

A guide on the impacts of domestic abuse on mental health and well-being

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We will review comments
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Foreword by Professor Gene Feder



As a GP, I first became aware of the profound links between domestic violence and abuse (DVA) and psychological distress through the narratives of patients who had experienced abuse and its long-term impact on their mental health and wellbeing. I was also aware how little evidence we had for guiding health care professionals in recognising and responding to DVA, leading to a quarter century of research that has shaped UK policy through national (NICE) guidelines.

Like health care professionals, family court professionals need to adopt good practice to reduce harm and safeguard the wellbeing of child and adult victims affected by court proceedings.

I commend this guide as a vital resource for promoting trauma-informed approaches within the court system, rooted in an understanding of the impact of DVA on mental health.

Although the prevalence and severity of DVA is greater for female victims, this guide is appropriately inclusive of male victims and people in same sex relationships.

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Foreword by Dr Roxane Agnew-Davies



Thank you for being willing to read this guide, and to improve practice.

As a younger clinical psychologist, I am embarrassed that in 15 years of practice in NHS settings, I counted the victims of domestic abuse whom I identified on one hand. Thirty years later, and from 2000, I have met thousands (to whom I am forever indebted), in my roles as Refuge manager, through research funding to develop means of psychological support and as an expert witness (particularly in Immigration Tribunals and in the Family Court).

I do not think that 'change' in numbers is due to an increase in domestic abuse, but more a change in my capacity to listen, to ask questions, to make it safe to disclose and in my willingness to try to make it safer for women and children.

In health settings, practitioners are taught as a fundamental ethical principle to 'do no harm', with obligation to avoid causing harm to patients during the provision of service. Along similar lines, as an expert witness, I was trained to be objective, to consider both sides and not to be partisan. What I came to realise in either medical or legal settings, was that to 'do nothing' to acknowledge or address the existence or impact of domestic abuse or coercive control was not a 'non-intervention' or 'non-partisan' but could at worst collude with, or even aggravate, the impact of abuse (since the abuser had often said to the victim that no-one would believe her, that she was 'mental' and that she would lose her kids).

I learnt to ask questions that enabled victims to disclose their fears, and that their behaviours sometimes spoke louder than words. Many women told me that the bruises heal, but the mind-games or the way the abuser made them feel still hurt them inside, and that they were afraid how the abuser would use contact proceedings to further entrap and abuse them and their children.

As I started to explain the impact of mental health problems, such as PTSD, that were caused by abuse to specialist domestic violence courts, and the implications for victims' capacity to give evidence, a few Judges approached me with horror that they were under duress to give up what they had understood that the Law required.

References:

[1] Department of Health and Social Care; The Health Foundation; Suzy Lamplough Trust; For Baby's Sake.

Foreword by Dr Roxane Agnew-Davies



That is not my intention at all. When commissioned by the Judicial College to train PIP Tribunal Judges and Panel members, I wanted to assist their understanding of mental illness, to develop an understanding of the evidence before them (in behaviour as well as the spoken word) and to consider reasonable adjustment to help victims give their best evidence (that is, to speak safely, truthfully and freely about their experiences) to assist the Court in making their determination. I wrote the first draft of this guide with that in mind. I have been very privileged to have heard victims as they take the risk to disclose their experiences, to witness their courage to talk about the impacts on their mental, emotional and physical well-being and the constraints on their freedom to act and parent as they would choose.

I hope we can save time for professionals in the family court who are willing to hear the true psychological evidence and to make decisions to promote the safety and wellbeing of children and their non-abusive parents for the future. Not everything will apply to the victim or family before you, but I hope that the guide will assist you to understand the evidence before you, the needs of the victim and the safest outcome for the children and the non-abusive parent.

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PART A | What this guide is about and who it is intended for

The foundation for this guide is that domestic abuse ('DA') is harmful to the physical and psychological wellbeing of any adult, or child who is exposed to it. Trauma can trigger ill health and psychological distress and mental and physical harm. The manifestation of trauma is often complicated by pre-existing or trauma-induced disabilities and chronic health conditions.

Abusive tactics can include but are not limited to:

- Coercion and threats;
- Economic abuse including child support, withholding resources, hiding assets;
- Weaponising children or child contact;
- Harassment;
- Intimidation;
- Emotional abuse;
- Bullying and smear campaigns intended to isolate;
- Manipulating institutions and professionals;
- Abusing and/ or delaying court processes; breaching orders; and ongoing litigation abuse.

It is important that safeguarding professionals working with families can recognise patterns of behaviours and the impact that they are having on vulnerable victims and how easily they can escalate.

The purpose of this guide is to raise awareness and improve best practice during proceedings for people who are experiencing domestic abuse. The guide is based on many years of academic research, clinical practice and co-production with lived experience as well as the guidance in the Equal Treatment Bench Book ('ETBB') which was updated in February 2026.²

References:

[2] Equal Treatment Bench Book - Courts and Tribunals Judiciary.

PART A | What this guide is about and who it is intended for

This guide is intended:

- To enable professionals working in the Family Court to have a clearer understanding of the correlation between domestic abuse and mental ill-health, the impact of mental ill-health on the parties to the Family Court, and of best practice; and
- To support victims of domestic abuse who are experiencing mental ill-health whilst they are navigating Family Court proceedings, including those who are litigants in person.

For the sake of brevity, we will use the term 'victim' when we talk about the person who is experiencing domestic abuse and the term 'perpetrator' when we talk about the person who is accused of abuse.

The following sources of further information may be found at the end of this guide:

- Getting support for victims experiencing poor mental health;
- National mental health support;
- Local mental health support;
- National domestic abuse support;
- References;
- Further reading; and
- Glossary of key terms

References:

[2] Dept of Health, Health Foundation, NIHR, Suzy Lamplugh Trust, For baby's sake

PART B | What is domestic abuse?

B1 What is domestic abuse?

Domestic abuse ('DA') can happen to anyone regardless of age, background, gender, sexual orientation, faith or ethnicity.

Domestic abuse may involve violence, but it does not have to. It is wider than that and can include financial abuse, 'honour' based abuse, forced marriage, female genital mutilation, and emotional, psychological and mental abuse.

It can be a single incident or a pattern of incidents of controlling or coercive behaviour, threatening, degrading and violent behaviour, including sexual violence and rape. It can be committed by a partner or ex-partner and also by a family member.

The victim and the other party need to be aged 16 or over, and be 'personally connected' to each other. To be 'personally connected,' the parties must be or have been:

- Married to each other or civil partners of each other; or
- Engaged to marry one another or enter into a civil partnership agreement with one another; or
- In an intimate personal relationship with each other; or
- Parents of the same child or have/ have had parental responsibility for the same child; or relatives.

The abuse may be directed at an adult or perhaps their child. The following behaviours amount to abuse, and it does not matter whether the behaviour consists of a single incident or a course of conduct:

- Physical or sexual abuse;
- Violent or threatening behaviour;
- Controlling or coercive behaviour;
- Economic abuse;
- Psychological, emotional or other abuse

Domestically abusive behaviour can be and often is a criminal offence. A victim can report their perpetrator to the Police.

PART B | What is domestic abuse?

B2 Coercive behaviour

Coercive and controlling behaviour ('CCB') describes a pattern of behaviour through which a perpetrator restricts a victim's autonomy and establishes ongoing dominance.³ It is not best understood as "relationship conflict", but as a course of conduct designed to govern another person's day-to-day life. Coercive control is typically psychological and cumulative, affecting behaviour, thinking, decision-making, relationships, and sense of self, and it commonly persists and adapts post-separation.⁴

Some signs of coercive and controlling behaviour can include but are not limited to:

- Isolation from friends, family or supportive networks or services
- Limiting a victim's access to finances
- Monitoring a victim
- Threatening or causing reputational damage
- Criticism and manipulation⁵

References:

[3] Stark, 2007

[4] Katz et al., 2020; Dalgarno et al., 2024

[5] Crown Prosecution Service, 2025

PART B | What is domestic abuse?

The Foundation of Domestic Abuse

It is important to note that coercive and controlling behaviour is not limited to intimate partner relationships. The severity and impact of coercive and controlling behaviour may be more clearly understood when professionals recognise that similar tactics are used by other perpetrator groups, including gangs,⁶ cults⁷ and terrorist organisations.

Coercive control is a way in which a person, group of people, or system secures a victim's compliance by progressively narrowing a person's choices, perceptions, and capacity to resist. While the use of such tactics is more readily recognised in contexts of organised groups or extremism, these same dynamics of coercive control are frequently minimised, normalised, or misunderstood within family and interpersonal settings.

Coercive and controlling behaviour is often referred to as a *type* of domestic abuse. This distils coercive control down into a category that a victim of domestic abuse *may* or *may not* have experienced. Coercive and controlling behaviour is not a type of domestic abuse, instead it is the foundation of domestic abuse. Coercive and controlling behaviour provides the structural conditions that allow abusive acts to occur, recur, and escalate. Even where harm appears to involve a single incident of physical violence in a relationship, the conditions that enable a perpetrator to act with a sense of entitlement or impunity against their partner or child are rooted in coercive and controlling behaviour and their domination over that person.⁸

For every disclosure, incident, or allegation of domestic abuse, professionals should assume that coercive and controlling behaviour is present, even where it is not immediately visible or has not been explicitly named. Assessment and decision-making should be conducted through a coercive control lens while critically evaluating how control might be present and influence events. This approach shifts professional attention from what happened most recently to how power and control operate over time, enabling a more accurate understanding of risk, harm, and victim and perpetrator behaviour.

References:

[6] Havard et al., 2021

[7] Robertson, 2024

[8] Robson et al., manuscript in preparation

PART B | What is domestic abuse?

Presentation of Victim Survivors

Victims of CCB and DA have experienced chronic trauma and exhibit conditioning responses and cognitive distortions. Over time, perpetrators commonly take control of victims' decision-making and punish perceived 'wrong choices', conditioning the victim to associate independent judgement with risk. As a result, individuals may struggle to make decisions, doubt their own perceptions, and fear getting things wrong. Many victims explicitly report that they no longer trust their own mind, believing that it was their judgement that led them into the relationship in the first place. This self-distrust makes decision-making and trust in professionals particularly difficult.⁹

Professionals may observe that a victim repeatedly seeks permission, changes their view when challenged, or appears unable to follow through on agreed plans. This should not be understood as lack of motivation, lack of capacity or disguised compliance. Prolonged coercive control keeps the brain in a perpetual state of survival or threat monitoring, also known as 'fight or flight' where safety is prioritised over everything else and day to day functioning can become impaired, especially in relation to memory.

Victims learn to microread their environment and the people within it to keep themselves safe. Instructions, assessments, and system processes may replicate the power dynamics of abuse and trigger fear-based compliance or withdrawal, even when interventions are intended to be supportive.

This is especially true where children are involved, as many perpetrators use the threat of children being taken away as a threat to control victims. A victim may subsequently fear that their children will be taken away when professionals become involved. It is important to reflect on how professional involvement may unintentionally mirror a perpetrator's control, and how, as a professional, one can overcome this with individual service users.

References:

[9] Badenes-Sastre et al., 2025; Nicholson and Lutz, 2017

PART B | What is domestic abuse?

