates coercive control is a significantly gendered phenomenon, with men predominantly being perpetrators against women (ONS, 2020), a finding which is reflective of the difference in the life experiences of women in British society. The recent rise of the #MeToo movement and protests across the UK in 2021, in response to female homicides, sexual violence and ongoing concerns around women's personal safety, signals the persistence of these issues. Legal parity between men and women is a relatively new position within the UK; rape in marriage was only outlawed in 2003 (Sexual Offences Act 2003) and prior to the introduction of The Sex Discrimination Act 1975, women were unable to open a bank account without the authorising signature of their father or spouse. Attitudinal surveys indicate

societal beliefs regarding issues of sexual consent are hugely disparate and often not aligned with current legislation. A recent YouGov survey found 1/3 of respondents reporting they ‘did not believe it was rape if a woman was pressured into having sex and there was no physical violence’ (YouGov, 2018, p.2). One third of male respondents agreed, ‘if a woman flirted on a date it wouldn’t be rape, even if she hasn’t consented’, a view supported by 21% of female respondents (YouGov, 2018).

These disparate and incongruous views around women’s rights to self-determination, as well as the overwhelming evidence of gender disparity observed in the proportion of women victims of coercive control, (ONS,2020) signals the importance of using a Feminist methodology to investigate this phenomenon. Although there is no single, agreed definition, it is the application of Feminist principals throughout the research process (Skinner, Hester and Mallos, 2013), by acknowledging the power differentials that can exist between researcher and participant and using research methods that minimise harm and ‘accept women’s stories of their lives as legitimate sources of knowledge’ and subsequently improve policy and practice (Campbell and Wasco, 2000, p.778).

The narratives of victims of domestic abuse and sexual violence are frequently dismissed by perpetrators, police, judges and juries and the media, in ‘a reflexive discounting of women’s stories of domestic violence’ (Epstein and Goodman, 2019, p.403). Feminist scholars have further argued there is evidence of epistemic injustice where witnesses are not believed ‘due to prejudice, implicit or explicit’ (Stewart, 2019, p.70). Pohlhaus describes this as the downgrading of women through ‘the deflation of credibility’ (2014, p.101). The evidence outlined

previously indicates women's accounts of abuse are often disjointed and broken, as a direct result of the physical violence and emotional trauma they have endured. This can result in a loss of narrative credibility, particularly in an adversarial environment, such as that encountered within the criminal justice system (Epstein and Goodman, 2019).

By understanding the fractured nature of these stories, feminist scholars can excavate through the trauma and facilitate the recovery of women's experiences to evidence that abuse. Empowering participants, through acknowledging their experiences, the impact of trauma and, the value of their contribution to the body of knowledge, is further evidence of congruence with a feminist methodology. One of the participants explained, 'I'm doing this because abusers rely on you being silent. I stayed silent for much too long'.

This summarises the researcher's aspirations for this study and aligns with a relativist ontological position, that reality cannot be viewed as a single, objective truth but, is something experienced uniquely through multiple lenses. This also aligns with an emic epistemological approach, where the researcher's role is acknowledged as a variable, with an impact on the design, conduct and outcome of the research. A feminist methodology engages the researcher in reflecting upon and acknowledging the impact of these factors on the research process to deliver authentic results (Malpass, Sales and Feder, 2015).

Determining the Method.

A Feminist methodology doesn't necessarily determine a qualitative or quantitative approach to research but indicates an application of the above

principles throughout the body of the work. A quantitative investigation could determine the frequency of sleep deprivation/ disturbance in intimate relationships and provide useful insights into this phenomenon and perhaps prompt further research however, using a didactic approach, e.g., ‘did you / didn’t you?’, fails to illuminate the lived experience of the phenomenon and, by default, ignores the voice of participants who give an affirmative response. A qualitative approach was therefore chosen to enable in depth exploration of survivors’ lived experience.

There are several methods available to researchers wishing to explore individuals’ experience of trauma. Focus groups have been employed to explore women survivors’ experiences of sleep deprivation (Humphreys, Lowe and Williams, 2008) however, several contraindications were identified for this method; research on domestic violence against women needs to place participant’s safety at the centre of the research design (WHO, 2010, p.10) whilst maintaining confidentiality. A Focus group could not guarantee that individual members wouldn’t share something they had learned in the group and divulge information that could put participants, or the researcher, at risk of reprisal. Another disadvantage is the inhibitory effect of sharing a platform with other survivors; participants may feel reluctant to share their experiences, especially if they have not established a sense of trust and rapport. The subsequent failure to disclose is recognised as a problem in studies exploring abuse and is considered a significant threat to validity (Ellseberg et al, 2001, p.2).

Finally, there was a significant risk of re-traumatisation, as a result of hearing the experiences of other participants (Lodrick, 2007, p.13). As a researcher with an

ethical obligation to promote and protect the well-being of group members, it was decided that Focus groups were not appropriate for this study or consummate with the researcher's skills as a novice researcher.

It was decided that one to one, semi-structured interviews would ensure the personal safety of participants, protect the confidentiality and anonymity of participants, whilst providing the richest data. A semi-structured approach was adopted as it provided some flexibility to the researcher. Interviews were conducted using some key questions (See Appendix Two) to explore the experience of sleep deprivation whilst also allowing participants to share their unique experience. The questions also acted as a prompt for the interviewer to sometimes re-orientate participants back to the topic, as they shared very broadly about their experiences of abuse.

The rationale for exploring this topic with women survivors of domestic abuse/ coercive control is outlined above. The term survivor is used consciously throughout this text to refer to participants in recognition of their victimisation and their recovery from abuse and regaining of power and resilience (Jordan, 2013)

Recruitment and the Gatekeeper.

Recruiting participants can be done using a variety of approaches however, when working with survivors of abuse it is vital to take a trauma-informed approach which acknowledges the complex impact of abuse and the subsequent risk of re-traumatisation and distress when discussing difficult or traumatic experiences (Lodrick, 2007, p.1). Researchers must ensure participants have access to support during their research journey and importantly, after they have

completed the interview, should they need to discuss any issues raised or experience re-traumatisation (WHO, 2001, p.23). Using a Gatekeeper can ensure there is appropriate support in place during and after the recruitment and interview phases. There is some debate around the role of gatekeepers and their influence on the choice of participant and in terms of screening participants, (Emmel et al, 2007, p.4) which may not be congruent with the researcher's own assessment of the 'ideal' participant however, a trusted gatekeeper can offer specialist support to participants within the context of an established, therapeutic relationship where participants feel accepted and validated.

Working within a Feminist methodology indicated the correct strategy was to adopt a collaborative approach and engage with services that were already invested in and had a relationship with the participant. The local Domestic Abuse Service were approached to present the Research Proposal and request their support to act as Gatekeeper. This involved recruiting participants from their client base who were actively engaged with the service, to offer a meeting space within their premises where interviews could be conducted and ensure a member of staff would be available after the interview, should support be required.

The Impact of the Covid Pandemic.

In May 2020, the ongoing Covid restrictions meant it was not possible to proceed with face-to-face interviews and after discussion with my research supervisor, it was agreed to defer the dissertation until the following academic year. Unfortunately, in the Spring of 2021 with many Covid restrictions still in place, it became clear it would not be possible to continue with the initial Proposal's plan

to conduct face to face interviews and in order to continue, virtual methods had to be considered.

Research Method.

Literature around conducting safe research with a vulnerable population using virtual methods did indicate that client safety and wellbeing could be achieved (Smith, Thew and Graham, 2018). A comparative study of online, versus face-to-face Focus groups, observed more in-depth discussion of sensitive issues amongst the online group. The authors speculated this was due to the perceived sense of anonymity affording confidence and greater disclosure (Woodyatt, Finneran and Stephenson, 2016, p.743), indicating potential improvements in the quality of data acquired when using these methods.

The revised research proposal involved conducting the interviews via an online platform using Zoom or telephone, depending on the participant's preference, and included plans to mitigate any risks inherent in this method. This included exploring with participants how they could ensure privacy during the interview process in order to avoid being interrupted and overheard with the resultant risk of disclosure to a third party.

Using online meetings as a method of engaging, both professionally and socially had been employed extensively during the pandemic lockdowns to reduce transmission and risk of exposure to Covid 19. Reflecting upon these interactions provided the researcher with useful insights into the challenges that can arise when unable to observe and reciprocate body language and, consequently I was acutely aware of the need to be an active and responsive listener. These

insights, along with my extensive experience as a Health Visitor, whose work involves frequent disclosures of distressing and emotionally challenging information, evidenced having the requisite skills to undertake remote interviews safely and effectively.

Further, it was agreed the research supervisor would provide emotional support should the researcher experience vicarious trauma as a result of exposure to distressing information during the course of the interviews, reflecting best practice advice for researchers (WHO, 2001)

Once the Research Proposal received ethical approval, the Domestic Abuse Service was approached to discuss the adjustments which had been implemented to ensure covid compliance and participant safety. The recruitment criteria to the study were: women aged 18 or over, who had experienced sleep deprivation because of their intimate partners action's and were no longer in an abusive relationship. Initially consideration was given to specifying a minimum period since the abusive relationship had ended, to allow time for healing and reduce the risk of re- traumatisation however, on reflection this was a counterintuitive restriction within a feminist methodology. Potential participants, though recognised as vulnerable for their experience of having survived abuse, where at liberty to determine their own readiness to partake in a study.

Ethical Considerations; Personal safety and Confidentiality.

Acting ethically is a fundamental principle that needs to be evident throughout the research process particularly when engaging with survivors of domestic abuse, with priority given to ensuring the respondent's and researcher's safety

(WHO, 2001). Further, my own position as a Registered Nurse required that I uphold my professional obligations under the Nursing and Midwifery Code of Conduct (NMC,2018) to ensure participants confidentiality and safety were preserved.

Safety measures were embedded throughout the research process and included ensuring participants' anonymity and confidentiality at all stages, in compliance with the moral contract between the participant and researcher and the legal obligations contained within the Data Protection Act (2018), GDPR (2016) and University of Worcester Policy (2018).

The Gatekeeper sought confirmation that any contact details forwarded to the researcher were a safe means of contact whilst participants also chose their preferred method of communication i.e., text, phone, or email for the initial exploratory discussion around taking part in the research.

Obtaining Informed consent is an ethical obligation of the researcher and as such it was felt important to have an initial discussion with potential candidates to provide an opportunity to clarify details of the research process and address any concerns. These conversations affirmed the purpose of the study was to explore sleep deprivation as a means of coercive control by asking about women's own personal experiences using the researcher's questions as a guide. It was explained the interviews would be recorded and transcribed with all identifying names or places removed and stored securely in an electronic format. Women were advised participation was entirely voluntary and they were able to withdraw their consent up to two weeks after the interview by advising the researcher of their unique number which they would be allocated at the beginning of their

interview. An explanation of this ‘non coercive disclaimer’ was seen as key to ensuring participants did not feel compelled into taking part (Fouka and Mantzorou, 2011, p.5). It also reiterated their right to change their minds, reflecting the principle within the Declaration of Helsinki which ‘asserts the rights and interest of individual research subjects above the generation of new knowledge through research’ (WMA, 2018).