Perpetrators' Use of Professionals

It is also critical to recognise that coercive control continues after a relationship breakdown, particularly where there is ongoing child contact or involvement in family court proceedings. In these contexts, professionals may find themselves drawn into the perpetrator's controlling strategies through repeated correspondence with the perpetrator, complaints, challenges to decisions, or the selective presentation of concerns about the victim's parenting, mental health and claims about substance misuse. This can create confusion for professionals and disproportionate scrutiny of the victim. To distinguish between victim and perpetrator, professionals should prioritise patterns of behaviour over time, rather than presentation or persuasiveness.

A perpetrator often uses professional involvement to continue coercive and controlling behaviour by repeatedly making complaints or raising concerns about the victim that require professional response.¹⁰ This essentially turns the professional into an extension of the perpetrator and professionals run the risk of becoming abusers 'by proxy' without realising. The perpetrator may contact professionals frequently, provide selective or one-sided information, and frame concerns in a way that triggers assessment, monitoring, or enforcement action.

As professional involvement continues, the perpetrator may introduce further concerns when earlier ones are not substantiated, or present ordinary behaviour by the victim, such as distress, missed appointments, boundary-setting, or difficulty following plans as evidence of risk. This can result in increasing professional scrutiny of the victim, while the perpetrator remains largely outside assessment or challenge. Professionals risk appearing aligned with the perpetrator if concerns raised by the perpetrator are put directly to the victim without careful judgement. As isolation of the victim is a core tactic of coercive control, any perception that professionals are working with or believe the perpetrator may lead the victim to disengage, as the professional is no longer felt to be a safe or supportive contact. Care should be taken in how allegations are brought up, reassurance given to the victim that concerns are being critically assessed, that the professional has identified patterns of coercive control, and that the professional's role is to promote safety and support.

References:

[10] Katz et al., 2020

PART B | What is domestic abuse?

Perpetrators' Use of Professionals

Perpetrators may appear calm, cooperative, and compliant with professional processes, while pressing for professionals to act on their concerns. Over time, professionals may find that a significant proportion of their contact, record-keeping, and decision-making is shaped by information provided by the perpetrator. Where this occurs, professional involvement may shift away from supporting the victim to examining and assessing them. Dr Katz addresses the issue of 'admirable' fathering and coercive control:

“To determine if children require protection from their fathers, professionals could examine whether the father is still perpetrating coercive control against the children and/or their mother through violence, harassment, threats, intimidation and/or manipulation. If he is, this may indicate that his performance of 'admirable' fathering is not genuine, and is part of his ongoing coercive control.¹¹ This should be considered by professionals even when a coercive control perpetrator has never used physical violence, as there is some evidence to suggest that non-violent perpetrators are as harmful as violent ones.¹²”

As previously discussed, professionals should examine interactions through a coercive control lens, looking for patterns of behaviour and considering whether professional involvement is reinforcing control rather than reducing risk.

References:

[11] Bancroft et al., 2012; Callaghan et al., 2018; Monk, 2020

[12] Crossman et al., 2015; Stark and Hester, 2019; Katz et al., 2020 pp. 320

PART B | What is domestic abuse?

Perpetrators' Use of Professionals

- 1 Apply a coercive control lens to domestic abuse cases. Look beyond individual incidents to identify patterns of domination, restriction, surveillance, and punishment, and assess how these patterns shape the victim's behaviour, risk, and engagement with services.
- 2 Work on the assumption that memory and concentration may be impaired due to trauma and prolonged stress. Provide information in writing, including names, roles, and contact details.
- 3 Offer written follow-up after meetings, such as short summaries of what was discussed, agreed actions, and next steps, where it is safe to do so.
- 4 Consider supportive adjustments that assist with memory and recall, including reminders of appointments, allowing note-taking, recording of meetings, or bringing a trusted person, subject to consent and safety considerations.
- 5 Be explicit about your role, powers, and limits, including how decisions are made and what will happen next, to reduce uncertainty and fear.
- 6 Exercise caution when raising perpetrator's concerns. Ensure victims understand these concerns are being critically assessed and do not represent an assumption of wrongdoing.
- 7 Do not assume limited support for the victim indicates lack of insight or poor protective capacity. Isolation is often a consequence of coercive control. Where safe, support victim-led reconnection with trusted people, specialist services, or community resources.
- 8 Monitor your own practice for imbalance. Notice if your time, documentation, or decision-making is being disproportionately shaped by the perpetrator's reports, and pause to reassess patterns of control.
- 9 Check safety before sharing information or using electronic communication, particularly where contact may be monitored. Perpetrators may have monitoring software on electronics or know a victim's passwords.
- 10 Do not assume separation reduces risk. Review post-separation control regularly, especially where there is ongoing child contact or court involvement.

PART B | What is domestic abuse?

B3 Trauma Bonding

One impact of domestic abuse is trauma bonding.¹³

There are two pillars that characterise trauma bonding: power imbalance and the intermittent nature of the abuse. In the power imbalance, the perpetrator is dominant and the other submissive over time to an extreme. The victim becomes more negative about themselves, more incapable of fending for themselves and thus more in need of the perpetrator, who at the same time develops a grandiose belief in their own power and absolute control over the victim, which masks their dependence on the victim to maintain their self-image.

The intermittent abuse by the perpetrator alternates with periods of more normal and acceptable behaviour, including contrition and apology. The victim lurches between hyper-arousal and dissociation during the abuse, depression and helplessness and perhaps self-blame afterwards,¹⁴ and relief or release when there is a calm period during which the perpetrator may try to make amends. The improved behaviour is designed to reduce the stress the perpetrator themselves has created, whilst also reinforcing the victim's dependency on them to feel better.

These dynamics are highly effective in producing strong emotional bonds and patterns of behaviour that are very difficult to break. Although a victim may seek support, trauma bonding, self-doubt, isolation and dependency mean that they are likely to seek comfort from the very person that has abused them and caused their distress.

References:

[13] Dutton, D. G. & Painter, S. 'Emotional Attachments in Abusive Relationships: A Test of Traumatic Bonding Theory', *Violence and Victims* Vol 8 Issue 2, Jan 1993, DOI: 10.1891/0886-6708.8.2.105

[14] See the section on PTSD to understand these terms

PART B | What is domestic abuse?

B4 Gaslighting

Gaslighting (from the 1944 film 'Gaslight') is the manipulation of someone into questioning their own perception of reality. Broadly, gaslighting is psychological manipulation of a victim which causes that victim to question their own thoughts, perception of reality, or memories and can lead to confusion, loss of confidence and self-esteem, uncertainty about emotional or mental stability, and a dependency on the perpetrator.

Gaslighting 'games' are played to make the victim doubt their sanity e.g., by stealing things that then mysteriously reappear. Perpetrators will confuse their partners by telling transparent or outrageous lies. Gaslighting is designed to remind the victim how dangerous confrontation can be and how dependent their well-being is on accepting the perpetrator's version of events. Narcissistic traits make many perpetrators masters at impression management. Knowing this, victims fear the perpetrator's version of events will be believed rather than their own.

Gaslighting can be an effective tool to control a victim. The victim may write off smaller incidents as 'one-off' events and not realise they are being manipulated systematically over time. Blaming the victim, telling victims that others are wrong or lying, and acting as if the perpetrator is the only source of 'true' information, makes victims and third parties question reality. Often acting with apparent concern, the perpetrator can mislead third parties, including professionals, into doubting the victim's experiences.

The courage of victim-campaigner Gisèle Pelicot in testifying about being drugged nightly by her husband Dominique and raped while unconscious in bed by strangers whom he invited for over a decade is a sombre example of those who participate in abuse of women without consent. For years, she was concerned about her health and mental health without any awareness of his daily drugging and exploitation.

PART C | Mental Health

C1 Links between domestic abuse ('DA') and mental ill health

Although DA is experienced by women and men, the majority of severe, repeated and sexual assaults are perpetrated by men.¹⁵ Most DA research has focused on the impact of intimate partner violence (IPV).

The main long-term association of IPV is mental illness, with a three-fold risk of depressive disorders, four-fold risk of anxiety disorders and a seven-fold risk of post-traumatic stress disorder (PTSD).¹⁶ Research has established a causal relationship between IPV and depression and suicide attempts.^{17 18} 30% female in-patients, 33% female out-patients and 32% male patients in mental health services reported experiencing domestic abuse over their lifetime.

In research conducted in Bristol and Cardiff, 76% of the 260 women interviewed, who were accessing domestic abuse services, reported significant psychological distress, 77% significant PTSD symptoms and over 70% significant symptoms of depression and anxiety,¹⁹ 70% of these women disclosed being exposed to severe domestic abuse.

Experiences of trauma (physical, sexual or psychological abuse) in childhood or in adulthood can all impact a victim's mental health²⁰ and be exacerbated by secondary victimisation by friends, family or professionals, including during legal proceedings.²¹

References:

- [15] Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH; WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet*. 2006 Oct 7;368(9543):1260-9. doi: 10.1016/S0140-6736(06)69523-8. PMID: 17027732.
- [16] Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, Astbury J, Watts CH. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. *PLoS Med*. 2013;10(5):e1001439. doi: 10.1371/journal.pmed.1001439. Epub 2013 May 7. PMID: 23671407; PMCID: PMC3646718.
- [17] Trevillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. *PLoS ONE* 7(12): e51740. <https://doi.org/10.1371/journal.pone.0051740>
- [18] Oram S, Trevillion K, Feder G, Howard LM. Prevalence of experiences of domestic violence among psychiatric patients: systematic review. *British Journal of Psychiatry*. 2013;202(2):94-99. doi:10.1192/bjp.bp.112.109934; Trevillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. *PLoS ONE* 7(12): e51740. <https://doi.org/10.1371/journal.pone.0051740>
- [19] Ferrari G, Feder G, Agnew-Davies R, Bailey JE, Hollinghurst S, Howard L, et al. (2018) Psychological advocacy towards healing (PATH): A randomized controlled trial of a psychological intervention in a domestic violence service setting. *PLoS ONE* 13(11): e0205485. <https://doi.org/10.1371/journal.pone.0205485>
- [20] Department of Health and Social Care and Agenda (2018) The Women's Mental Health Taskforce, Final report. Available online: <https://www.gov.uk/government/publications/the-womens-mental-health-taskforce-report>
- [21] Matsakis, A.T (1998) Trust after trauma: a guide to relationships for survivors and those who love them. New Harbinger Publications; Katirai, N (2020) Retraumatized in court. *Arizona Law Review*, 62 (81), 82-124; Prathikshaa, C. (2025) A study on secondary victimization and its impact on the recovery process of sexual assault survivors. *IJARST*, 5 (4), June. doi: 10.48175/IJARST-27673; Rivera, E.A., Sullivan, C.M & Zeoli, A.M. (2012) Secondary victimization of abused mothers by family court mediators. *Fem. Criminol.*, July 7(3), 234-252

PART C | Mental Health

C1 Links between domestic abuse (DA) and mental ill health

Victims may not disclose the harm caused to their psychological well-being. Barriers to disclosure, even to mental health professionals,²² can include:

- Fear of consequences
- Fear of further violence
- Fear of Adult and Children's Social Care involvement
- Fear they will not be believed
- Shame, self-blame or fear that medical notes will be weaponised and misinterpreted
- Psychological distress
- Professional failure to recognise and report abuse.

The ETBB²³ uses the term 'mental disability' to apply to anyone with 'mental impairment' that may call for extra consideration in a court hearing, such as those with:

- Mental ill health, e.g., depression, anxiety, PTSD, obsessive-compulsive disorder ('OCD'), personality disorders, eating disorders, schizophrenia, bipolar disorder
- Learning disabilities
- Developmental disorders
- Neurodiverse conditions, and
- Brain injury (which may be acquired or from birth).

References:

[22] Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *British Journal of Psychiatry*. 2011;198(3):189-194. doi:10.1192/bjp.bp.109.072389

[23] Equal Treatment Bench Book - Courts and Tribunals Judiciary, Ch. 4, paras 6, 7, 10, 11

C2 Vulnerability factors

No specific characteristics make some victims more vulnerable than others to domestic abuse. Complicating factors may include:

- Responses of others, including attitudes and behaviour of professionals
- Access to support
- Previous experiences of domestic abuse including in childhood
- Dependents with additional needs
- Learning difficulty, poor health or factors increasing dependency on 'care giver'
- Life stressors e.g., language barrier; education; employment, financial dependence
- Immigration status
- Fear of being rejected by family or the wider community;
- 'Honour' based abuse
- Disability discrimination and oppression, and being less aware of their rights
- Poor mental health.

How a perpetrator might make mental health problems worse:

- Telling the victim that nobody will believe them
- Threatening to report them to the authorities
- Withholding the victim's medication or access to health care
- Administering excessive medication
- Encouraging drug or alcohol dependency
- Telling the victim that they are 'mental' or 'mad' or 'crazy'
- Diagnosing the victim with mental health conditions
- Threatening to have the victim sectioned
- Talking on behalf of the victim in the GP surgery or with healthcare professionals
- Convincing the victim and third parties that the victim or the children cannot manage without the perpetrator.

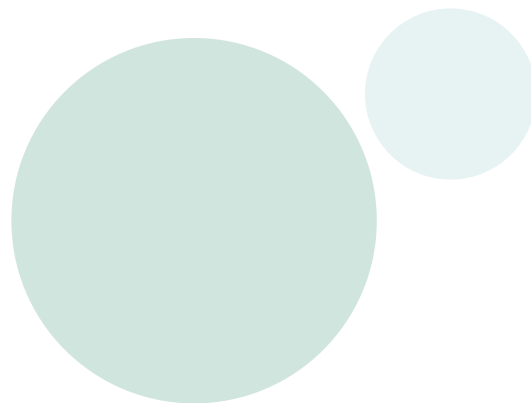
PART C | Mental Health

C3 Wider problems associated with DA²⁴

Wider problems associated with domestic abuse can include but are not limited to:

- Symptoms of anxiety, depression, post-traumatic stress disorder
- Sleep disorders
- Suicidal tendencies or self-harming
- Drug/ alcohol use
- Unexplained chronic gastrointestinal symptoms
- Unexplained gynaecological symptoms, including pelvic pain, bleeding, STIs
- Unintended pregnancies or terminations, delayed pregnancy care, miscarriage, premature labour and stillbirth. Domestic abuse often starts or worsens in pregnancy
- Unexplained genitourinary symptoms, including bladder or kidney infections
- Unexplained chronic pain
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Headaches, cognitive problems, hearing loss
- Repeated visits or calls to the GP with no clear diagnosis
- Someone else (partner, relative or 'friend') speaking 'for' the victim.

Physical illness significantly increases the risk of poor mental health and vice versa. 37% of physically ill people also have mental illness, mainly depression and anxiety.²⁵



References:

[24] National Institute of Clinical & Health Excellence (NICE), 2018

[25] Equal Treatment Bench Book - Courts and Tribunals Judiciary, Chapter 4, para. 12

PART C | Mental Health

C4 Suicidal Ideation | Trauma-Informed and Trauma-Responsive Guidance²⁶

Ideas about suicide or self-harm

As a practitioner, you might hear or observe:

- ✦ Various statements that alert you, such as 'I don't want to be here anymore,' 'I can't go on' or 'There's no point (in being alive)'
- ✦ Signs of hopelessness, chronic fear or entrapment with no way out
- ✦ Signs of withdrawal from support networks, or of giving up hope for a future
- ✦ Signs of self-harming or risk-taking behaviours.

It can be disturbing to hear that anyone has thought of suicide or self-harm, but both are common reactions to feeling trapped by domestic abuse or coercive control without a means to escape. A victim may have been threatened, intimidated, told they do not deserve to live or can never be safe from further harm, or they might have come to believe that.

It is important to understand that while people may express a desire to escape overwhelming pain, fear or distress, at the same time they also want relief, safety and support. What is often sought is not death, but an end to their suffering. The thoughts may not be a fixed wish to end life or endure more injury, but more a trauma response to overwhelming fear, lack of control, or a belief that there is no other way to escape abuse. In a similar way, self-harming behaviours may be efforts to regulate intense distress, manage dissociation, express suffering or regain a sense of control. Sometimes they may also function as a way to appease a perpetrator, prevent escalation, or reduce harm in the context of coercive control. They can fluctuate in intensity over time.

These behaviours are responses to trauma but may be misinterpreted in legal proceedings if the context of abuse, threat or coercive control is not understood. They can be misunderstood as evidence of personal instability, mental illness or reduced parenting capacity, without identifying past abuse or risk of further harm, and thereby can lead to unsafe or unjust outcomes.

References:

[26] Equal Treatment Bench Book – Courts and Tribunals Judiciary Disability Glossary Mental Ill Health

PART C | Mental Health

C4 Suicidal Ideation | Trauma-Informed and Trauma-Responsive Guidance

If it is safe to do so, you could:

- ✦ Ask the victim to say a bit more or ask 'What do you mean?'
- ✦ Establish the context e.g., 'What has someone said or done to make you feel that way?'
- ✦ Listen and validate: Acknowledge distress without judgement or guessing solutions
- ✦ Do not argue, persuade, or shame: Avoid minimising or trying to 'talk them out of it'
- ✦ Ask what has helped the victim to keep going in the past; what future do they want; and what /who has helped them keep going or feel safer when times are tough etc. Protective factors can include children, pets, family and/or friends. Be careful not to point these out as this may make them feel guilty. Instead, allow them to explain to you whether there is something stopping them acting on their thoughts.
- ✦ Ask, 'What do you need to feel safer right now?' or 'What or who might help when you feel this low/hopeless?' This may guide the victim toward their own coping strategies.
- ✦ Facilitate access to appropriate support. You could ask, 'Are you willing to call your GP and tell them what you have just told me?' or 'Would you like me to call them for you?' Please refer to the support pages in Section H of this Guide and consider GP, hospital A & E departments, mental health services, helplines and specialist domestic abuse services.

Always prioritise safety and respond to immediate risk. Follow safeguarding procedures where there is imminent danger.

Never be afraid to take action if you feel someone is at risk of suicide. The worst thing to do is to assume it is someone else's responsibility to protect them or to take no action at all. Speak to a senior, a manager or a safeguarding lead.

PART C | Mental Health

C5 What if the person does not raise the subject of disability?²⁷

5.1 How to support someone to talk about their mental health

A victim may not disclose to the court or other professionals that they may be struggling with their mental health or that they are experiencing difficulties. This may be due to the stigma attached to poor mental health, limited knowledge of the court's powers to make adjustments or fear that they will not be taken seriously or supported. It is important to acknowledge that the victim may need help in understanding their mental health needs. Judges and other safeguarding professionals are not permitted or trained to make diagnoses of mental health conditions and should signpost victims appropriately. The Court should be alert to any indicators that adjustments might be required.

5.2 Breaking the silence

Despite experiencing the ongoing effects of domestic abuse, many victims may be reluctant to raise concerns regarding the impact of court proceedings on their mental health. This may be due to their perpetrator being present or being triggered by memories of previous abuse or because they are finding it hard to stay present during proceedings, especially under hostile cross-examination.

Bath Mind²⁸ suggest the following approaches:

- ✦ *"You seem to be distressed by this situation. Is there anything which would help reduce your anxiety?"*
or
- ✦ *"Is there anything you would like to tell us about your situation? Is there anything we can do to help?"*
or
- ✦ *'I would like to ask you if you are experiencing any mental distress or have a mental health condition. If you want to tell me, 'Say yes'. If you feel unable to tell me or you do not have a mental health condition, say 'no comment'.'*

References:

[27] [Equal Treatment Bench Book - Courts and Tribunals Judiciary](#), Ch. 4, paras 69-71

[28] [Mind](#) is a mental health charity

PART C | Mental Health

C5 What if the person does not raise the subject of disability?

Some other ideas to help someone talk about the impacts of domestic abuse on psychological distress would be to say:

'Domestic abuse can contribute to both physical injury and emotional and psychological harm. What changes, if any, in how you feel, have you noticed since the abuse began?'

or

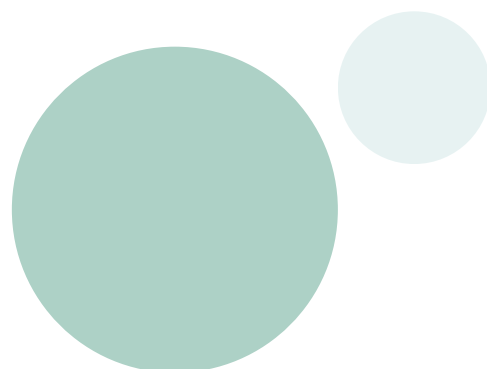
'Sometimes victims say that the mental abuse or mind-games are the worst part of domestic abuse. Many leave because they are afraid that the abuse is damaging their mental health. Has this been your experience? How has living in fear affected the way you feel, think, or what you do?'

or

'Some victims feel depressed, suicidal, traumatised or just go numb after being abused. Some are more likely to drink or use drugs to manage the pain. Do these experiences resonate with you, and how are you trying to manage them?'

When asking a victim about their mental health difficulties, it is important to consider:

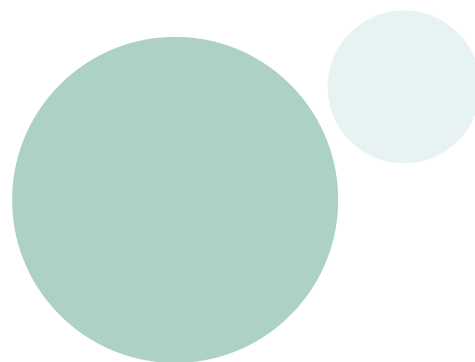
- ✦ A perpetrator may have made accusations that a victim has poor mental health;
- ✦ The victim may find it hard to recognise their symptoms as being a response to domestic abuse;
- ✦ Domestic abuse and mental health issues may carry stigma, fear or mistrust if they were to be disclosed.



C5 What if the person does not raise the subject of disability?

Poor practice by professionals identified by victims include:

- ✦ Poor training/ limited understanding of domestic abuse and the impacts on mental health
- ✦ Failure to recognise domestic abuse and to make referrals to specialist services
- ✦ Minimising the perpetrator's behaviour and focusing on the victim's response to trauma without the context of their experience of domestic abuse
- ✦ Victim-blaming
- ✦ Offering short-term interventions rather than long-term therapeutic support and recovery
- ✦ Diagnosing mental health without appropriate training or qualifications.



PART C | Mental Health

C6 Myths about domestic abuse and mental health

Failure to recognise the cause of poor mental health, failure to offer support, excusing the perpetrator, minimising continued abuse and blaming the victim can profoundly impact victims of domestic abuse.