Safeguarding Responsibilities.

As part of the researcher’s ethical obligations, any disclosure of safeguarding concerns had to be made known to the appropriate services. It was notable that one woman withdrew on these grounds as she cited significant fears that the contents of the interview would be called for and used as evidence in Family Court proceedings. She expressed her frustration and her sense of being silenced from sharing her experience of domestic abuse which she felt would have contributed to the body of knowledge this research was exploring.

It is notable that fear of repercussions in Family courts was raised as a reason for non-disclosure of domestic abuse in a study undertaken by the Ministry of Justice (2020). The study found victims worried that disclosing a significant history of abuse would present as failure to protect children and would therefore have repercussions in legal judgments around child contact (Ministry of Justice, 2020, p.50). This is shared here as evidence of the ongoing contemporary conflicts surrounding the silencing of women’s voices through the fear that stories describing their own abuse will be used against them.

Personal Safety

Establishing personal safety through the interview was another purpose of the preliminary discissions with the focus on finding a secure space to conduct the interviews. As per the protocol, none of the participants were in abusive relationships however it was important to ensure participants could set aside time in a private space in order to avoid disruption to participants' narrative and ensure no breaches of confidentiality took place which could pose a risk of disclosure, particularly by children or family members who may retain links with perpetrators (WHO, 2001). Discussion also took place around the risks of re-traumatisation and the role of the Gatekeeper in providing a follow-up phone call after the interview to offer support if it was required.

Ensuring participants' wellbeing, complies with the requirement for the researcher to minimise harm (WHO, 1999; CIOMS, 2016, p.20), particularly where there is a known risk that discussing previous abuse can result in re-traumatisation and in women who have PTSD. This is recognised as a presenting feature in many women who have experienced domestic violence with prevalence rates suggested between 45-84% (Sharhabani-Arzy et al. 2003, p.1336). Awareness of this obliges researchers to embed a trauma informed approach within their research protocol and ensure they are able to respond appropriately. I discussed with potential participants the risk of becoming distressed and the mitigations in place to support them; they could stop the interviews at any time for a break or withdraw completely if they felt unable to continue. It was also explained the Gatekeeper, with whom they had an established, trusted relationship, would provide support via a telephone call after

the interview. All the women acknowledged the potential for distress but emphasised they considered it was important to share their experiences and go ahead with the interviews. As a researcher I felt these discussions helped to build rapport and trust, which are seen as key factors in enhancing disclosure particularly where 'underreporting is widely considered a common threat to validity' (Ellsberg et al.,2008, p.1600).

Following these initial discussions, five women took part in interviews, two were via Zoom and three via telephone. The participants signed and returned the consent forms and on the day of the interview, were allocated a participant number which they could use to contact the researcher should they wish to withdraw their consent. The interviews were recorded and subsequently transcribed by the researcher. Transcribing was done as contemporaneously as possible to start the process of familiarisation with the data. The interviews lasted between fifty minutes to one hour and forty-five minutes, with one interview taking place over two telephone calls. Collectively they generated 47,000 words and produced a rich source of data that was subsequently analysed using Thematic Analysis.

Thematic analysis.

This method of data analysis is underpinned by a Qualitative philosophy thus maintaining congruence with the researcher's stance and has gained prominence as a method in qualitative research. Thematic analysis is recognised as providing researchers with both an inductive method of looking at data, to explore and capture people's reality and deductively, to manifest more latent content that has been depicted in the interviews (Braun and Clarke, 2017). The

researcher is encouraged to familiarise themselves with the data, a process which began with transcribing and continued as transcripts were read and reread. Once familiarisation had taken place, coding generation began which required the researcher to label things seen within the data. Codes can be semantic, carrying a surface meaning, such as a description of an episode of violence, ‘he stuck sharp things in my feet whilst I was asleep’ or latent, which capture assumptions that underpin surface meanings such as expressing the view that women should put up with violence in marriage ‘I made my bed and was told I had to lie in it’.

Once codes were generated, they were clustered together. For example, ‘I’m the lion in this house’ fell within the theme, ‘Power and the empathy vacuum'. As a novice researcher I required a means of visualising and then grouping the codes. This was achieved by colour coding each participants’ narrative, then quotes/ words and paraphrases which represented codes, were written on individual, post-it notes. These were then posted on a wall allowing them to be situated with others, as themes were generated (See Appendix 3). It also allowed for a period of reflection and development of the final themes, to ensure relevance to the research question, ‘Is sleep deprivation used as a means of coercive control and if so, how does it present?’. These six themes are explored in the Analysis and Results section.

Study Limitations.

The coronavirus pandemic necessitated an adaptation of the research method from face-to-face interviews to the use of remote methods. The advantages and disadvantages of these methods have been discussed elsewhere but on

reflection, the quality, depth and breadth of data obtained through the interviews was considerable; over 47,000 words were recorded and transcribed, 270 codes identified and six themes generated.

A greater number of participants would have provided an even richer source of data and it is important to acknowledge the limitations of a small study in terms of extrapolation to the broader experiences of women experiencing sleep deprivation and coercive control however, this is an acknowledged limitation of small-scale qualitative studies.

The research succeeded in giving participants an opportunity to share their experiences which all the participants voiced was important, in spite of any personal trauma they endured by revisiting their experiences. Pippa explained, ‘I’m hoping in some small way to raise awareness’, whilst Jane stated, ‘We’ve had our voices stolen, being silenced is the big thing we’ve all experienced’.

A further limitation of the study is the researcher’s inability to offer the interviews through the medium of Welsh. As an English speaker in an area of Wales with 43.9% of the population speaking Welsh (ONS, 2011), it is important to acknowledge this may have inhibited first language Welsh speakers coming forward. Conducting interviews in a second language or using an interpreter are recognised as presenting challenges around establishing rapport and thus potentially reducing disclosure and thus validity, as well as raising concerns around the accuracy of interpretation (Cortazzi, Pilcher and Jin, 2011). The Welsh Language Act 1993 embeds in law the obligation to provide oral and written information in the medium of Welsh across institutions such as government agencies and health service providers. Although this does not apply

within the context of this research it is important to acknowledge this limitation could have been a barrier to a significant number of women taking part in the research and potentially reduces the intersectionality of the research.

Chapter Four - Results.

This chapter considers the themes that were generated from the rich data obtained from the interviews which took place with five women aged between thirty and eighty-one years old, three via telephone and two via Zoom interview. All the participants were in heterosexual relationships which ranged in duration from eighteen months to forty years.

No further demographic information was requested by the researcher however one of the women described herself as mixed race when she shared her experiences of racist abuse by her husband, towards her and her children.

Braun and Clarke (2019) suggest generating themes is a creative, reflexive process and captures common, recurring patters within the data, which are underpinned by a central organising concept, the core of the theme. Using this method allowed for a reflective and creative exploration of the codes and subsequent generation of the following themes.

The women's interviews chronicled not just their experiences of sleep deprivation but their journey through and recovery from, abuse. The sense of a journey was notable, as was the troubling impression that these women had escaped with their own and their children's lives, as finality thinking was a theme across all the narratives. For the purposes of anonymity, pseudonyms have created to provide continuity with each woman's individual narrative.

Theme One - Rapid commitment and Isolation.

All the participants described a highly accelerated courtship phase, of finding themselves in an unfamiliar environment, often cut off from friends and family and alone with the perpetrator. This was evidenced through the narratives of rapidly developing relationships with pressure for early commitment,

'It went from practically not knowing each other to living together almost instantly, it was quite fast moving' (Faith). Jane was quickly isolated as she moved away with the perpetrator, leaving family behind, and hadn't seen them for forty years. This added to her sense of being cut off from sources of support which was compounded when her husband also 'banned everyone from visiting'.

Initially, isolation wasn't seen as problematic but representative of the intensity of a new romantic relationship. Faith acknowledged she didn't know her partner very well but, 'he seemed very caring, very nice'. Pippa recalled, 'before I knew it, I stopped going out with friends, but it was OK because I was in love'.

This initial perception of perpetrators is seen as an important feature in coercive relationships as it facilitates attachment between the couple (Enander, 2011, p.31). Speaking fourteen years later, Pippa acknowledged this accelerated attachment happened in the context of establishing control, 'I didn't need any one cos I had him, that's when the attachment was formed, it started to go downhill from there'. Kathy also recognised the perpetrator's motivation, 'It started really quickly. He knew he had to be on this'.

Isolation and rapid commitment are often signs that a relationship is following a trajectory into abuse as the perpetrator also seeks to cut off external sources of

support and assert control. A woman's friends can be a significant source of support (Stark, 2007, p.266) and therefore threaten control, which explains the perpetrators efforts to sever these relationships. Grace shared how she fell out with her mother because 'she didn't like the way he was with me'. What almost passes unnoticed in this statement is the falling out takes place between mother and daughter, not mother and Grace's husband, whose words were so belittling.

Margaret explained whenever she was on the phone her husband would constantly walk back and forth,

'He hides so I can't see him on the stairs or hides around the corner in the lounge so he's listening to everything'.

If friends rang, he would tell callers she was in the bath or simply hang up on them. Once control and isolation were established the perpetrators behaviour rapidly changed and women saw an emergence of coercive and controlling behaviours including acts which prevented, interrupted, and shortened sleep. These are explored below.

<u>Theme two - Sleep denied. Expectations of companionship, servitude and sex.</u>

From contemplating going to bed, to sleeping peacefully and safely, to having enough rest, perpetrators found ways to delay, interrupt, limit, deny and control sleep. It was apparent that without exception, these took place within a wider context of other coercive, controlling and abusive behaviours. Perpetrators placed their needs for companionship, sex, food and drink above the needs of their partners and were often affronted and became aggressive, either verbally, physically or both when they were met with refusal to comply.

‘Whatever he wanted he thought was his. ‘There wasn’t discussion no, no discussion, no. Demands’. (Faith)

Some perpetrators would try to assert control over when the women could go to bed, citing women’s roles as companion or carer, then quickly resort to name calling when women declined, because they were tired. Kathy’s partner suffered with a form of epilepsy and would often insist she stay awake all night in case he had a fit, despite her own fatigue. On other occasions he’d insist she stay up and watch horror films which she explained, ‘I couldn’t watch’ or encourage her to drink alcohol despite this being contraindicated due to the medication she took. When she declined, she was ‘boring’. When Faith was caring for her 3 young children, she had no help from her husband. ‘When the twins came, he was bored of being a dad, he didn’t take his paternity leave’ but when she refused sex because she was exhausted, ‘he would be nagging all night, saying you don’t love me’.