Victims experiencing poor mental health as a result of domestic abuse might encounter myths such as:

- ✦ 'All the abuse is historic. We need to move forward for the sake of the children.'
- ✦ 'What did they do to get in such a state? They should pull themselves together.'
- ✦ 'Once a mental patient, always ...It's only a matter of time before they break down so the children aren't safe with them.'
- ✦ 'How could they look after the children if they can't look after themselves?'
- ✦ 'They have a diagnosis so what has happened to them must be their fault.'
- ✦ 'They're so difficult. They're not engaging.'
- ✦ 'We can't cope with someone like that.'
- ✦ 'It's not our speciality/ business.'
- ✦ 'They might be dangerous.'
- ✦ 'They have been separated for a long time; they should be over it by now.'

Some (but not all) of the myths and realities are explored below:

Myth 1: Victims in psychological distress are unfit parents

Reality: Victims can have a formal diagnosis but still prioritise care, guidance and support of their children and listen to their child's wants and needs and respond appropriately. The child's welfare, safety and well-being may be at risk from exposure to domestic abuse by the perpetrator.

PART C | Mental Health

C6 Myths about domestic abuse and mental health

Myth 2: Victims with a mental illness are not able to recover.

Reality: Many victims are able to recover from poor mental health caused by domestic abuse, especially after accessing ongoing support. Research shows that women who engaged with domestic abuse support services showed significant improvements in their mental health, especially if they had therapeutic as well as advocacy support.²⁹ It is important to acknowledge that some victims who continue to experience poor mental health experience ongoing domestic abuse including stalking, controlling behaviour via litigation abuse and threats to take children.

Myth 3: Accessing support for mental health problems is an admission of not being able to cope

Reality: Everyone's response to domestic abuse is different, including how they access and engage with professional support services. Trauma, especially trauma caused by domestic abuse, can impact a victim's ability to form supportive, trusting, relationships with professionals and therefore their response and their ability to seek support. Seeking support demonstrates healthy progress to healing trauma.

Myth 4: The perpetrator is mentally ill or has anger management problems

Reality: Anger is a healthy feeling. People who are not perpetrators experience anger and can have mental illness; however domestic abuse is a conscious, deliberate, targeted behaviour toward the victim.

Myth 5: Perpetrators abuse due to adverse childhood experiences

Reality: Adults who experienced domestic abuse in childhood may perpetrate similar behaviours in their future relationships, but domestic abuse is a choice. There are many people who have experienced adverse childhood experiences who do not go on to perpetrate domestic abuse.

References:

[29] Ferrari G, Feder G, Agnew-Davies R, Bailey JE, Hollinghurst S, Howard L, et al. (2018) Psychological advocacy towards healing (PATH): A randomized controlled trial of a psychological intervention in a domestic violence service setting. PLoS ONE 13(11): e0205485. <https://doi.org/10.1371/journal.pone.0205485>

PART C | Mental Health

C6 Myths about domestic abuse and mental health

Myth 6: Treatment of substance misuse will stop the abuse

Reality: A common misconception is that drug and alcohol misuse is never the root cause of domestic abuse. Domestic abuse stems from a desire for power and control over another person. Substance misuse may affect behaviour but domestic abuse does not occur without pre-existing abusive tendencies.

Myth 7: At least he's a good dad/ He'd never hurt the children

Reality: The Domestic Abuse Act 2021 and PD12J recognise children as victims of domestic abuse in their own right if they witness domestic abuse. Children who have witnessed abuse between their parents or abuse toward a parent or caregiver, are to be regarded as victims of domestic abuse, and consideration should be given to the safety and welfare of the child and the victim when making decisions on safe contact. See the Domestic Abuse Commissioner's website and the Children's Commissioner's website.

Myth 8: The victim continuously chooses abusive partners

Reality: Victims of domestic abuse can have poor self-worth and are vulnerable when entering into new relationships. Perpetrators often target people with vulnerabilities and people they can manipulate. Professionals should not judge victims while they navigate trauma. If victims are not given the tools to recover and recognise unhealthy behaviours, they will be at risk of further exploitation.

Myth 9: The victim should be over it by now because they have been separated for a long time. The victim seems unwilling to move on.

Reality: Domestic abuse can, and often, does continue long after a relationship has ended. When the victim finds the courage to end an abusive relationship or seek support, they are challenging a perpetrator's control. Perpetrators employ a broad range of post-separation coercive and controlling tactics including patterns of psychological and/ or economic abuse, weaponising of children and the manipulation of systems and professionals. The impact of ongoing post separation abuse on victims and their children may be life-long.^{30 31}

References:

[30] Spearman KJ, Vaughan-Eden V, Hardesty JL, Campbell J. Post-separation abuse: A literature review connecting tactics to harm. J Fam Trauma Child Custody Child Dev. 2024;21(2):145-164. doi: 10.1080/26904586.2023.2177233. Epub 2023 Feb 16. PMID: 38784521; PMCID: PMC11114442.

[31] See the Post Separation Power and Control Wheel, published by DAIP in Duluth, Minnesota, which also produce graphic wheels about misuse of power and control and equality wheels.

C7 Risks in family court proceedings

Family court proceedings can be a means to enforce unwanted contact and lend weight to threats made by a perpetrator. Court processes and post-separation arrangements for children can often provide an avenue for further abuse. Perpetrators may attempt to control the situation by manipulating family law professionals including alleging unsatisfactory care by their ex-partners. They may pursue child arrangements orders as a means of access to, or revenge against the primary carer, irrespective of the wishes or needs of the children. Child arrangements can place both children and domestic abuse victims at risk, not least because they may provide perpetrators with access or the means of access to their ex-partner's address and phone number.

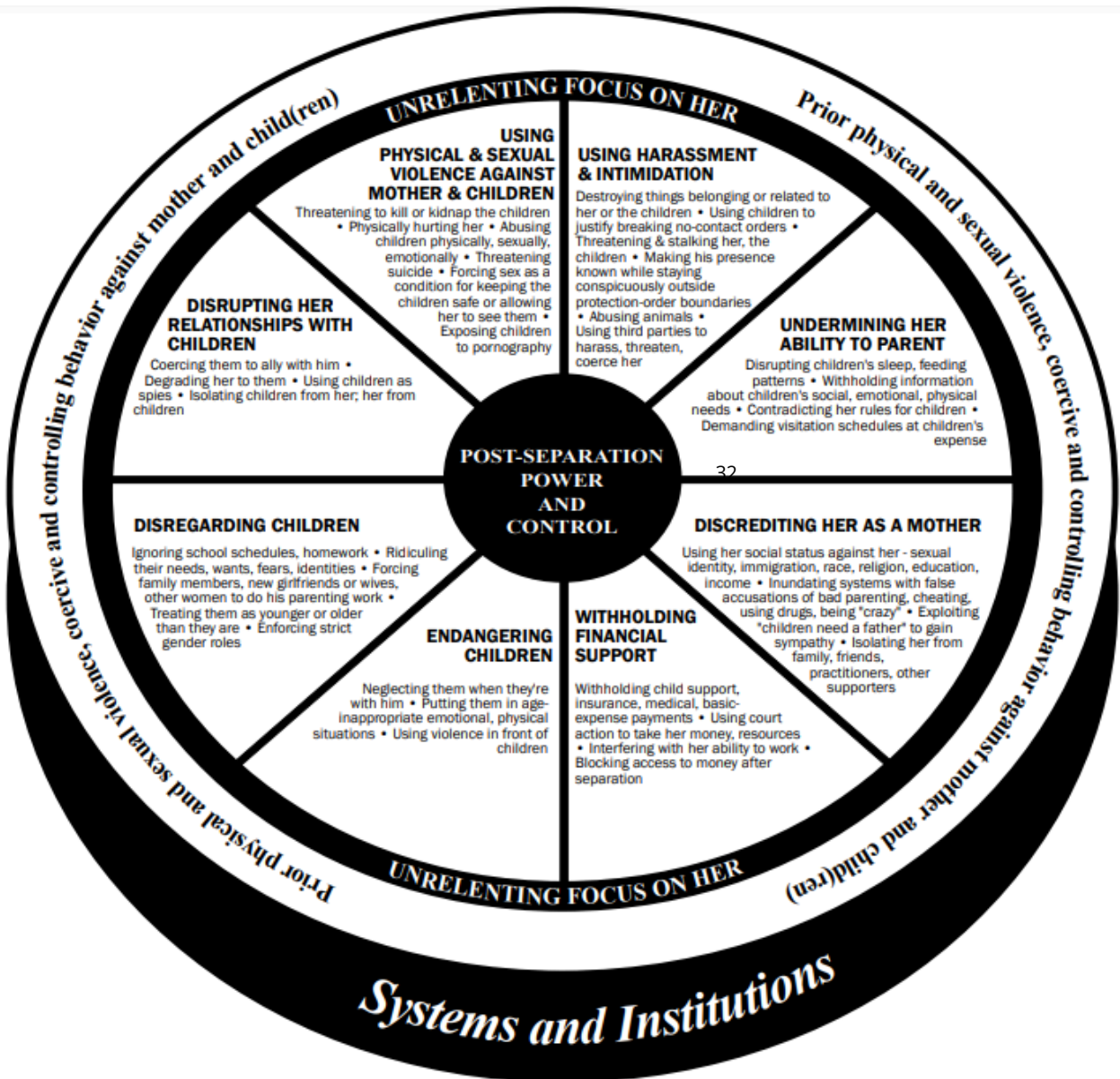
The Duluth post-separation power and control wheel³² is shown overleaf in Section C8. It is used internationally to facilitate the identification of different coercive and controlling behaviours and to help raise awareness of abuse extending beyond physical violence. It is intended to be used by victims as well as by those who come into contact with or support those who have experienced domestic abuse.

References:

[32] Domestic Abuse Intervention Programs, Home of The Duluth Model

C8 Duluth post-separation power and control wheel³³

You can also view the wheel online by [clicking here](#) on the image below.



DOMESTIC ABUSE INTERVENTION PROGRAMS

202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.TheDuluthModel.org

References:
[33] Domestic Abuse Intervention Programs, Home of The Duluth Model <https://www.theduluthmodel.org/wp-content/uploads/2021/10/Post-Separation-Power-and-Control.pdf>

PART D | Mental diagnoses

D1 A word of caution about diagnoses, disorders and other terms

The American Diagnostic and Statistical Manual (commonly used by psychiatrists) classifies mental suffering as disorders which, in itself, can be seen as a judgmental or negative term. The International Classification of Diseases³⁴ (the European classification system) talks about diseases, but many people argue that the medical model is unhelpful in understanding psychological distress. The ETBB refers to mental disabilities. The term 'psychological (rather than mental) distress' can include thoughts, feeling and behaviour and is not stigmatising.

One purpose of categorising symptoms (signs of distress) is to help a clinician find the right treatment or medication and is sometimes required for access to a specific service. However, common symptoms (such as sleeping difficulty) are found in many different conditions and the same person might be given different diagnoses by different clinicians (for instance, by a GP and by a psychiatrist) or at different times. The same type of medication (such as antidepressants) may be used to treat a wide variety of symptoms or conditions.

Clinical psychologists and other therapists are likely to be more concerned about how a condition affects a person's functioning, or capacity to cope with daily life, and will focus on the specific needs of an individual rather than a category of diagnosis. However, they may be required to offer a diagnosis, for a medicolegal report.

D2 Who can help

Over 90% people experiencing psychological distress are treated by their G.P. in the UK, who may diagnose a mental health problem. The person can self-refer to NHS Talking Therapies, which were first known as IAPT (Improving Access to Psychological Therapies), designed to offer basic support by non-medical staff (who have had some training in CBT) to people with mild or moderate conditions. Secondary services may be provided by one or more of the following:

References:

[34] International Classification of Diseases (ICD)

PART D | Mental diagnoses

A Psychiatrist - who is a medically trained doctor who has specialised in psychiatry and can prescribe medication.