Margaret experienced nightly interruptions to meet the demands of her husband for drinks and personal care despite his ability to get up in the morning and go out for a walk independently. ‘He’s in and out all-night shouting and you have no peace’.

Jane described how she would go to bed only to be faced with her husband’s demands,

‘‘What the heck are you doing going to bed? I didn’t say you could just fuck off to bed, get up. I want food or I want a drink, I want this, or I want that’, and that was if he was taking it easy’.

Perpetrators often created a sense of unease and menace around bedtime with veiled threats of harm, ‘you can go to bed, but then in a threatening tone, don’t get too comfy cos I’ll be in later’ (Jane).

Faith experienced physical and financial abuse and shared the fears she felt about night-time,

‘Nights are even worse, you don’t know what’s coming…you go to bed it should be peaceful but it’s not and even if you do get that peace you’re still wondering if the bedroom door opens, what’s going to happen’.

Three of the women shared the experience of being forced to stay awake or woken to discuss issues, often relating to their partners’ bogus concerns about the women’s commitment to the relationship. Jane stated,

‘He would sit me at the kitchen table and make sure I engaged with him, even when I was totally exhausted, he’d stop me going back to bed. I’d be exhausted all day; he’d sleep all day’.

Pippa also experienced this unrelenting demand for attention that could go on literally all night, despite her begging for sleep,

‘I was forced to wake up, he would go on constantly, saying we need to talk. Hours, hours he’d sit there all night, wanting to discuss things. I was cheating on him, I didn’t love him, I was rejecting him’.

Kathy too was woken up by her partner, ‘He’d pretend to have fits to wake me up and he’d make it up’.

Jane summed up the intensity and distress of these nights, describing how her husband would,

‘Shout and swear in my ear, he’d make accusations, criticisms, arguing, it was like the inquisition; it would take all night sometimes’.

The women’s overt requests to be allowed to sleep were largely ignored or they met with an array of tactics to prevent sleep that ignored their pleas and were often violent. This is particularly pertinent in prosecuting coercive control. As CPS advice indicates, coercive control occurs when ‘the behaviour has a serious effect on the victim and the perpetrator knows or ought to know, the behaviour has a serious effect on the victim’ (CPS, 2017). The women’s begging to be allowed to sleep is unambiguous in conveying their distress and perpetrators would have clearly known, or should have known, the impact their behaviour was having. Pippa explained,

‘I was forced to wake up, he would go on constantly, say we need to talk, we need to talk. This would go on for hours, he’d sit there all night wanting to talk’.

On one of these occasions, her twelve-year-old son intervened, going into the bedroom saying, ‘Leave my mum alone’. One night, her partner flipped the mattress whilst she was in bed. He would take the quilt off her and on one occasion, stabbed the air bed she had bought, to replace the bed he had chopped up,

‘So, I had nothing to sleep on, so he could talk to me. It was just constant all the time’.

Jane described how her partner would rock her bed to wake her up. They lived in a bungalow, and he would often stand outside, banging on the windows. In the winter, ‘he’d take my bedding away and open all the doors to let the cold in’. Sometimes he would move furniture in the middle of the night, switch off the electricity and call from another room.

‘Obviously you wake up and you’re in fear and you can’t put on a light, and it would result in my having a fall, that would be my fault, obviously’.

Theme three - Torture and violence. Terrorizing sleep.

Analogies to torture are entirely appropriate as the descriptions of participants efforts to appeal to perpetrators to stop their torment, were repeatedly ignored, despite literally begging. Article 3 of the Human Rights Act 1998, states,

‘Torture occurs when someone deliberately causes very serious and cruel suffering (physical or mental) to another person. This might be to punish someone, or to intimidate or obtain information from them’ (Human Rights Act 1998).

Pippa was left feeling desperate and exhausted, ‘I’d be crying cos I wanted to sleep’. Janes’ partner subjected her to horrific physical assaults and then would wake her in the early hours,

‘When you’ve taken a pasting, you’re really groggy, you can’t answer, he’d demand that I get up and make a drink or food, demand I leave, watch me pack’.

Their descriptions conveyed their desperation to be given the emotional and physical space to sleep, resonant of Biderman’s descriptions of victims of torture,

bargaining with their captor who then briefly capitulates (Baldwin et al, 2016, p.1176) further reinforcing an attachment through the granting of sleep or rest. Pippa and Jane both shared how they experienced brief periods when things would be ‘fine’ but ‘then it would start again’(Pippa). Jane explained,

> ‘It was evolving all the time the way he used threats. Then he’d change tactics as soon as he felt I got used to that then he’d switch, constantly battling uphill’.

She experienced appalling physical violence when she slept and catalogued how her husband had stuck sharp objects in her feet, hit her with a baseball bat, broken a chair over her sleeping body, smothered her, strangled her, set fire to her bedding. She was so fearful of what might happen, she slept with a fire extinguisher under her bed.

There was also an expectation by four of the perpetrators that sex would be available without meaningful consent or prior discussion. Participants described their partners as moody and sulky if they refused sex. Respect and trust were absent which had the effect of making some of the participants feel enduring shame. Jane explained there was plenty of discussion of her partners’ sexual preferences and about ‘bringing in someone else’, which had the effect of ‘making me feel disgusting’.

Faith also reported, ‘If he wanted sex and I wasn’t in the mood cos I was tired he’d make me feel guilty ‘til I did it anyway, just to get it over with’.

Jane described how ‘I had woken up with somebody forcing their cock in your mouth’. Kathy conveyed the sense of foreboding around night times,

‘You just dread, I hope he falls asleep on the sofa. He was cruel, a cruel, cruel, man’.

Theme four -The impacts of sleep deprivation.

The adverse impacts of sleep deprivation were evident across all the transcripts and were not only felt in the immediate aftermath of broken nights but, appeared to have a cumulative effect that persisted, sometimes years after the relationship had ended. Margaret had only just separated from her husband but within weeks noticed that her persistent diarrhoea had resolved. Faith developed trigeminal neuralgia, caused by years of grinding her teeth in her sleep, a symptom reported in a study looking at the impact on sleep from living with domestic violence (Lowe, Humphreys and Williams, 2007, p.556). One of the participants in their study reported developing Fibromyalgia, a condition Jane had been diagnosed with, and which she attributed to years of abuse. Significantly, it is known to deteriorate with poor quality sleep (Singh et al., 2018).

All the women described overwhelming fatigue and confusion, headaches, and mental exhaustion in the immediate days after poor, broken sleep, which affected their ability to maintain work schedules and carry out basic tasks. Faith was made to drive her husband to work at five in the morning (and by necessity, their three children), a journey she estimated would have taken him five minutes on foot. She was then faced with caring for the children all day with no respite or opportunity to catch up on sleep. When asked what her husband did when he came home, she laughed, ‘Oh that’s all he ever did, he was always falling asleep’.

Pippa recalled how dangerous it felt driving the children to school when she was so exhausted,

‘I was just like a zombie I wasn’t functioning at all, I’d get up take the kids to school in the car, I was on my knees’.

Her fears were valid as evidence indicates a significantly increased risk of accidents when driving whilst sleep deprived (Czeisler et al. 2016). She also experienced other symptoms, in common with other participants, including loss of appetite which was reported by four of the women. Margaret lost a lot of weight, as did Pippa who reported nausea and subsequent weight loss, because of headaches caused by lack of sleep. Kathy too reported significant weight loss,

‘Because I was so down you know, there’s no motivation, not even for eating.’

Jane explained,

‘You feel like you’ve evaporated. Appetite was affected, I was being sick several times a day, started losing my hair.’

There was also a notable impact on the women’s abilities to think and perform routine activities They discussed feelings of utter exhaustion and the subsequent impact on their self-esteem ‘You feel less than Human’ (Jane). Pippa felt she had been useless as a mum, at home and in work because,

‘I couldn’t do it because I was ill. My boss would ring and say you haven’t made this call.’

The link between domestic abuse and an increased risk of depression and other mental health problems is well established (Roberts et al.,1999; Dienemann et al., 2000; Mechanic, Weaver and Reisick, 2008) and was reflected in participants reports of adverse impacts on their mental health with symptoms of anxiety, depression, and confusion. Attributing all these symptoms solely to sleep deprivation is not possible due to the wider context of abuse and coercive control, which participants all experienced however, some of the symptoms do have confirmed links with chronic sleep deprivation.

Theme Five - Power and the empathy vacuum.

This theme contextualises sleep deprivation as a phenomenon occurring within relationships characterised by perpetrators' misappropriation of power, cruelty and insensitivity to the suffering of their intimate partners. As a Feminist researcher it is important to acknowledge the researchers' visceral response to the narratives. This should not be viewed as a limitation of the study but rather an opportunity for a qualitative researcher to 'employ their passionate, discomforting emotions as sites of knowledge rather than as a threat to objectivity' (Bischoping, 2019, p.5). For the researcher, it was arresting how much effort perpetrators made to control and dehumanise their partners. As Jane explained,

'You're told you're not worthy of using the toilet and you can shit or piss in a bucket cos that's all you're good for, you're no better than an animal'.

Perpetrators established and maintained the power within relationships often by using language to inflate their importance. Sometimes the simplest comments

were the most effective at conveying a clear message about expectations and behaviours. Jane's husband described himself thus, 'I'm the Lion in this house' whilst Margaret's husband established rules early on with comments such as, 'I don't like it when women talk' and by telling her to 'Keep quiet, don't talk to me whilst I'm watching the Telly'. These statements had the desired effect on Jane, shutting her down, with the result she reported feeling very lonely.

Four of the women shared instances where they had reason to engage with health services. Jane, Kathy and Faith explained how their partners always insisted on accompanying them to medical appointments. They described the perpetrator's anger when accessing medical care and an indifference to their suffering. Jane explained, when she was having a breast examination (by a male doctor),

'I could hear his chair moving and he was puffing and blowing. Anything to do with my health was a total nightmare. On the drive home he was ranting and raving, he pushed me out of the car, drove off, all because, I let a doctor fondle my breast's'.

She recalled when she was pregnant, he'd refused to allow her to have a vaginal examination, which resulted in mother and unborn baby being subject to an unnecessary x-ray. He also prevented her breast feeding their first child because 'they're my breasts'.

When Faith was in hospital with her twins, her husband told her, 'There's no way he's (a male doctor) putting his fingers up you'. She subsequently needed an examination and was 'on pins' in case he found out.

Margaret was hospitalised for five days after a serious fall at home and her husband failed to bring in her dentures, glasses, or clean clothes, despite visiting daily. Subsequently she found eating very difficult and reading impossible for the duration of her hospital stay. On her return home he said, ‘it’s nice you’re home, what’s for tea?’ then sat down to read his paper.