A Clinical Psychologist - who has trained for about six years, usually has a first degree in psychology, and a Master's or PhD in clinical psychology. They specialise in talking therapies and will have been trained to work with different conditions, in different types of therapy, to use tools such as questionnaires and work with different groups of people (such as children, adults, older adults and people with special needs).

A Community Psychiatric Nurse - who has trained as a nurse and then had specialist training in mental health conditions.

An Occupational Therapist - who is trained to help people manage everyday tasks as well as they can, and to support their skills to promote independent living when possible.

A Social Worker in Mental Health - who provides support and advocacy to identify needs and risks and help someone access the right level of support and care.

A Counsellor - who has been trained in person-centred therapy and to provide a safe space to talk about troubles.

Many of these professionals will have had no, or only basic, training to understand domestic abuse and coercive control. If someone is experiencing domestic abuse, they are likely to need and benefit from help from a specially trained advocate, an IDVA³⁵ or ISVA³⁶, as well as support to recover their well-being.

References:

[35] Independent Domestic Violence Adviser

[36] Independent Sexual Violence Adviser

PART D | Mental diagnoses

D3 Diagnoses commonly associated with domestic abuse

This guide covers the most common diagnoses, namely, Anxiety, Depression, PTSD and personality disorder. Each one is explained briefly. The guide goes on to consider context for developing the condition as a function of domestic abuse, and the impact on the victim's capacity to follow court proceedings. Some treatments available are listed. Sources of support are set out at the end of this guide.

D4 Anxiety

What is anxiety?

There are different types of anxiety. General anxiety is an unpleasant feeling that is there all the time and seems unconnected to particular events or things. Acute panic attacks are specific episodes when the person is scared by the strength of their feelings and feels unable to calm down. They may think that they are going to faint, are having a heart attack, or have a desperate desire to escape.

Victims experiencing or recovering from domestic abuse may experience high levels of fear and anxiety in a number of different ways, including:

- ✦ Fear in response to current danger, based on past or ongoing threats, harassment, abuse and/ or violence from their perpetrator(s)
- ✦ Fear triggered during flashbacks to past abuse or intrusive memories about their perpetrator(s)
- ✦ Generalised anxiety including hyper-vigilance and chronically high arousal levels (related to post-traumatic stress)
- ✦ Fear of the future including risks of further abuse, fear for their children and fear of managing alone.

Anxiety should never be confused with fear, which is a healthy response to real danger. It is natural and adaptive that a person at risk of harm experiences changes to their nervous system. In an abusive relationship, a victim is likely to experience an acute stress reaction, which includes changes to their breathing, heart rate, temperature and digestive system.

PART D | Mental diagnoses

D4 Anxiety

When there is ongoing abuse, the victim's hyperarousal levels may never return to normal. Even after a single incident, previously neutral events, such as a raised voice, using a kitchen knife, tying a neck scarf or a sudden noise may provoke intense fear and a desire to escape. The response can be immediate, intense and extreme. Living under forced conditions, when a person is devoid of strength to protect themselves, increases the likelihood that the response becomes automatic.³⁷

The picture becomes more complex over time; current thinking is that domestic abuse can never truly be regarded as historic. Victims who left their perpetrators have been stalked and murdered years after separation. Victims of stalking describe a range of symptoms including agitation, anxiety, depression and suspicion as well as somatic (bodily) symptoms like headaches and stomach problems.³⁸ Many victims fear their perpetrators indefinitely, based on their experiences and inadequate protection. Victims can be pressured to remain in contact with the very source of danger through court proceedings or child arrangements.

Some victims may present to their GP with persistent, generalised symptoms of severe anxiety. They may have lost their ability to control their physical reactivity to events that remind them of the trauma and are continually heightened to the degree experienced during the abuse. These chronic symptoms, including apprehension that further abuse could happen at any time, may develop into panic disorder, generalised anxiety disorder or agoraphobia.³⁹ These symptoms can last for years and be aggravated by further trauma. A history of childhood sexual abuse is a strong predictor of hyperarousal in adult victims of domestic abuse.⁴⁰

References:

[37] Marjorie Holiman, 1997

[38] Dressing, H., Kuehner, C & Gass, P. (2005) Lifetime prevalence and impact of stalking on a European population: epidemiological data from a middle-sized German city. *British Journal of Psychiatry*, 187, 168-72

[39] Dutton, D. G. & Painter, S. 'Emotional Attachments in Abusive Relationships: A Test of Traumatic Bonding Theory', *Violence and Victims* Vol 8 Issue 2, Jan 1993, DOI: 10.1891/0886-6708.8.2.105

[40] Griffing S, Lewis CS, Chu M, Sage RE, Madry L, Primm BJ. Exposure to interpersonal violence as a predictor of PTSD symptomatology in domestic violence survivors. *J Interpers Violence*. 2006 Jul;21(7):936-54. doi: 10.1177/0886260506288938. PMID: 16731993.

PART D | Mental diagnoses

D4 Anxiety

How does anxiety affect victims in court?

Anxiety may affect a victim's attention, ability to process information and their capacity to recall events. It may also cause strong physical or bodily reactions, including difficulty breathing, fear of being sick, fainting, or having a heart attack, and usually causing a strong desire to escape (rather than standing one's ground or up for the truth).

Support for people with anxiety

It can be a challenge to separate a victim's current fears (which should be respected as appropriate and inform safety planning) and their anxieties (which might be eased by anxiety management techniques).

Support can include:

- 1 Acknowledging the response of fear as healthy when in real, imminent danger
- 2 Reducing physical symptoms e.g., by relaxation, breathing or mindfulness exercises
- 3 CBT approaches to help cognitive management of anxieties
- 4 Medication.

D5 Depression

What is depression?

Depressive disorder, or depression, is a common mental health condition that can happen to anyone. It is characterised by a low mood or loss of pleasure or interest in activities for long periods of time.

This is different from regular mood changes and feelings about everyday life. Depressive episodes last most of the day, nearly every day, for at least two weeks. People with depression may experience disturbed sleep and changes to their appetite. They may have feelings of low self-worth, thoughts about dying and hopelessness about the future. Tiredness and poor concentration are also common.

Depression results from a complex interaction of social, psychological and biological factors. People who have lived through abuse, severe losses or other adverse events are more likely to develop depression.⁴¹

References:

[41] People who have lived through abuse, severe losses or other stressful events are more likely to develop depression. Women are more likely to have depression than men. See <https://www.who.int/news-room/fact-sheets/detail/depression>

PART D | Mental diagnoses

D5 Depression

Why are victims of domestic abuse likely to suffer from depression?

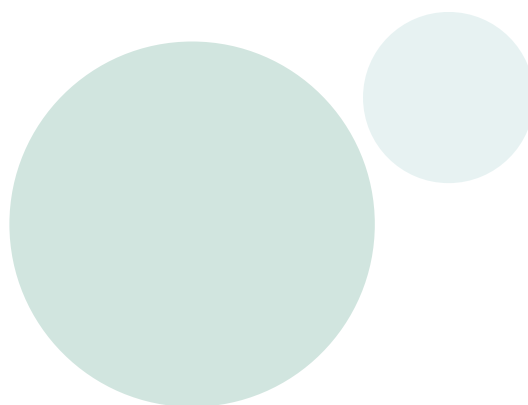
Domestic abuse is strongly and consistently associated with both depressive disorders and suicide.

People exposed to controlling behaviour are more than twice as likely to have depressive symptoms as members of the general population.

Women exposed to physical and sexual violence are four or five times more likely to have depressive symptoms compared with members of the general population.⁴²

Women experiencing abuse are at greater risk of mental health conditions. Having a mental health condition means one is more vulnerable to abuse, particularly for depression.⁴³

Victims of IPV who seek advocacy support in the UK also report higher levels of abuse and on average 26% higher depression than in the general population when they first contact services.⁴⁴ These decrease over time such that depression rates in women who have left an abusive relationship up to one year earlier may return to similar levels as those in the general population.⁴⁵



References:

- [42] e.g. Lövestad S, Löve J, Vaez M, Krantz G. (2017) Prevalence of intimate partner violence and its association with symptoms of depression; a cross-sectional study based on a female population sample in Sweden. BMC Public Health. Apr 20;17(1):335. doi: 10.1186/s12889-017-4222-y.
- [43] Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, Astbury J, Watts CH. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. PLoS Med. 2013;10(5):e1001439. doi: 10.1371/journal.pmed.1001439. Epub 2013 May 7. PMID: 23671407; PMCID: PMC3646718.
- [44] Herbert, A., Heron, J., Barnes, M. et al. (2022) Exploring the causal role of intimate partner violence and abuse on depressive symptoms in young adults: a population-based cohort study. BMC Med, 20, 1. <https://doi.org/10.1186/s12916-021-02182-3>; Ferrari, G., Agnew-Davies, R. et al (2016) Domestic violence and mental health: a cross-sectional survey of women seeking help from domestic violence support services. Global Health Action, 9: 29890 - <http://dx.doi.org/10.3402/gha.v9.29890>
- [45] Trevillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. PLoS ONE 7(12): e51740. <https://doi.org/10.1371/journal.pone.0051740>

PART D | Mental diagnoses

D5 Depression

Why are victims of domestic abuse likely to suffer from depression?

At Refuge, 51% of women's ratings indicated severe depression and a further 23% moderate depression.⁴⁶ In the PATH trial, 72% of women seeking support from domestic violence services presented with clinically significant depression.⁴⁷

Survivors of rape, torture and trauma are at increased risk of suicide attempts, in many cases because suicide seems the only solution to escape from pain. Substance use can also increase because alcohol or drugs help avoidance of or override unwanted feelings through anaesthesia.

Buller et al⁴⁸ reviewed nineteen studies with 13,797 participants and concluded that gay and bisexual men who had sex with men and were victims of intimate partner violence were more likely to suffer from depressive symptoms. In a study by Baccus et al⁴⁹ of gay and bisexual men attending a UK sexual health service, 81 out of 106 men (76.4%) said that negative and potentially abusive behaviours made them feel anxious or depressed.

In a review of help-seeking by male-victims of domestic violence and abuse undertaken by Huntley et al,⁵⁰ 3 studies explored diminished confidence and the potential role of post-traumatic stress disorder.

References:

- [46] Agnew-Davies R. Reframing psychological symptoms in the context of domestic violence. 37th Annual Meeting Society for Psychotherapy; June 2006; Edinburgh UK2006.
- [47] Ferrari G, Feder G, Agnew-Davies R, Bailey JE, Hollinghurst S, Howard L, et al. (2018) Psychological advocacy towards healing (PATH): A randomized controlled trial of a psychological intervention in a domestic violence service setting. PLoS NE 13(11): e0205485. <https://doi.org/10.1371/journal.pone.0205485>
- [48] Buller AM, Devries KM, Howard LM, et al. Associations between intimate partner violence and health among men who have sex with men: a systematic review and meta-analysis. Plos Med 2014; 11: e1001609–e1001609. DOI: 10.1371/journal.pmed.1001609.
- [49] Bacchus L, Buller A, Ferrari G, et al. Occurrence and impact of domestic violence and abuse in gay and bisexual men: A cross sectional survey. International Journal of STD & AIDS. 2016;28(1):16-27. doi:[10.1177/0956462415622886](https://doi.org/10.1177/0956462415622886)
- [50] Huntley AL, Potter L, Williamson E, et al Help-seeking by male victims of domestic violence and abuse (DVA): a systematic review and qualitative evidence synthesis BMJ Open 2019;9:e021960. doi: 10.1136/bmjopen-2018-021960

PART D | Mental diagnoses

D5 Depression

How might depression occur as a symptom of domestic abuse?

- ✦ Negative thoughts (after emotional abuse, blame, allegations)
- ✦ Disrupted planning of daily life, at home, work and socially (after physical abuse or coercive control)
- ✦ Lack of positive events (after enforced isolation and entrapment)
- ✦ Suicidal ideation (to escape abuse)
- ✦ Grief, sadness and hopelessness consequent on the experiences of abuse
- ✦ Guilt, shame and self-blame
- ✦ Lack of sleep following abuse and nightmares about further harm

How might depression affect victims in court?

Depression negatively affects mood, concentration, memory, capacity to talk, motivation to explain and hope for the future.

Support and treatment for depression

Practice guidelines⁵¹ recommend anti-depressant medications, usually prescribed by a GP, and talking therapies as first-line treatments. Although medications are easily accessible, questions remain about the impact of their long-term use, side effects, and patients' preferences for psychological support.⁵²

Depression tends to recur but there is little research on the longer-term outcomes related to anti-depressant medication. Depressive experiences extend beyond symptoms and affect social, physical, and psychological functioning. Interpersonal therapy (IPT) works as well as anti-depressant medication for those with depression who do not respond to medication, cannot tolerate their side effects, or prefer psychotherapy; if given either treatment, about half will respond to treatment (i.e., show more than 50% reduction of symptoms).⁵³ However, many victims of domestic abuse have reported that medication did not resolve the impact of abuse (see above).

References:

[51] Clinical Practice Guideline for the Treatment of Depression, APA, 2019 [Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts](#)

[52] McHugh RK, Whitton SW, Peckham AD, Welge JA, Otto MW. Patient preference for psychological vs pharmacologic treatment of psychiatric disorders: a meta-analytic review. *J Clin Psychiatry*. 2013 Jun;74(6):595-602. doi: 10.4088/JCP.12r07757. PMID: 23842011; PMCID: PMC4156137,

[53] Cohen ZD, Breunese J, Markowitz JC, Weitz ES, Hollon SD, Browne DT, Rucci P, Corda C, Menchetti M, Weissman MM, Bagby RM, Quilty LC, Blom MJB, Altamura M, Zobel I, Schramm E, Gois C, Twisk JWR, Wienicke FJ, Cuijpers P, Driessen E. Comparative efficacy of interpersonal psychotherapy and antidepressant medication for adult depression: a systematic review and individual participant data meta-analysis. *Psychol Med*. 2024 Nov 4;54(14):1-10. doi: 10.1017/S0033291724001788. Epub ahead of print. PMID: 39494789; PMCID: PMC11578913.

PART D | Mental diagnoses

D6 Post-Traumatic Stress Disorder (PTSD)

Psychological support can have at least five elements:

- 1 normalising victims' reactions in the context of domestic abuse. (Sadness is a natural reaction to what has happened to them and their family.)
- 2 addressing suicidal ideation
- 3 cognitive-behavioural work on planning (for themselves, rather than being controlled)
- 4 cognitive-behavioural work on negative thoughts (to redress psychological abuse)
- 5 other approaches e.g., looking at anger, grief, inner child or relationship work.

D6 Post-Traumatic Stress Disorder (PTSD)⁵⁴

What is PTSD?

Post-traumatic stress disorder (PTSD) may develop after exposure to an extremely threatening or horrific event (or series of events) characterised by all of:

- 1 Re-experiencing the traumatic event or events in the present in vivid intrusive memories, flashbacks, or nightmares; typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations;
- 2 Avoidance of thoughts and memories of the event(s), or avoidance of activities, situations, or people reminding of the event(s); and
- 3 Persistent perceptions of heightened current threat (e.g., indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises).

The symptoms last for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Complex PTSD (ICD-11)

Complex post-traumatic stress disorder (Complex PTSD) may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic abuse, repeated childhood sexual or physical abuse).

References:

[54] 11th revision of the International Classification of Diseases (ICD-11) [International Classification of Diseases \(ICD\)](#)

PART D | Mental diagnoses

D6 Post-Traumatic Stress Disorder (PTSD)

Beyond PTSD, Complex PTSD is characterised by severe, persistent:

- 1 Problems in controlling affect (emotion);
- 2 Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure; and
- 3 Difficulties in sustaining relationships and in feeling close to others.

These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Factors leading to particularly severe or enduring symptoms of PTSD include the following:

- 1 The trauma was caused by humans rather than by a natural disaster
- 2 The trauma was caused by a person known to the victim
- 3 The experience of abuse is personal and individual, rather than shared
- 4 Continued proximity to the abuser(s)
- 5 The trauma was repeated rather than an isolated incident
- 6 The trauma occurred in a previously safe environment
- 7 There has been rape or sexual violence
- 8 There is little sympathetic social support
- 9 There is a history of previous abuse or violation.

PART D | Mental diagnoses

D6 Post-Traumatic Stress Disorder (PTSD)

Why are victims of domestic abuse likely to suffer from PTSD or CPTSD?

Post-Traumatic Stress Disorder (PTSD) was first used to describe symptoms of combat veterans. The diagnosis had tremendous significance because it meant that victims suffered from a real problem, for which there was a name and treatment and also that their symptoms were normal reactions to terrifying and life-threatening experiences.⁵⁵ A victim's experience of domestic abuse, or 'intimate terrorism' can be compared to that of casualties of war, torture, natural disasters or captivity. In effect, they may have been held hostage at home.⁵⁶

The first criterion for a diagnosis of PTSD to be met is the experience of a horrifying event that threatens death or injury. In a study of the UK adult population in 2014, 1 in 25 had experienced extensive physical and sexual abuse; 80% of these were women, nearly all of whom had been assaulted by a partner; half had been threatened with death, and many had experienced physical and sexual abuse from childhood.

Reviews show that childhood and adult abuse put mental health and personhood at risk and are major causes of profound psychological and emotional difficulties, shown in a wide range of signs of distress and dysfunction, including PTSD.⁵⁷ Lifetime prevalence of exposure to trauma has been estimated between 23% and 76% in women, and 10%-15% lifetime rates for PTSD.⁵⁸

Over 75% of clients presenting to mental health services have some history of trauma.⁵⁹ There is evidence that rates of PTSD are higher in countries with conflict and in cultural groups with traditional gender roles.

References:

- [55] E.g., Zayfert, C., & Becker, C. B. (2007). Cognitive-behavioral therapy for PTSD: A case formulation approach. The Guilford Press.
- [56] E.g., Stark, E. (2007). Coercive control: How men entrap women in personal life. Oxford University Press.
- [57] Williams, J. & Watson, G. (2016), Surviving their lives: women's mental health in context. In D.J. Castle & K. M. Abel (eds) Comprehensive Women's Mental Health, ch.1, 1-13. Cambridge University Press
- [58] Wade D, Varker T, Kartal D, Hetrick S, O'Donnell M, Forbes D. Gender difference in outcomes following trauma-focused interventions for posttraumatic stress disorder: Systematic review and meta-analysis. Psychol Trauma. 2016 May;8(3):356-64. doi: 10.1037/tra0000110. Epub 2016 Feb 8. PMID: 26854354.
- [59] Valinejad, C. (2015). Delivering efficient psychotherapy. Clinical Psychology Forum, 271, 33-35.

PART D | Mental diagnoses

D6 Post-Traumatic Stress Disorder (PTSD)

Why are victims of domestic abuse likely to suffer from PTSD or CPTSD?

PTSD does not necessarily ease after victims have tried to leave their abusive partners. In an early survey of victims of stalking, 30% of whom were stalked by ex-partners,⁶⁰ 37% victims met the criteria for a diagnosis of PTSD, and a further 18% had the clinical features but did not qualify for the initial criterion (threatened or actual physical harm). Victims of protracted stalking (on average lasting six months) were three times more likely to have clinically significant PTSD than people who experienced brief harassment lasting a few days.⁶¹ PTSD symptoms tended to diminish over time if the stalking stopped, but 10% of victims remained troubled by unwanted intrusions and reminders long afterwards.

How might symptoms of PTSD affect people in court

Each of the symptoms associated with PTSD can have direct effects on a victim's capacity to follow proceedings and give evidence.

Dan Siegel⁶² conceptualised the optimal zone of arousal in which an individual can function effectively (emotionally regulated, cognitively flexible, and socially engaged) as the 'window of tolerance'. Within this window, individuals are able to process stimuli without becoming overwhelmed or shutting down. Porges' Polyvagal Theory⁶³ complements Siegel's work. According to Porges, activation of the dorsal vagal complex is associated with immobilisation and collapse (hypoarousal), while sympathetic activation is linked to fight-or-flight responses (hyperarousal). The model has particular relevance for trauma survivors, who often experience chronic dysregulation of arousal due to disruptions in neurobiological development and autonomic function.⁶⁴ Trauma-related conditions such as PTSD and C-PTSD are characterised by narrowed or unstable windows, making it difficult to stay within the optimal zone.

Briefly, being obliged to talk about experiences is highly likely to trigger past memories of traumatic incidents which can be difficult to control. Many people experience a 'cascade effect' when one memory quickly follows another, so it is very difficult to separate incidents, stay present to follow questions and to not become overwhelmed physically and emotionally.

References:

- [60] Pathé M, Mullen PE. The impact of stalkers on their victims. *Br J Psychiatry*. 1997 Jan;170:12-7. doi: 10.1192/bjp.170.1.12. PMID: 9068768.
- [61] Purcell R, Pathé M, Mullen PE. Association between stalking victimisation and psychiatric morbidity in a random community sample. *Br J Psychiatry*. 2005 Nov;187:416-20. doi: 10.1192/bjp.187.5.416. PMID: 16260815.
- [62] Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. Guilford Press.
- [63] Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. WW Norton & Company.
- [64] Corrigan, F. M., Fisher, J. J., & Nutt, D. J. (2011). Autonomic dysregulation and the window of tolerance model of the effects of complex emotional trauma. *Journal of Psychopharmacology*, 25(1), 17-25.

PART D | Mental diagnoses

D6 Post-Traumatic Stress Disorder (PTSD)

How might symptoms of PTSD affect people in court

- ▶ Avoidance symptoms, which are characteristic of PTSD, are often misunderstood in court as lack of interest, skirting the issue, vagueness or reluctance to 'tell the truth'.
- ▶ A heightened sense of threat means that victims are highly likely to be extremely frightened to be in the proximity of the perpetrator, even with special measures in place.
- ▶ If they have Complex PTSD, victims will struggle to control a roller-coaster of intense and painful emotions.
- ▶ Their experiences of abuse and betrayal by someone they trusted and loved has a profound impact on their capacity to trust others or to expect respect.
- ▶ Their self-esteem which has been damaged by often years of psychological abuse adds to the likelihood that they will feel misunderstood, unworthy, blame themselves, and expect others to do the same.
- ▶ Dissociation (going numb or blank) is associated with memory problems, inconsistencies, withdrawal, apathy, despair, seeming to be 'not present' and inability to defend oneself under cross-examination.