Family events such as birthdays, Christmas and funerals were particularly challenging, as perpetrators became more volatile and unpredictable, behaviour which appeared to stem from a change in focus away from them. ‘If it wasn’t about him, he’d spoil it’. Kathy lied to her partner about the date of her parents’ funerals because ‘it was just terrifying he would turn up’.

Jane explained how birthdays and Christmas could be ruined.

‘Nobody else was allowed to come, then he’d wind up, he’d spoil the day completely by tantrum or finding something wrong. I was frightened to have any pleasure in the end’.

Pippa came home from a family funeral to find ‘he’d smashed it up, the only two items he’d left were two sofas he couldn’t get through the door.’

Women were also humiliated and shamed by perpetrators’ blatant infidelities. Jane’s husband insisted on moving his girlfriend and her son into their family home and then criticised the state of the floors, saying they weren’t clean enough for his girlfriend.

‘He treated me like a slave and tried to humiliate and degrade me in front of her’.

The building blocks of control are easily overlooked, and like sleep deprivation, often hidden in plain sight. As Faith explained, ‘He expected me to do everything. He got me to put his socks on’. Like Jane’s husband, he repeatedly asserted his position as head of the household,

‘He wouldn’t lift a finger ‘cos he went to work. ‘I’m the breadwinner so you do everything else’’.

He too, was unfaithful when he ‘literally slept with, then moved in with my next-door neighbour’.

Theme Six - Finality thinking

Like the previous theme, finality thinking was generated because it formed a significant thread throughout the narratives. Finality thinking, either through suicidal ideation, homicidal ideation or homicidal threats were often the final prompts for a decision to leave, though some of the participants lived with threats to kill or suicidal threats, for years.

Pippa’s partner frequently threatened suicide but it was following the realisation that she was contemplating ending her own life, ‘I would have happily walked into the sea’, that gave her the impetus to end the relationship. Her partner left, threatening suicide on the way out. ‘I slammed the door on him because I thought if he’s dead he’ll stop with me’. He continued to stalk her for two years, a high-risk behaviour associated with an increased risk of domestic homicide (Rai et al. 2020), only stopping when she met a new partner.

Kathy got to the point where, ‘I knew the kids were safe and I just thought what is the point of being here now?’ A week later she found herself considering putting a pillow over her partners’ head and killing him. This prompted the decision to escape the relationship.

‘I went cold … I felt like killing him and that scared me even more than the thought of him killing me’.

In an act of extraordinary psychological cruelty when Jane’s partner threatened suicide, she explained,

‘I’d talk him round, he’d turn round, ‘Well, you saved me tonight but you’re going to pay for it tomorrow.”

She was also faced with multiple threats of murder by shotguns, (her husband owned firearms, so this was a credible and terrifying threat) gang rape, beheading, killing the children whilst she watched and then killing her. It was her husband’s words though, that gave her the impetus to leave. Her voice got louder and louder as she repeated this conversation, simulating his voice,

‘Ive got this butterfly in a jar, he said. It keeps trying to escape and I have to keep pushing it back, I have to force it back, and that’s what it’s like with you’. All he is doing is keeping me alive to torture me, I was never going to escape, he would kill me one way another and I just thought I’ve got to do this now, it’s now or never.’

Margaret was eighty-one-years-old when we spoke and described how one night, her husband had his hands round her throat, an action with a high risk of

homicide (Glass et al. 2008) and is strongly associated with establishing coercive control (Thomas, Joshi and Sorensen, 2008). She was also highly fearful that, despite his disabilities, he could get into her home ‘because of his Army experiences and training’.

Faith didn’t experience direct threats of homicide or vocalise suicidal ideation but in talking about the impact of her abuse, she shared how she was now a completely different person, ‘I’m a shell of my life because of everything I’ve been through’. Her statement resonated with the theme of a life lost and was therefore included to indicate the existential threat posed by her husband’s behaviour.

This chapter has presented the results of this study, by exploring the six themes which were generated from participants narratives. They have confirmed that sleep deprivation was used as a means of coercive control and demonstrated the wide variety of means used by perpetrators to deprive their intimate partners of sleep, highlighting the importance of this small study. Participants disclosed acute and long-term, adverse impacts on their mental and physical health and described how sleep deprivation took place within a wider context of coercive control and abuse. The next chapter discusses the findings, their implications and recommendations for further studies and practise.

Chapter Five -Discussion.

Introduction.

This chapter will explore the insights gained from analysis of the themes and consider the implications of the findings. It explores the argument for prosecuting sleep deprivation as a form of torture and the unexpected finding that the narratives share many similarities with the Homicide Timeline (Monkton Smith, 2020). For contiunuity and clarity, recommendations are discussed in the relevant sections.

Domestic abuse literature has indicated sleep deprivation is used as a method of coercive control (Stark, 2007; CPS, 2017; Tetlow, 2015) however, most academic studies have focused on sleep loss and disruption as a consequence of living with domestic abuse, rather than a deliberate tactic used by perpetrators. This is surprising given the widespread recognition of sleep deprivation as a powerful tool in the repertoire of torture techniques (Biderman 1957; O'Mara and Schiemann, 2019) and the ease with which these techniques can be used in the domestic setting. Unfortunately, a particular feature of sleep deprivation is its deniability and invisibility (Stark, 2007, p.205) something noted across the narratives. As Pippa said, 'I didn't realise it was domestic abuse, I didn't think you could get help, didn't even cross my mind'.

How common is the phenomenon of Sleep Deprivation?

This small qualitative study has provided a rich source of data about the experiences and effects of sleep deprivation in a small group of survivors however, it is not possible to estimate the frequency of this phenomenon within

the wider population. Given the significant, adverse effects highlighted in the results, explored below, establishing frequency of sleep deprivation in this context is imperative, especially as quantitative data is currently scarce. A study looking at Family Violence found 4.1% of husbands were reported as having 'prevented women getting adequate rest' (Silverman et al. 2016, p.152). Further work is required to establish how often sleep deprivation is employed, especially given the links to adverse outcomes for victims.

Circumstances of sleep deprivation.

The study confirmed sleep deprivation was used as a means of coercive control and highlighted a wide variety of tactics used by perpetrators. Some of these centred around the perpetrator's exploitation of their partners to provide companionship, care, and sexual interaction. Within intimate partner relationships there is usually a shared expectation of companionship and sexual intimacy however, the study found significant evidence of unreasonable demands by perpetrators to have their needs met whilst ignoring those of their partners. In many instances, participants would assert their need for sleep or rest but this would frequently result in an escalation of pressure.

Tactics.

Both nonviolent and violent techniques were used to coerce the women into responding to perpetrators demands and are included (See appendix) to illustrate the range of experiences the women were subjected to.

Non-violent techniques including begging, nagging, joking, tickling, name calling, verbal insults and threats. Physical violence was a significant feature in four of

the relationships and ranged in intensity from pushing and slapping to incidences of extreme violence which were potentially fatal including smothering, stabbing, hitting with a baseball bat, hitting with a chair, and setting fire to bedding. Tactics which were highly focused on preventing sleep included being dragged out of bed, being flipped off a mattress, shaking beds, removing bedding, particularly in the winter and setting fire to bedding.

These techniques were used until the women stayed awake. This repeated cycle of pressure, resistance, and acquiescence created a sense of hopelessness which, when combined with the impact of sleep deprivation was debilitating and is a notable feature in the dynamic of controlling and coercive relationships (Mitchell and Raghavan, 2021, p198). This cycle also served to reinforce the behaviour the men looked for, as over time the women could predict the consequences of non-compliance.

The impact of sleep deprivation

In line with previous work, looking at the impact of sleep deprivation, the study found evidence of short and long-term, adverse consequences on the women's mental and physical health. All the participants reported symptoms of depression which are strongly associated with poor sleep quality (Rio et al., 2018.; Peach, Gaultney and Gray, 2016). Nausea and poor appetite with subsequent weight loss, were reported frequently and attributed to inadequate sleep. It is possible these symptoms were further aggravated by living with coercive control which is linked to an increased risk of depression, suicidal ideation, and suicide (Ellsberg et al 2008) and a complex form of PTSD, thought to develop in response to the

inescapable nature of the abuse and the hypervigilance this creates in victims (Dutton and Goodman, 2009, p.753).

This finding has significance for women accessing health care providers with reports of disturbed sleep and / or depressive symptoms. Given the number of overall women experiencing domestic abuse and the established links with poor mental health and sleep disturbance, women presenting with these symptoms should prompt a sensitive enquiry about the woman's intimate relationship in line with initiatives such as 'Ask and Act' (Welsh Government, 2017).

The combined impact of the living with sleep deprivation within a wider context of coercive control, is not an area that has been previously explored but raises the spectre of an exponential risk of experiencing adverse impacts. Furthermore, recognising sleep deprivation as a means of torture adds another layer of threat and concern regarding the victims' wellbeing.

Sleep Deprivation as an Offence.

The study found frequent examples where the use of sleep deprivation would be recognised as an offence under Section 76 of the Serious Crime Act 2015. That is, 'where the perpetrator repeatedly or continuously engages in behaviour that results in serious harm, on at least two occasions and which the perpetrator knew or ought to know, the behaviour will have a serious effect' (CPS, 2017). Placing responsibility with the perpetrator, contextualises sleep deprivation as an act of coercive control and positions the behaviour as a criminal act (CPS, 2017).

Unfortunately, challenges remain around the prosecution of coercive control, particularly around the identification and recognition of coercive acts and the

difficulties in obtaining evidence (Bishop and Bettinson, 2018, p.8). For example, investigating police officers use of risk assessment tools, such as the DASH RIC (Richards, 2009), fail to capture 'the *particularity* of coercive control, the strategic ways in which a specific abuser individualizes his abuse' (Stark and Hester, 2018, p.87).The limitations of current risk assessments, indicate the need to develop more sensitive and specific tools which uncover the detail of coercive control, including sleep deprivation (Myhill and Hohl, 2016), as well as ongoing training for investigating officers and the wider criminal justice system, to move beyond an incident-focused approach. The 'Domestic Abuse Matters' training was developed in response to these challenges and evaluation of the programme confirmed a 'small impact on measures of police officer knowledge of coercive control and attitudes to domestic abuse' (Brennan and Myhill, 2017, p3.).

Conviction rates for coercive control, which are one means of reflecting the effectiveness of training, are still low (ONS, 2020) further highlighting the importance of training that is responsive to new insights, such as knowledge around the use of sleep deprivation.

Difficulties surrounding recognition are further complicated by the finding that participants themselves did not see their experience of sleep deprivation as 'domestic abuse', even though they recognised their distress. The subsequent dissonance they experienced, resulted in feelings of confusion and anxiety. Pippa thought she was going crazy whilst Faith explained 'I didn't realise it was abuse because 'it wasn't physical'.

Lack of recognition can be a significant barrier to seeking help for victims and could be another contributory factor in the persistently low conviction rates for crimes of coercive control.