Treatment and support for PTSD

People suffering from PTSD, especially if they have experienced prolonged trauma, need a staged model of care:⁶⁵ a) crisis/ emergency intervention, b) support, recuperation and psychological adjustment, and c) long term symptom management and reintegration into the community.

References:

[65] Herman 1992; [Helen Bamber Foundation](#) | [Strength to Fly](#).

PART D | Mental diagnoses

D6 Post-Traumatic Stress Disorder (PTSD)

Treatment and support for PTSD

An international expert in the treatment of trauma⁶⁶ highlighted the need for traumatised individuals to have experiences that directly contradict their helplessness and physical paralysis that result from traumatic experiences. He summarised the critical steps in treating PTSD as providing:

Safety: when people's own resources are inadequate to deal with threat, they need to rely on others to provide a safe place and care as well as help to re-establish social support.

Anxiety management: distinguishing between real-life threats and haunting, irrational fears; strengthening anxiety management skills by relaxation, breathing and guided self-dialogue.

Emotional processing: the victim needs to re-experience the event(s) without feeling helpless, separating the past from the present e.g., by EMDR or specialist trauma-focused CBT therapy.⁶⁷ (Medication and general counselling are not enough alone.)

D7 Personality Disorder

It is widely accepted that the psychiatric classification of personality disorders is unsatisfactory.⁶⁸ Personality disorder can be defined as variations or exaggerations of normal personality attributes, or enduring characteristics that impair wellbeing or social function. They are found in about 10% of the general population and much more often (up to 80%) in psychiatric populations. There is no single known cause and normally a combination of social, biological and psychological factors are involved, and many people have experienced significant lifetime traumas.⁶⁹ Memory systems related to the self and others are central to personality disorder and these depend on learning experiences in early relationships (often called early attachment bonds).

References:

[66] Van der Kolk, B. A. The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. Viking, 2014. ISBN 9780670785933.

[67] National Institute of Clinical & Health Excellence (NICE), 2018

[68] The British Psychological Society, <https://www.bps.org.uk>

[69] Mizen, S., Rost, F. & Cardoso, F. (2025). Improving support for people with complex mental health difficulties. Centre for Mental Health.

PART D | Mental diagnoses

Borderline Personality Disorder

People with borderline personality disorder (BPD) experience significant stigma, even with regards to care delivery⁷⁰ not least because of preconceptions about the diagnosis and misconceptions about its un-treatability.

Borderline personality disorder (BPD) is a common but severe mental illness associated with functional impairment and substantial comorbidity.⁷¹

The Diagnostic and Statistical Manual of Mental Disorders – 5th edition estimates prevalence between 2-6% in the general population, 20% among psychiatric inpatients, and is diagnosed about 75% of the time in women.⁷²

Emotionally Unstable Personality Disorder is not a formal diagnosis in the Diagnostic and Statistical Manual of Mental Disorders – 5th edition, but is often used interchangeably with BPD, and is a condition described in the ICD.

BPD Symptoms

A pervasive pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:

- 1 Frantic efforts to avoid real or imagined abandonment
- 2 A pattern of unstable and intense relationships characterised by alternating between extremes of idealisation and devaluation
- 3 Identity disturbance: markedly and persistently unstable self-image or sense of self
- 4 Impulsivity in at least two areas (e.g., spending, sex, substance use, reckless driving, binge eating) that are potentially self-damaging
- 5 Recurrent suicidal behaviour, gestures or threats or self-mutilating behaviour

References:

[70] Ring D, Lawn S. Stigma perpetuation at the interface of mental health care: a review to compare patient and clinician perspectives of stigma and borderline personality disorder. J Ment Health. 2025 Feb;34(1):57-77. doi: 10.1080/09638237.2019.1581337. Epub 2019 Mar 12. PMID: 30862201.

[71] Volkert J, Gablonski TC, Rabung S. Prevalence of personality disorders in the general adult population in Western countries: systematic review and meta-analysis. Br J Psychiatry. 2018 Dec;213(6):709-715. doi: 10.1192/bjp.2018.202. Epub 2018 Sep 28. PMID: 30261937.

[72] Diagnostic and Statistical Manual of Mental Disorders – 5th Edition

PART D | Mental diagnoses

D7 Personality Disorder

BPD Symptoms

- 6 Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours)
- 7 Chronic feelings of emptiness
- 8 Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- 9 Transient, stress-related paranoid ideation or severe dissociative symptoms

People with BPD are very sensitive to environment and circumstances, especially separation or other events that trigger fears of abandonment. BPD often co-occurs with depression.

Support with BPD

There are several effective therapies available to treat patients with BPD and in guidelines, BPD-specific psychotherapy is recommended as the first-line treatment, whereas treatment with medication is not evidence-based for patients with BPD.⁷³

Treatments are more likely to be beneficial if they are long term, intensive, well-structured and well-integrated with other services.⁷⁴ Talking therapies that have been shown to be effective in some cases include: Dialectical Behavioural therapy (DBT), Cognitive Behavioural therapy (CBT), Schema-focused therapy, Mentalisation-based therapy (MBT), Systems Training for Emotional Predictability and Problem-Solving (STEPPS) and Transference-focused psychotherapy (TFP).

References:

- [73] Stoffers-Winterling JM, Storebø OJ, Kongerslev MT, Faltinsen E, Todorovac A, Sedoc Jørgensen M, Sales CP, Edemann Callesen H, Pereira Ribeiro J, Völlm BA, Lieb K, Simonsen E. Psychotherapies for borderline personality disorder: a focused systematic review and meta-analysis. *Br J Psychiatry*. 2022 Sep;221(3):538-552. doi: 10.1192/bjp.2021.204. PMID: 35088687.
- [74] British Psychological Society <https://bps.org.uk>

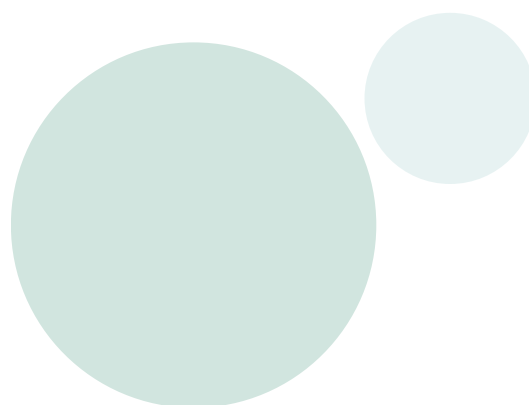
PART D | Mental diagnoses

D7 Personality Disorder

Support with BPD

However, even in well-developed health-care systems, fewer than one in four patients receive access to BPD-specific psychotherapy.⁷⁵ People with some of the most complex mental health difficulties (including personality disorder, eating disorder and problematic substance use, often co-occurring) are currently poorly served by existing health care provision and encounter entrenched negative attitudes, discrimination and stigma.⁷⁶ Without good pathways to care in the community many end up in hospitals long-term and often do not get the necessary therapeutic support to recover.

Despite that, the symptoms usually wane with age such that during their 30s and 40s, most people with BPD have more stable relationships and occupational functioning.



References:

[75] Iliakis EA, Sonley AKI, Ilagan GS, Choi-Kain LW. Treatment of Borderline Personality Disorder: Is Supply Adequate to Meet Public Health Needs? Psychiatr Serv. 2019 Sep 1;70(9):772-781. doi: 10.1176/appi.ps.201900073. Epub 2019 May 29. PMID: 31138059; [hEARD - JUICE Research Unit - GMMH - NHS](#)

[76] Mizen, S., Rost, F. & Cardoso, F. (2025). Improving support for people with complex mental health difficulties. Centre for Mental Health.

PART E | Difficulties created by litigation for those experiencing poor mental health

E1 Difficulties created by litigation for those experiencing poor mental health⁷⁷

People may be affected in many ways by litigation, some more visibly than others.

Prior to a hearing, especially for litigants in person (LIPs), difficulties may include:

- ✦ Difficulty reading or understanding paperwork.
- ✦ Reduced ability to cope with stress; difficulty coping with persistent requests (often experienced as demands) for information from solicitors, and difficulty complying with multiple orders and deadlines within a short time.
- ✦ Greater difficulty accessing voluntary sector advice due to difficulty communicating and understanding advice; difficulty generating the motivation to find a source of advice.

During a hearing, litigants in person (LIPs) with poor mental health may have:

- ✦ Communication difficulties.
- ✦ Difficulty absorbing information or understanding what is being asked.
- ✦ Difficulty focusing due to a limited concentration span.
- ✦ Auditory or visual hallucinations that disturb their understanding of reality.
- ✦ Problems with medication (side effects; wearing off; increased dose to get through).
- ✦ Worse symptoms; the stress of the hearing may exacerbate symptoms.
- ✦ Some signs of aggression and agitation, or a tendency to interrupt others speaking.

Attending court with the perpetrator, even with special measures in place, can trigger mental distress.

References:

[77] [Equal Treatment Bench Book - Courts and Tribunals Judiciary](#), Ch. 4, paras 5, 15–17

PART E | Difficulties created by litigation for those experiencing poor mental health

E1 Difficulties created by litigation for those experiencing poor mental health

Other features of a court process which commonly trigger mental distress include:⁷⁸

- ✦ Noise
- ✦ Interruptions
- ✦ Too many people or conversations.
- ✦ Being asked to concentrate on reading, writing or talking (especially for long).
- ✦ Time pressures, demands and deadlines.
- ✦ Long sessions (interviews, meetings and court sittings).
- ✦ Unfamiliar dress and unknown rules.
- ✦ Presence of technology, such as CCTV, that may provoke mistrust or paranoia.
- ✦ Change of arrangements or personnel.
- ✦ Authority figures and official procedures.
- ✦ Questioning or interrogation.
- ✦ Feelings of not being listened to or believed.
- ✦ Loss of control or choices, feeling excluded from decision-making.
- ✦ Feelings of being pushed, rushed or hushed.
- ✦ Shocks and sudden changes.

Other features of a court process which commonly trigger mental distress include:

E2 Memory difficulties⁷⁹

A witness with poor mental health may have difficulty reconstructing events in chronological order. Difficulty in remembering things is also associated with depression. Further, memory can be affected by some types of medication. It may be an error of law not to make reasonable adjustments in facilitating the giving of evidence for those who have memory loss. Memory problems may just affect the level of detail or precision, not the reliability or credibility of the testimony as a whole.

References:

[78] "Achieving justice for victims and witnesses with mental distress: A mental health toolkit for prosecutors and advocates" Mind (2010).

[79] Equal Treatment Bench Book - Courts and Tribunals Judiciary, Ch. 4, paras 59-60

PART E | Difficulties created by litigation for those experiencing poor mental health

E2 Memory difficulties

The Centre for Study of Emotion and Law⁸⁰ has pooled and conducted many studies to address questions about reliability (accuracy) vs credibility (true/not) of people giving evidence in court. In summary, people who have suffered trauma:

- ✦ Cannot always retrieve memories/ their memories can be fragmented
- ✦ May suppress memories/ encode them differently
- ✦ May delay disclosure/ exhibit avoidance symptoms of PTSD
- ✦ May be inconsistent due to their capacity to control emotions at the time
- ✦ May find their manner being questioned or misunderstood (e.g., dissociation may be misunderstood as lack of interest, rather than an index of profound distress)
- ✦ May be unduly affected by questioning

E3 The risk of systemic weaponisation

When the legal system is used as a vehicle for ongoing control, it keeps victims trapped in the same physiological 'danger response' they experienced during the relationship, preventing recovery and influencing their presentation in court. It is really important for the court to recognise the presentations of trauma responses.