An example of good practice to address these gaps in knowledge is the collaboration between Welsh Women's Aid and the Welsh government (Welsh Government, 2015) to provide a toolkit for use in educational establishments as 'environments where positive attitudes towards gender equality and healthy, respectful relationships can be fostered'. This proactive, preventative model aligns with calls for greater education and awareness-building programmes around coercive control though more remains to be done, particularly within the Criminal Justice System and amongst Social Care and Health providers.

Perpetrator Profiles.

The findings raised significant questions regarding the profiles of perpetrators who use sleep deprivation as part of their 'repertoire' of abuse. The study saw evidence that the women begged to be allowed to sleep but were ignored, indicating the perpetrators 'knew, or should have known' (CPS, 2017), they were causing suffering. Despite this, they continued to demonstrate low empathy and often complete indifference to the distress of their intimate partners.

Interrogation.

Participants described how perpetrators would interrupt or prevent sleep to have lengthy conversations, often related to spurious concerns around fidelity and the woman's commitment to the relationship. These episodes often took place in the middle of the night and could go on for hours. They were highly distressing and

akin to undergoing interrogations, aligning with the ‘sleep deprivation as torture’ discourse.

Interrupting sleep was clearly a tactic of coercion and control which continued even when the women started experiencing severe adverse, physical, and psychological symptoms resulting in increasingly less ‘space for personhood to breathe’ (Stark, 2007, p.274). The sense of perpetrators desire to diminish the women was a powerful observation and reflective of the unrelenting efforts employed to assert control.

Understanding why perpetrators behave this way may give some indication of the means to change these behaviours. Theories of perpetration indicate links between experiencing childhood trauma, childhood exposure to domestic abuse (Kadiani et al, 2020) and personality disorders (Ehrensaft, Cohen and Johnson, 2006) and increased likelihood of becoming a perpetrator. Evolutionary theory suggests controlling patterns of behaviour and jealousy are linked to ensuring genetic survival and allocation of resources to any progeny (Peters, Shackelford and Buss, 2002, p.264).

What these theories fail to comprehensively explain, is why perpetrators response to their own trauma results in abusive behaviour directed towards their intimate partners. Violent, coercive, controlling behaviour is often excused by perpetrators as a response to women’s failure to meet nebulous standards of accepted femininity and behaviour (Monkton Smith, 2020, p.1272) however, if we place the behaviour outside the context of the relationship, we observe torture and the tortured.

Changing the discourse and redefining this behaviour as torture, realigns the perpetrators behaviour, not as a response to the perceived failure of intimate partners to meet domestic obligations, but reframes it as a conscious act to incapacitate and inflict suffering (Tetlow, 2005, p12). Given the challenges of prosecuting coercive control, particularly within a legal system where 'gender inequalities and gendered assumptions are in evidence' (Bishop, 2016, p.9), there is a powerful argument for pursuing these crimes as torture (Tetlow,2005). This would encourage analysis of the minutiae of perpetrators behaviour, which though this lens, becomes highly significant, illuminating the lived experience of the victim/survivor. Further, it removes the element of victim blaming (Poletta, 2009, p.1491) which is absent from discourse around torture victims where the focus is on the perpetrator.

The confluence of the use of sleep deprivation, with evidence of finality thinking across the narratives may be indicative of a higher risk for extreme violence, control and domestic homicide and suicide / involuntary manslaughter. Previous work to establish risk factors for domestic homicide has identified prior domestic violence as the most significant risk factor (Campbell et al.,2007, p.253) whilst non-fatal strangulation is another indicator of risk (Glass et al.,2008, p.277). The presence of finality thinking in the narratives and the identification of these risk factors, prompted an examination of the Homicide Timeline (Monkton -Smith, 2020) which led to an unexpected finding.

The Homicide Timeline.

The Homicide Timeline was developed by Monkton- Smith (2020) following analysis of extensive documentation relating to domestic homicides which occur

at a rate of approximately 2 -3 women per week in the UK (Ingala-Smith, 2020). The timeline identifies key, common features along a temporal, eight stage process. Revisiting the narratives through this lens, produced an unexpected result as they mirrored stages of the timeline, with the exception that the relationships in this study ended before a fatal event.

In common with the timeline, this study found evidence of previous abuse by perpetrators with one exception, where this was the perpetrator's first relationship. There was also rapid commitment and separation from support networks, followed by the use of coercive and controlling behaviours within the relationship, reflecting features described in stage three. Monkton Smith (2020, p.1277) notes this stage can vary in duration from weeks to years but, at the point where there is a perception by the perpetrator of intent to leave, or perceived threats to their control, this can act as a trigger and an escalation in frequency or severity in abuse. It is possible the angry and violent responses noted when women underwent medical examinations or attended family functions, could be viewed as a re-assertion of control and ownership, after perpetrators perceived a challenge to their dominance. Their reactions were meant to act as a powerful reminder that personal agency was an illusion and, to re-establish power.

Attempts to leave where made in four of the narratives and were all met with resistance, reassertion of control and often an escalation in coercion and tactics related to sleep deprivation. The night-time interrogations to question fidelity would escalate, along with threats by perpetrators to commit suicide and, threats to kill. Dobash and Dobash (2015, p.39) suggest a perpetrator may decide to

‘change the project, from keeping her, to destroying her’, with homicide becoming a real possibility. Jane recognised this change in thinking when her husband talked of her as ‘his butterfly in a jar’, prompting her decision to leave. Evidence from the narratives indicated three of the women became acutely aware of the risk to life; through contemplating suicide, heightened awareness of the risk to their own life, because of homicide, and in one case, contemplating murder. These insights prompted action that ultimately led to their escape, though the risk of homicide remained significant as three participants experienced stalking and threats to kill. Clearly, there was a divergence from the timeline in the experiences of women in this study however, the findings raise significant questions about sleep deprivation as a previously unknown, and unexplored indicator of increased risk for fatal outcomes. This is an area that would benefit from further research to establish any links with suicide and homicide but also to ascertain if there is any evidence of sleep deprivation as a feature of control by perpetrators who were killed by their victims.

This discussion has explored key themes and unexpected findings that have emerged from the study. Further research is required exploring the short- and long-term impacts of sleep deprivation as two of the women in the study experienced chronic health problems because of their experiences. Given the current epidemic of domestic abuse, it seems reasonable to assume that there are significant numbers of survivors living with long term health problems which require greater investigation and a coordinated response. Establishing specialist health services with awareness of the co-morbidities that can present in survivors, working in a trauma informed way, could be life altering for women living with unrecognised consequences of years of abuse.

Limitations

A limitation of this study was the small sample size consisting of five, English speaking participants. Although the demographic data indicated a wide age-range of survivors, from thirty-four to eighty-one years and one participant identified as mixed race, there was a lack of diversity in the sample resulting in reduced intersectionality. It is also important to note that the researcher was an English speaker working in a part of the Country with a high proportion of Welsh language speakers. This could have impacted negatively on recruitment of women whose first language was Welsh and who prefer to communicate through the medium of Welsh.

Additionally, this small study explored the experience of female survivors which, due to the gendered nature of coercive control was essential however, further studies could explore the use of sleep deprivation in male survivors and the LGBTQ+ community to highlight any nuances in the experience of sleep deprivation.

Finally, the author is acutely aware this study has not addressed the impact of exposure to sleep deprivation on children and young adults. This is a significant area of study that urgently needs further investigation.

Chapter Six - Conclusion.

This qualitative study has provided a rich source of data around the lived experience of sleep deprivation, as part of a regimen of coercive control and provided insights into the frequency and methods used to deprive of sleep. It has confirmed findings from previous sleep studies which identified an array of adverse, short, and long-term impacts on health, including depression, low self-esteem, poor memory and suicidal thinking and the development of chronic health conditions. Given the centrality of sleep to human health and wellbeing, the lack of studies looking at sleep deprivation is surprising however, findings from this study contribute to our knowledge of this phenomenon and highlight the need for further studies.

A report reviewing Police responses to violence against women and girls, refers to ‘the epidemic of violent and abusive offending’ in England and Wales and calls for an ‘unequivocal commitment’ to addressing the issue (HMICFRS, 2021, p. 6). The report was published two weeks prior to submission of this study and therefore not referenced in the body of this work but makes specific reference to a theme identified within this study, namely lack of recognition and poor prosecution rates for coercive control. It is nearly six years since the Introduction of s.76 of the Serious Crime Act 2015 and there remains a clear need for further studies and dissemination of findings around how coercive control, including sleep deprivation, is ‘done’.

It has been argued here that coercive control is akin to torture and should be prosecuted as such. Moving away from victim blaming and rethinking domestic abuse, through exploring and illuminating the experience, may challenge

traditional concepts. Further studies may enable the Police, and Criminal Justice sector to respond more effectively to coercive control, and society to better recognise the torture that is taking place within homes across the country.

There is a requirement for significantly more investment in the aftercare of women who have suffered abuse, as well as improved awareness and recognition of long-term health conditions acquired as a result of living with sleep deprivation and other forms of coercive control. Funding to support women survivors should be sustainable in recognition of the epidemic nature of the problem and to ensure continuity of services.

Concerns were addressed within the research proposal regarding the challenges of working remotely and participant wellbeing. However, these were not realized as no adverse consequences were identified by participants and the rich data obtained is further testament to the success of this method and the support of the Gatekeeper.

Finally, the study has highlighted the value of a Feminist Methodology to give voice to survivors who are the experts in their experience of sleep deprivation. Using a trauma informed approach, respects and safeguards participants and has led to unexpected findings, new knowledge and signals the need for further work around sleep deprivation as a means of coercive control.

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Appendix One - Biderman's Chart of Coercion (Biderman, 1957)

Method of Coercion	Purpose of Tactic.
Isolation.	Deprives victim of all social support. Victim develops an intense concern with self. Victim becomes dependent on abuser.
Monopolization of perception.	Fixes victim's attention on immediate predicament. Eliminates stimuli competing with those controlled by abuser.
Induced debility and exhaustion.	Weakens mental and physical ability to resist.
Threats.	Cultivates anxiety and despair.
Occasional Indulgences.	Provides positive motivation for compliance.
Demonstrating omnipotence.	Suggests futility of resistance.
Degradation.	Makes cost of resistance more damaging to self-esteem than capitulation.
Enforcing trivial demands.	Develops habits of compliance.

Appendix Two - Interview Questions.

Research Project for Dissertation: 'Is sleep control used as a method of coercive control? An examination of the lived experience of sleep deprivation in intimate partner relationships.'

1. Could you tell me a little bit about the beginning of your relationship/ how you met?
2. I am particularly interested in learning about how your ex-partner may have interfered or disrupted your ability to sleep.
3. I wonder how quickly you noticed these things happening?
4. Can you tell me about the things he did?
5. Did you have verbal arguments with your ex-partner about this?
6. Did he ever wake you up using physical violence?
7. Did this happen regularly or was it more sporadic and unpredictable?
8. (Supplementary question if positive response to Question 6) This must have been very frightening, I wonder did this have an impact on your ability to get off to sleep or stay awake?
9. Where you ever woken by your ex-partner demanding sex? How did this affect you?
10. Did your ex-partner try to control where or when you went to sleep?
11. Can you tell me about the impact these experiences had on your daily life?
12. Did these experiences make it difficult for you to get off to sleep or stay asleep?
13. Did you feel afraid or anxious about going to sleep?
14. Now you have left the relationship, is your sleep still affected or are you sleeping better now?

Thank you so much for sharing your experiences with me. Is there anything else we haven't discussed today that you would like to tell me about the things that happened to you? I understand that some of what you've told me must have been difficult to share and I'm wondering if you would like to speak to someone further about the issues we have discussed?

Submitted by Suzanne Richards Student number 18010515.

Appendix Three - Techniques to interrupt /prevent sleep.

Non-Violent techniques.	Violent Techniques
Demanding food/ drinks Begging Nagging Tickling Name calling Verbal insults Threats Opening windows in the winter/ reducing room temperature. Removing bedding Playing loud music.	Hitting Slapping Smothering Strangling Burning bedding Sticking sharp objects in feet Hitting with a baseball bat/ chair Flipping the mattress Destroying the bed Dragging out of bed Shaking the bed frame Sexual assaults.

Appendix Four – Application for Ethical Approval.

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APPLICATION FOR ETHICAL APPROVAL

(UNDERGRADUATE & POST GRADUATE TAUGHT STUDENTS)

To be completed by staff, associate researchers and students enrolled on postgraduate research degrees proposing to undertake ANY research involving humans [that is research with living human beings; human beings who have died (cadavers, human remains and body parts); embryos and fetuses, human tissue, DNA and bodily fluids; data and records relating to humans; human burial sites] or animals.

SECTION A: RESEARCHER AND PROJECT DETAILS	
Student Name	Suzanne Richards
Email *(Must be a University of Worcester email)*	Rics1_18@worc.ac.uk
School	School of Psychology
Student Status	Masters
Supervisor / Tutor	Beverley Gilbert
Course	Understanding Domestic and Sexual violence
Module	4003
Project Title	'Is sleep deprivation used as a method of coercive control? An examination of the lived experience of sleep deprivation within intimate partner relationships'.

SECTION B: APPLICATION DOCUMENT CHECKLIST

PLEASE NOTE:

- **All research materials / supporting documentation must be submitted as separate documents with this form.**
- **Please ensure the documents are clearly named to indicate what they are.**
- **Your proposal will not be reviewed without these documents. If these documents are not received by the submission deadline date your proposal will be returned to you.**

Please indicate which documents are included:

☒ Participant Information Sheet (PIS) & Privacy Statement *(University of Worcester Template)*

☒ Consent Form *(University of Worcester Template)*

☒ Interview Guide / Schedule

☒ Questionnaires

☒ Letter / Email from Gatekeeper granting access to research site, data or population

☐ Other *(Please specify)*

➢

☒ Have you included details about how GDPR requirements have been met?

☒ Have you read both the **Research Proposal Checklist Declaration** (Section C) and **Declaration of Student** (Section D)?

☒ Is the application being sent from a University of Worcester email address?

If the answers to any of these questions change during the course of your research, you must alert your Supervisor/Tutor immediately.

Section B: Checklist

		Yes	No
1.	Does your proposed research involve the collection of data from living humans?	X	☐
2.	Does your proposed research require access to secondary data or documentary material of a sensitive or confidential nature from other organisations?	☐	X
3.	Does your proposed research involve the use of data or documentary material which (a) is not anonymised **and** (b) is of a sensitive or confidential nature **and** (c) relates to the living or recently deceased?	☐	X
4.	Does your proposed research involve participants who are particularly vulnerable or unable to give informed consent?	X	☐
5.	Will your proposed research require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited?	X	☐
6.	Will financial inducements be offered to participants in your	☐	X

	proposed research beyond reasonable expenses and/or compensation for time?		
7.	Will your proposed research involve collection of data relating to sensitive topics?	X	☐
8.	Will your proposed research involve collection of security-sensitive materials?	☐	X
9.	Is pain or discomfort likely to result from your proposed research?	☐	X
10.	Could your proposed research induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	X	☐
11.	Will it be necessary for participants to take part in your proposed research without their knowledge and consent at the time?	☐	X
12.	Does your proposed research involve deception?	☐	X
13.	Will your proposed research require the gathering of information about unlawful activity?	☐	X
14.	Will invasive procedures be part of your proposed research?	☐	X
15.	Will your proposed research involve prolonged, high intensity or repetitive testing?	☐	X

16.	Does your proposed research involve the testing or observation of animals?	☐	X
17.	Does your proposed research involve the significant destruction of invertebrates?	☐	X
18.	Does your proposed research involve collection of DNA, cells, tissues or other samples from humans or animals?	☐	X
19.	Does your proposed research involve human remains?	☐	X
20.	Does your proposed research involve human burial sites?	☐	X
21.	Will the proposed data collection in part or in whole be undertaken outside the UK?	☐	X
22.	Does your proposed research involve NHS staff or premises?	☐	X
23.	Does your proposed research involve NHS patients?	☐	X

If the answers to any of these questions change during the course of your research, you must alert your Supervisor/Tutor immediately.

SECTION C: RESEARCH PROPOSAL CHECKLIST

	Does your proposed research involve the collection of data from living humans?		
	Does your proposed research require access to secondary data or documentary material of a sensitive or confidential nature from other organisations?		
	Does your proposed research involve the use of data or documentary material which (a) is not anonymised **and** (b) is of a sensitive or confidential nature **and** (c) relates to the living or recently deceased?		
	Does your proposed research involve participants who are particularly vulnerable or unable to give informed consent?		
	Will your proposed research require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited?		
	Will financial inducements be offered to participants in your proposed research beyond reasonable expenses and/or compensation for time?		
	Will your proposed research involve collection of data relating to sensitive topics?		
	Will your proposed research involve collection of security-sensitive materials?		
	Is pain or discomfort likely to result from your proposed research?		
	Could your proposed research induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?		
	Will it be necessary for participants to take part in your proposed research without their knowledge and consent at the time?		
	Does your proposed research involve deception?		
	Will your proposed research require the gathering of information about unlawful activity?		
	Will invasive procedures be part of your proposed research?		
	Will your proposed research involve prolonged, high intensity or repetitive testing?		
	Does your proposed research involve the testing or observation of animals?		
	Does your proposed research involve the significant destruction of invertebrates?		
	Does your proposed research involve collection of DNA, cells, tissues or other samples from humans or animals?		

	Does your proposed research involve human remains?		
	Does your proposed research involve human burial sites?		
	Will the proposed data collection in part or in whole be undertaken outside the UK?		
	Does your proposed research involve NHS staff or premises?		
	Does your proposed research involve NHS patients?		

If the answers to any of these questions change during the course of your research, you must alert your Supervisor / Tutor immediately.

RESEARCH PROPOSAL CHECKLIST DECLARATION

By submitting this application via my UW email account I am declaring that I have answered the questions above honestly and to the best of my knowledge.

Student:	Suzanne Richards	**Date:**	18/03/2021
Supervisor / Tutor		**Date:**	

You must now complete **SECTION D** (below) and submit the completed form to your Supervisor.

SECTION D: FULL APPLICATION

Details of the Research

Outline the context and rationale for the research, the aims and objectives of the research, and the methods of data collection. This should draw on the previous literature and should be more than simply a set of aims and objectives. The methods of data collection also need to be justified, and the selection of specific measures or tests should be justified in relation to their validity for the population in question.

Coercive control, as defined by the Home Office (2015, p.3), became an offence under the Serious Crime Act (2015) and, although recorded crimes rose from 9053 in 2018 to 17,616 in 2019, (ONS, 2019) they remain low, when taken in the context of overall crimes of domestic abuse of 746,291 in 2019(ONS, 2019). Analysis within the report suggests this increase in recording is a feature for new offences and could be due to improvements in recognizing incidents of coercive control by police (ONS, Section 5, 2019) however, public understanding of this crime is still growing and victims may not recognize coercive control is taking place simply because 'it falls on the extreme end of a spectrum of acceptable male behavior' (Bishop and Bettinson, 2017, p.9)

The creation of an offence of coercive control indicates a paradigm shift in the understanding of the complex nature of domestic abuse which historically has been viewed as a series of singular, episodic insults of domestic violence into a continuum model of insidious coercion and control that can impact on all areas of a victim's personal life. Hart and Hart (2018, p.79) summarize this conflict around the perception of coercive control, describing it as 'an isolation created by invisible chains, a strangling silence where others demand evidence of 'a significant event''. Disclosures from clients in my professional practice regarding their experiences of being subjected to sleep control and deprivation by current or former partners, led to reflection that this may be a more commonly used means of coercively controlling behavior than has been previously recognized and as such would constitute an offense, as it falls within the UK government definition of coercive control, in particular around 'regulating everyday behaviour' (Serious Crime Act, 2015).

Stark (2007, p.261, p.271) makes frequent references to control of sleep stating, 'the materiality of abuse begins with a partner's control over the basic necessities of daily living including…..sleep'. A literature review revealed only a small number of papers exploring the link between sleep deprivation and control i.e. where perpetrators would deliberately limit and /or interrupt sleep (Lowe, Humphreys and Williams 2007, Silverman et al. 2016),

highlighting a considerable gap in the research. Sleep deprivation has been linked to pervasive and deleterious impacts on health including; poor immune responses, increased risk of cardiovascular disease (Irwin 2015) and impaired cognitive skills and emotional intelligence (Killgore et.al 2008) and significantly, is recognized as an enhanced interrogation technique that was used by the US government on 'unlawful combatants' in the aftermath of the 9/11 attacks (McCarthy, 2015). Indeed, Tetlow (2016, p.186) argues that domestic abuse should be reframed as a crime of torture, asserting 'our streets are littered with torture chambers' and techniques including sleep deprivation should be banned under a 'pattern crime'.

Increasing awareness amongst victims, those supporting them and within the criminal justice system could help victims recognize coercion is taking place and empower them. In order to test the theory that sleep deprivation is used as a tool of coercive control it is important to explore the lived experience of survivors. Undertaking research within a Feminist paradigm frames domestic abuse and coercive control as strategic tools to perpetuate male advantage and acknowledges the powerful atmosphere of a pervasive 'devaluing and dismissal of women's experiences of domestic violence' (Epstein and Goodman, 2019, p.403) with the resultant 'over-riding tendency for women not to disclose experiences of violence' (Elsberg and Heise, 2002, p.1602). This silence around the experience of sleep deprivation indicates an interpretivist ontological approach to research as it gives a voice to participants, enabling a detailed exploration of the lived experiences of survivors. In this dynamic, the emic epistemological position of the researcher is also recognized as pivotal; as a facilitator of disclosure of the lived experience, the researcher needs to acknowledge the potential to influence outcomes for good or bad (Elsberg and Heise 2002, p.1600, WHO,1999) and therefore search for solutions to maximize beneficence and minimize harm, principles contained within the World Health Organization standards for research (WHO 1999), by demonstrating sensitivity and actively engaging in a reciprocal relationship.

When considering methodology to explore the experience of sleep deprivation, it is important to acknowledge what barriers there may be to disclosure and identify a methodology that minimizes these and facilitates safe disclosure. Focus groups have inherent risks around confidentiality, have the potential to induce vicarious trauma in other participants and limit opportunities for each individual to tell their story due to time

restraints. Semi structured, one to one interviews would allow the establishment of rapport and trust, give greater guarantees around confidentiality and give participants time to return to specific topics and explore them, as recall allows. Once the interviews have taken place they will be transcribed by the researcher who will then complete a thematic analysis (Clarke and Braun 2017), a means of identifying codes within the data which can then be used to build themes. This technique is considered a rigorous means of interpreting data and allows 'analysis of patterns within and across data' (Clarke and Braun, p.298 2017).

Who are your participants/subjects? *(if applicable)*

Domestic Abuse is recognized globally as a gendered crime; a multi country study conducted on behalf of the World Health Organization in 2003 looked at the prevalence of intimate partner violence and found physical and sexual violence was widespread, with women substantially more at risk of violence from an intimate partner than anyone else (WHO, 2013). Within the UK, figures released by the Office of National statistics indicate that women represented 75% of victims of domestic abuse related crimes for the year ending March, 2018 (ONS, 2019). As women are the group most affected by these crimes it seems pertinent to explore their experiences of coercive control and behaviour in order to gain insights into their lived experiences. As such participants to this study would be women survivors of domestic abuse who are living free of their abusive partner. The rationale for excluding women who are still in a relationship with their abusive partner is based on the considerable risk that participation poses to the woman if her partner finds out about her involvement. The duration of the separation from the abusive relationship is not relevant here, what is important is the woman's own sense of resilience and recovery and willingness to participate.

How do you intend to recruit your participants? *(if applicable)*

This should explain the number of participants and the means by which participants in the research will be recruited. If any incentives and/or compensation (financial or other) is to be offered to participants, this should be clearly explained and justified. The sample size should be justified either on the basis of a power analysis, or on the basis of previous studies.

I have approached the local Domestic Abuse Service (DAS) to ask them to act as Gatekeeper for the purposes of recruiting to the study. This ensures that participants already have an established relationship with the Service staff with whom they feel safe and supported. The gatekeeper service will facilitate recruitment to the study through sharing information with women who are currently engaged with their service. A leaflet (See Appendix 1) will be provided by the researcher to explain the aims of the study, how the research will be conducted and how participants confidentiality and safety will be protected It will also outline the researcher's obligations and duty of care to follow Safeguarding protocols should there be disclosure to the researcher. Once a woman expresses herwillingness to participate, she will be asked her preferred mode of contact which and given consent to share contact details As a qualitative study, sample size does not reduce validity, indeed 'a feature of qualitative inquiry is that it includes elements of quality' (Holloway and Galvin, p28 2017) however I would hope to recruit at least 6 participants in order to maximize the opportunities to explore this topic. As Holloway and Galvin (2017 p.34) suggest, 'it is better to deliver a small scale, insightful study than overstretch the resources and time of the novice researcher'. No financial compensation or inducement will be offered to participants.

How will you gain informed consent/assent? *(if applicable)*

Where you will provide an information sheet and/or consent form, please append this. The University of Worcester Participation Sheet and Privacy Statement template must be used. If you are undertaking a deception study or covert research, please outline how you will debrief participants below.

Consent is a key principle of ethical research and particularly important when working with vulnerable participants (which includes women survivors of domestic abuse), especially when research involves divulgence of personally sensitive, potentially distressing, information. An information sheet will be shared with potential recruits by the local DAS and will explain the purpose of the research is to explore women's experience of sleep control/ deprivation as a means of coercive control in an intimate relationship. This will be through participating in a one-to-one recorded interview with a female researcher. It will explain the potential risk of distress that participants might experience, their right to withdraw from the research up to two weeks after the interview has taken place and the Safeguarding obligations of the researcher. It will be explained that their personal data will be anonymized and any data will be used, stored and published, in compliance with the Data Protection Act (2018) and General Data Protection Regulation (2016) and University of Worcester policy (UOW, Participants will be advised that the Gatekeeper will not have access to the raw data but may have sight of the final report wherein all data will be anonymized with no personal identifiers. Potential recruits will be given the opportunity to discuss with the researcher any concerns they have prior to commencing the interviews

where consent can be explored further, with an understanding that they can withdraw from the study up to 2 weeks after completing the interview.

Confidentiality, Anonymity, Data Storage and Disposal *(if applicable)*

Provide explanation of any measures to preserve confidentiality and anonymity of data, including specific explanation of data storage and disposal plans. Plans for data storage and disposal must be feasible given the nature of the study.

Maintaining the confidentiality of participants is paramount; it forms part of the moral contract between researcher and participant and is a legal requirement under the Data Protection Act (2018) and GDPR (2016). It is vital to protect the safety of vulnerable participants who could be at risk of reprisal (Ellsberg and Heise (2002) if it was revealed that they had partaken in research regarding their abuse and, as an obligation of the researcher as a Registered Nurse and Health visitor, must comply with the requirements of the NMC Code of Professional Conduct, in particular Section 4.2..(NMC

Any consent forms will be stored in a locked filing cabinet at the researcher's place of work prior to being destroyed 2 weeks after interviews in line with University of Worcester policy. Recordings of interviews will be stored in a device that is password protected and transcribed at the earliest opportunity and then destroyed. Each interviewee will be attributed a number which will be recorded on the Participant Information sheet at the time of interview. If the participant wishes to withdraw they can contact the researcher and request withdrawal of the numbered interview up to 2 weeks after the interview has taken place.

Potential Risks to Participants / Subjects / Researcher *(if applicable)*

Identify any risks for participants/subjects that may arise from the research and how you intend to mitigate these risks. Potential risks to the researcher must also be considered. Risks may include physical, practical, psychological and emotional consequences of participation.

There are several areas of risk inherent in conducting research with women survivors of domestic abuse (WHO 2001). Personal safety is paramount and ensuring that interviews take place in a safe venue is vital (Sullivan and Cain, 2004). It is intended that interviews take place on the premises of the local DAS where participants would be familiar with the setting, have a sense of safety and could access support. If participants request interviews take place elsewhere it would be necessary to undertake a risk assessment to ensure all parties are not at risk of intrusion by the perpetrator or other adults or children and that the alternative venue could provide privacy. Interruptions can impact on the interview process itself and pose a risk of disclosure to third parties. However, for some participants, meeting at their own home can engender a feeling of security and facilitate greater disclosure (Letherby, 2003, p.108).Women who are currently in a relationship with a perpetrator would not be invited to participate as evidence indicates that where abusers have discovered their partner has participated in research it has precipitated an attack (WHO, 2001) and may risk reprisal against the researcher or workers in the DAS..

Women discussing personal experiences of abuse can become distressed (Elsberg and Heise, 2001) and experience trauma anew. However, by acknowledging this and allowing time to recover, participants are often happy to proceed. Mclinton Appolis et al. (2015) conducted a systematic review to look at risks, benefits or regrets as a result of partaking in research around Violence and abuse. They found some benefits including a sense of relief, sense of sharing and of being listened to, though the authors argue that researchers should consider the risk/benefits ratio as a part of their ethical considerations.

Participants would be advised beforehand that they can end the interview at any time. An advantage of conducting interviews in the DAS is that there are familiar workers on hand who could provide emotional support should it be required. As part of the researchers duty of care a list of agencies would be available who could provide more specific services should these be indicated.

As a health worker with extensive experience of disclosure of distressing information and working with individuals in the community, I feel confident in my abilities to cope with disclosures however in recognition of the risk of vicarious trauma (Lodrick, 2007) I plan to have pre and post interview discussions with my research supervisor in order to have the opportunity to debrief and ensure compliance with lone worker policy should interviews take

place within the community. Within the DAS center I will ensure a second individual is on hand in case of an unforeseen circumstances.

Other Ethical Issues

Identify any other ethical issues (not addressed in the sections above) that may arise from your research and how you intend to address them.

It is important to acknowledge a significant minority of the population of Wales are First language Welsh speakers. As a University student conducting research in the third sector, I am not bound by the Welsh Language Act (1993) however, I feel it is ethical to declare my limitations as a non -Welsh Speaker. Evidence looking at conducting research in a second language suggests data collected could be qualitatively different (Cortazzi, Jin and Pilcher, 2011).By declaring my limitations I will enable potential participants to make their decision to partake based on a full disclosure of the researcher's position.

Published Ethical Guidelines to be followed

Identify the professional code(s) of practice and/or ethical guidelines relevant to the subject of the research.

Council for International Organizations of Medical Sciences (CIOMS) (2016) *International Ethical Guidelines for Health-Related Research involving Humans*. Geneva. CIOMS.

Available at: https://cioms.ch/wp-content/uploads/2017/01/WEB-CIOMS-EthicalGuidelines.pdf

Nursing and Midwifery Council (2018) The Code .Professional Standards of Practise and behaviour for nurses, midwives and nursing associates. Nursing and Midwifery Council.

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Lodrick, Z. (2007) 'Psychological Trauma- Worker every Trauma worker should know', The British Journal of Psychotherapy Integration, Vol. 4 (2), pp.1-16.

Lowe, P., Humphreys, C and Williams, S.J. (2007) 'Night Terrors Women's experience of not sleeping where there is domestic violence', Violence Against Women, Volume 13, Number 6, pp.549-561.

McClinton Appolis,T. Lund, C., de Vries, D.J. and Matthews, C. (2015) 'Adolescent's and Adult's experiences of being surveyed about violence and abuse: A systematic review of harms, benefits and regrets'. American Journal of Public Health 105(2):e31-e45. doi10.2105/AJPH2014.302293

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Silverman, J.G., Balaiah, D., Decker, M.R., Boyce, S.C., Ritter,J.,Naik, D.D., Nair, S. Saggurti, N. and Raj, A. (2016) 'Family Violence and maltreatment of Women during the Perinatal period: Associations with infant Morbidity in Indian Slum Communities', Maternal and Child Health 20, pp.149-157.

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Tetlow, T. (2016) 'Criminalizing 'Private' torture', William and Mary Law Review,

Vol.58, Issue 1, pp.183-250.

University of Worcester (2019) Researchers, Supports and Visitors Privacy Notice University of Worcester. Available at: https://www2.worc.ac.uk/informationassurance/visitor-privacy-notice.html

Welsh Language Act. (1993) Available at: http://www.legislation.gov.uk/ukpga/1993/38/contents

Welsh Assembly Government (2019) Wales Safeguarding Policy

Available at: http://www.myguideapps.com/projects/wales_safeguarding_procedures/default/

World Health Organisation (1999) ‘Putting Women’s safety First: Ethical and safety recommendations for research on domestic violence against women’ Geneva, WHO. Available at: https://www.who.int/gender/violence/womenfirtseng.pdf

DECLARATION OF STUDENT

By submitting this form via your University of Worcester email account, you are confirming the following:

- I have read the University's Ethics Policy and any relevant codes of practice or guidelines and I have identified and addressed the ethical issues in my research honestly and to the best of my knowledge.

- I confirm that I have a data management plan in place in accordance with the policy for the effective management of research data.

Student Signature: S. V. Richards **Date:** 21/02/2021

DECLARATION OF SUPERVISOR / TUTOR / MODULE LEADER

Undergraduate & Post Graduate Taught Students

☐ I am satisfied that the student has identified and addressed the ethical issues and grant ethical approval for this research.

Post Graduate Taught Students only

☐ I refer this Application for Ethical Approval to University Research Ethics Panel for review.

Supervisor Signature: ..... **Date:** .....

Appendix Five - Informed Consent Form.

University of Worcester

INFORMED CONSENT FORM (NON-NHS RESEARCH)

Title of Project: Is sleep deprivation used as a method of coercive control? An examination of the lived experience of sleep deprivation within intimate partner relationships.
Participant identification number for this study:
Name of 7Researcher
S. Richards.

I, the undersigned, confirm that (**please initial boxes as appropriate**):

1.		I have read and understood the information about the project, as provided in the Information Sheet dated _____ or it has been read to me.	
2.		I have been able to ask questions about the project and my participation and my questions have been answered to my satisfaction.	
3.		I understand that taking part in this study involves a one to one interview which will be recorded. I understand the recording will be transcribed as soon as possible after the interview and the recording will then be destroyed. The transcribed notes will be stored securely on an electronic device until the dissertation project is completed.	
4.		I understand that taking part in the study has a potential risk of causing me upset and distress and	

		that there is a risk that a third party could observe or overhear the interview and disclose my information to a third party with potential risk to myself and others.	
5.		I understand I can withdraw up to 2 weeks after the interview date without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.	
6.		I understand that the information I provide will be used for the completion of a dissertation project the results of which may be published.	
7.		I agree that my anonymized information can be quoted in research outputs.	
8.		The procedures regarding confidentiality have been clearly explained (e.g. use of names, pseudonyms, anonymisation of data, etc.) to me.	
9.		I understand that personal information collected about me that can identify me, such as my name will not be shared beyond the study team.	
10.		I consent to the audio/video recording.	
11.		I understand that other researchers will have access to this data only if they agree to preserve the confidentiality of the data and if they agree to the terms I have specified in this form.	
12.		I give permission for the anonymised transcripts of the interview that I provide to be deposited in University of Worcester archive so that it can be used for future research and learning.	
13.		I voluntarily agree to participate in the project.	
14.		I know who to contact if I have any concerns about this research	

Name of Participant	Signature	Date
Name of Researcher	Signature	Date

Appendix Six – Participant Information Sheet.

PARTICIPANT INFORMATION SHEET AND PRIVACY NOTICE

'Is sleep deprivation used as a method of coercive control? An examination of the lived experience of sleep deprivation within intimate partner relationships.'

Invitation

The University of Worcester engages in a wide range of research which seeks to provide greater understanding of the world around us, to contribute to improved human health and well-being and to provide answers to social, economic and environmental problems.

We would like to invite you to take part in one of our research projects. Before you decide whether to take part, it is important that you understand why the research is being done, what it will involve for you, what information we will ask from you, and what we will do with that information.

We will in the course of this project be collecting personal information. Under General Data Protection Regulation (GDPR) 2016, we are required to provide a justification (what is called a "legal basis") in order to collect such information. The legal basis for this project is "**task carried out in the public interest**". Since the personal information we will be collecting in this project is defined under GDPR as "special category" data, that is more sensitive data requiring greater protection,

we must identify an additional legal basis. This additional legal basis is **"*necessary for scientific research in accordance with safeguards*"**.

You can find out more about our approach to dealing with your personal information at https://www.worcester.ac.uk/informationassurance/visitor-privacy-notice.html.

Please take time to read this document carefully. Feel free to ask the researcher any questions you may have and to talk to others about it if you wish. You will have at least 14 days to decide if you want to take part.

What is the purpose of the research?

This study aims to explore how sleep deprivation and/ or control of sleep is used as a means of coercion and control in intimate partner relationships.

Who is undertaking the research?

Suzanne Richards, MA Student, Understanding Domestic and Sexual Violence.

Project developer and researcher

Rics1_18@uni.worc.ac.uk

Who has oversight of the research?

The research has been approved by the Research Ethics Panel for the College of Psychology in line with the University's Research Ethics Policy. The University of Worcester acts as the "Data Controller" for personal data collected through its research projects & is subject to the General Data Protection Regulation 2016. We are registered with the Information Commissioner's Office and our Data Protection Officer is Helen Johnstone (infoassurance@worc.ac.uk). For more on our approach to Information Assurance and Security visit: https://www.worcester.ac.uk/informationassurance/index.html.

Why have I been invited to take part?

You have received this invitation because you are a survivor of Domestic abuse who is living free from domestic abuse and being supported by the local Domestic abuse service.

We are hoping to recruit 6 participants for this study.

Do I have to take part?

No. It is up to you to decide whether or not you want to take part in this study. Please take your time to decide; we will wait for at least 14 days before asking for your decision. You can decide not to take part or to withdraw from the study until 14 days following data collection. If you wish to have your data withdrawn please contact the researcher with your participant number and your data will then not be used. If you do decide to take part you will be asked to sign a consent form.

What will happen if I agree to take part?

If you agree to take part,

- The Domestic abuse service will ask you to provide your preferred method of communication to share with the researcher. This could be via email or text message or telephone.
- The researcher will then contact you to discuss any questions or concerns you may have regarding any aspect of the research process.
- If you are happy to proceed, we will agree a convenient day and time to undertake an interview via computer or telephone where you will be asked about your experiences.
- You will then be sent an electronic copy of the consent form to read and return to the researcher on the day of the interview.
- Once you return the consent form to the researcher you will be allocated a number which you can use in any further communication. This ensures your anonymity.
- If you are happy to take part, the researcher will send you a link to use on the day of the interview as well as contact details in the event of technical or other difficulties in accessing the meeting.
- The interviewer will conduct the interview in a private room where there can be no access by third parties.
- The interview will take approximately one hour.
- The researcher will use the Zoom facility to do an audio recording of the interview or record facility on the phone if that is your preferred method. This allows the interviewer to ensure a faithful record of the interview is obtained and enables the recording to be stored securely.

- The interviewer will check you are happy to proceed and give your consent to the interview.
- Before starting the interview, the interviewer will ensure you are comfortable and will not be interrupted. This is to ensure your safety and prevent disclosure of your personal information to a third party.
- If at any time during the interview process you wish to take a break or completely stop the interview you can do so. Please just ask.
- Once the interview is over you may want to talk about the experience with someone. As part of our duty of care, you will be offered a follow up call from the DAS to check how you are feeling and offer you the chance to talk further. Contact details for local and national helplines are also listed below.
- Taking part in the research is entirely voluntary. You may feel that having considered taking part, you no longer wish to do so and decide to withdraw. You can do this up to 14 days after the interview, by contacting the researcher and giving the number you were allocated. Your data will then be destroyed.

What are the benefits for me in taking part?

By taking part in this research, you will be helping to increase understanding of how sleep deprivation and control are used to coerce and control intimate partners. This is a poorly understood form of coercive control and raising awareness of this phenomenon may help victims and those that work with them.

Survivors who take part in research often report a positive feeling of having been listened to and appreciate the opportunity to have their experiences heard.

Are there any risks for me if I take part?

- There is a risk that taking part could be traumatic and result in you feeling distressed and upset however, many survivors have said having the opportunity to talk about their experiences and being listened to can be positive and empowering.

- Due to the current Covid-19 crisis it is not safe to undertake research face to face. As a result of this you must be willing to take part virtually. There is a risk that a third party could observe or overhear the interview and disclose your information to a third party with potential risk to yourself and others.

If you do feel distressed and need further support after the interview you may find the following numbers helpful.

Domestic Abuse Service 01267 238410

Live Fear Free 0808 8010 800

The Samaritans 116 123

What will you do with my information?

Your personal data / information will be treated confidentially at all times; that is, it will not be shared with anyone outside the research team or any third parties specified in the consent form unless it has been fully anonymised. The exception to this is where you tell us something that indicates that you or someone else is at risk of harm. In this instance, we may need to share this information with a relevant authority; however, we would inform you of this before doing so.

During the project, all data / information will be kept securely in line with the University's Policy for the Effective Management of Research Data and its Information Security Policy.

We will process your personal information for a range of purposes associated with the project primary of which are:

- To use your information along with information gathered from other participants in the research project to seek new knowledge and understanding that can be derived from the information we have gathered.
- To summarise this information in written form for the purposes of dissemination through a dissertation, conference papers, journal articles or other publications. Any information disseminated / published will be at a summary level and will be fully anonymised and there will be no way of identifying your individual personal information within the published results.
- To use the summary and conclusions arising from the research project for teaching and further research purposes. Any information used in this way will be at a summary level and will be fully anonymised. There will be no way of identifying your individual personal information from the summary information used in this way.

If you wish to receive a summary of the research findings or to be given access to any of the publications arising from the research, please contact the researcher.

How long will you keep my data for?

Your personal data will be retained until the project (including the dissemination period) has been completed.

At the completion of the project, we will retain your data only in anonymised form. This anonymised data will be archived and shared in line with our Policy for the Effective Management of Research Data

How can I find out what information you hold about me?

You have certain rights in respect of the personal information the University holds about you. For more information about Individual Rights under GDPR and how you exercise them please visit: https://www.worcester.ac.uk/informationassurance/requests-for-personal-data.html.

What happens next?

Please keep this information sheet. If you do decide to take part, please either contact the researcher using the details below.

Thank you for taking the time to read this information.

If you decide you want to take part in our project, and we hope you do, or if you have any further questions then please contact: Suzanne Richards at rics1_18@uni.worcs.ac.uk

If you have any concerns about the project at this point or at any later date you may contact the researcher (contact as above) or you may contact the Supervisor: Beverley Gilbert via b.gilbert@worc.ac.uk

If you would like to speak to an independent person who is not a member of the research team, please contact Karen Dobson at the University of Worcester, using the following details:

Karen Dobson

Secretary to Research Ethics Panel for College of Business, Psychology and Sport.