A robust understanding of trauma is essential for professionals to identify when a perpetrator is weaponising a victim's mental health or disability.

It is a common tactic for perpetrators to use the victim's trauma-induced symptoms to reinforce narratives of 'instability' or 'incapability' within court systems.

References:

[80] Originally Jane Herlihy and Stuart Turner; now under the umbrella of the Royal Holloway University

PART E | Difficulties created by litigation for those experiencing poor mental health

E4 What practitioners and the family court can do to help⁸¹

4.1 Practitioners

Existing in a sustained state of 'survival mode' prevents abuse/ trauma victims from being able to process information cognitively. This is because the brain and body prioritise safety and reacting to the perceived threat, and the part of the brain that prioritises safety means that emotional processing, memory, information processing and so forth is usually 'offline'.

Practitioners can do simple things to help such as:

- ✦ Write down their name for the victim
- ✦ Leave their card
- ✦ Undertake follow up visits
- ✦ Sending straight-forward emails in which they summarise a discussion.

4.2 The Family Court

The Equal Treatment Bench Book⁸² offers 'important advice which every judge and every justice of the peace is under a duty to take into account when hearing a case involving people with one disability or another.' This section outlines the help that can be offered at different stages:

Advance planning before a hearing

Courts should have systems for identifying at an early stage if any adjustments will be needed. Judges or case workers should check application forms at an early stage and undertake follow-up enquiries if an issue is identified. If no issue is apparent, it would be good practice to ask routinely at the beginning of any preliminary hearing if there are any special needs. It may be that an immediate adjustment is needed to enable a person to participate.

Where a need for adjustments has come to a judge's attention, it is a good idea to liaise with the administration to ensure that requested adjustments are followed through. Steps taken to implement the adjustments in advance of the final hearing will help avoid postponement.

References:

[81] [Equal Treatment Bench Book - Courts and Tribunals Judiciary](#), Ch. 4 paras 20-25

[82] [Equal Treatment Bench Book - Courts and Tribunals Judiciary](#), Ch. 3, para 4

PART E | Difficulties created by litigation for those experiencing poor mental health

Advance planning before a hearing

The kinds of adjustments that need to be decided in advance of the full hearing include:

- ✦ An accurate time estimate allowing for slower pace, more breaks and/or shorter days
- ✦ Booking any interpreters who are needed
- ✦ Booking any special rooms that are needed
- ✦ Booking an intermediary (and for them to see cross-examination questions)
- ✦ Making arrangements for taking evidence by video link
- ✦ Notifying advocates in advance of any major constraints on cross-examination style
- ✦ Applying in advance of the hearing if the presence of an Emotional Support Animal would aid participation.⁸³

Consultation, case management and ground rules hearings⁸⁴

It is important not to guess or assume what adjustments an individual might need. Every individual is different, so the individual should be asked. It may later become apparent that further adjustments are needed or that previously identified adjustments are not needed.

Where needs are complex or will have a significant impact on the court process, ask individuals what adjustments would be helpful. It may be necessary to ask them also to provide evidence from their GP or a consultant on the impact of their difficulties. In such cases it may be helpful, especially when dealing with a LIP, to explain to the litigant what information the court requires and that this will need to be shared with the other party. In some cases, it may be appropriate to seek a report from an intermediary.

Where the focus is to establish a litigant's needs and how they will be managed, requests for adjustments and any medical evidence provided should be discussed with all the parties present during a case management or a ground rules hearing. The proposed adjustments may not be the entire focus but part of a wider case management discussion; what matters is that the subject is fully explored.

Ideally the subject of communication style will be discussed at a ground rules or case management preliminary hearing, so that the judge and advocates are forewarned.

References:

[83] *Equal Treatment Bench Book - Courts and Tribunals Judiciary*, Ch. 4, paras 61-65

[84] *Equal Treatment Bench Book - Courts and Tribunals Judiciary*, Ch. 4, paras 26-33, 53

PART E | Difficulties created by litigation for those experiencing poor mental health

Adjustments for case preparation⁸⁵

Adjusting the way communication takes place, before hearings take place, depends on the needs of an individual, but may include simplifying the wording of correspondence or court orders and providing documents/ guidance leaflets in Easy Read format, if available. Adjustments to correspondence, that may help for many learning/ developmental disabilities, include:

- ✦ Using short sentences and simple punctuation.
- ✦ Using uncomplicated language.
- ✦ Avoiding jargon.
- ✦ Using 'you' and 'we' rather than the third person.
- ✦ Writing rather than spelling numbers.
- ✦ Using bullet points for key points.
- ✦ Using sub-headings and allowing white space between sections.
- ✦ Using larger print, clear typeface, greater spacing, coloured paper.
- ✦ Photos/drawings/concrete symbols to support text.
- ✦ Being careful about loss of formatting on emails.
- ✦ An easy language paragraph that summarises the decision.
- ✦ For written judgments, using tools online to make language simpler, which will assist judges to write for a person with poor literacy.⁸⁶
- ✦ Where written or telephone communication is difficult, confusing or stressful, holding additional case management preliminary hearings.
- ✦ Being more explicit with instructions, i.e., state what seems obvious (e.g., precisely to whom documents should be sent; explaining that, if the respondent is represented, 'send to the respondent' means 'send to the respondent's solicitor').
- ✦ Avoiding making too many orders or giving too many instructions and tasks at once, or which are to be completed at one time.
- ✦ Extending time limits for taking action.
- ✦ Allowing longer hearing times for case management/preliminary hearings.
- ✦ Making necessary adjustments to any case management/preliminary hearings (e.g., booking a suitable room). Many of the adjustments which would be needed at a full hearing may be necessary at preliminary hearings but can be overlooked at that stage.

References:

[85] [Equal Treatment Bench Book - Courts and Tribunals Judiciary](#), Ch. 4, paras. 34-35

[86] [Readability Test - WebFX](#)

PART E | Difficulties created by litigation for those experiencing poor mental health

- ✦ Ensuring case management/preliminary hearings have a fixed start time, to avoid exacerbating any underlying stresses that person may have. If several are listed together, taking the disabled person's preliminary/case management hearing first.
- ✦ Holding telephone case management rather than requiring the disabled party to travel
- ✦ Expediting the final hearing date.
- ✦ Bearing in mind that mental ill health might affect an individual's attitude towards and ability to participate in forms of mediation.

General examples of adjustments for the hearing⁸⁷

Adjustments for a hearing will depend on the type of proceedings, the needs of the individual and whether fairness to each party is preserved. Examples include:

- ✦ Adjustments for particular impairments⁸⁸
- ✦ Taking into account the guidance in Practice Directions about dealing with vulnerable witnesses
- ✦ If travel to or attendance at the venue creates major difficulty, adjustments may entail holding some or all of hearings by video link (accessible from home or a local community facility) or telephone, or in a venue nearer the disabled party.
- ✦ Adjust the layout of the room to reduce likely anxiety.
- ✦ Adjust the order evidence is heard so that the disabled witness is not kept waiting longer than necessary or can give evidence while medication is most effective.
- ✦ If their mental health is likely to deteriorate over the course of a multi-day hearing, it may be best that they give evidence first. On the other hand, if they are a LIP, who will have to be able to conduct some form of cross-examination, it may be better if the other side's witnesses go first. It will not always be critical that the individual is cross-examined on their own witness statement.
- ✦ Use powers to prevent inappropriate questioning where appropriate.
- ✦ Allow a carer to be present, near to the disabled person. It helps if they can be given set times for the beginning and end of the hearing.
- ✦ Restrict the number of people attending the hearing and/or restrict reporting, whilst having careful regard to the requirements of 'open justice' and transparency in your jurisdiction.

References:

[87] [Equal Treatment Bench Book - Courts and Tribunals Judiciary](#), Ch. 4, paras. 36–47

[88] See the [Equal Treatment Bench Book - Courts and Tribunals Judiciary](#). Disability glossary

PART E | Difficulties created by litigation for those experiencing poor mental health

- ✦ Explain and introduce every person within the hearing room.
- ✦ Look out for signs of stress, discomfort, fatigue or lack of concentration as the hearing progresses.
- ✦ If a hearing needs to go part-heard or to be adjourned, note on the file what adjustments will be required on the next occasion.

Breaks and shorter hours⁸⁹

It may be necessary to adjust the timing, length or number of breaks, e.g. to allow for tiredness, shorter concentration spans, anxiety and relief from stress, taking medication, receiving out of court explanation e.g., via an intermediary.

It may be necessary to adjust the length of the day, starting later (e.g. to allow for medication or accessible travel) or finishing earlier (e.g. because of tiredness, medical appointments, avoiding rush hour travel).

Ideally, the need for more breaks, shorter days and/or a slower communication style will have been identified in advance, as this will extend the length of the hearing. If insufficient time is allowed, there may be a temptation to cut necessary breaks or to speed up the process, which may cause the disabled person additional stress.

Communication⁹⁰

Depending on the nature of the disability, it may be necessary for the judge, advocates and other court staff to adjust their communication style. Suitable adjustments by the judge may involve:

- ✦ Using the person's name and ensuring they are paying attention before speaking
- ✦ Explaining in simple language and short sentences (not idioms) what will happen
- ✦ Offering any necessary support with reading/ understanding court documents
- ✦ Allowing a self-representing litigant more time to take notes. Allowing extra breaks. People with comprehension difficulties will tire more easily
- ✦ Not assuming, that because a person has difficulty in communicating, they have a difficulty understanding what is said. On the other hand, an ability to speak with apparent fluency may disguise difficulties in understanding
- ✦ Checking understanding by asking the person to repeat back what they think has been said. Do not ask, "Do you understand?" People might wrongly believe they have understood or be reluctant to admit they have not.

References:

[89] Equal Treatment Bench Book - Courts and Tribunals Judiciary, Ch. 4, paras 48-51

[90] Equal Treatment Bench Book - Courts and Tribunals Judiciary, Ch. 4, paras 52-54

PART E | Difficulties created by litigation for those experiencing poor mental health

Adjustments to cross-examination⁹¹

Judges have a duty to intervene to ensure vulnerable witnesses give evidence as best they can. Adjustments to cross-examination, if thought appropriate by the court, may involve:

- ✦ Allowing a witness to give evidence behind a screen, so that they feel safer and can focus
- ✦ Allowing a party acting in person to give evidence from the advocate's table, rather than having to move to a witness table or stand
- ✦ Imposing time limits on cross-examination
- ✦ Advising advocates that they need not 'put' their case in cross-examination but should ask direct or unambiguous questions
- ✦ Avoiding the (immediate) repetition of questions, as this may suggest that the answers are not believed and by itself encourage a change. The same question can be asked at a later stage to check that consistent answers are being given
- ✦ Avoiding making assumptions about lifestyle and usual timing of activity
- ✦ Allowing witnesses to tell their own story in their own way

Encourage advocates to:

- ✦ Proceed at a slower pace, allowing extra thinking time to answer
- ✦ Signpost when moving to new topics ("I am now going to ask you about...")
- ✦ Break down questions into short, separate elements

And to avoid:

- ✦ Idiomatic language or 'legalese'
- ✦ Tag questions
- ✦ Hypothetical or abstract questions
- ✦ Questions which suggest the answer

References:

[91] [Equal Treatment Bench Book - Courts and Tribunals Judiciary](#), Ch. 4, paras 55-58

PART E | Difficulties created by litigation for those experiencing poor mental health

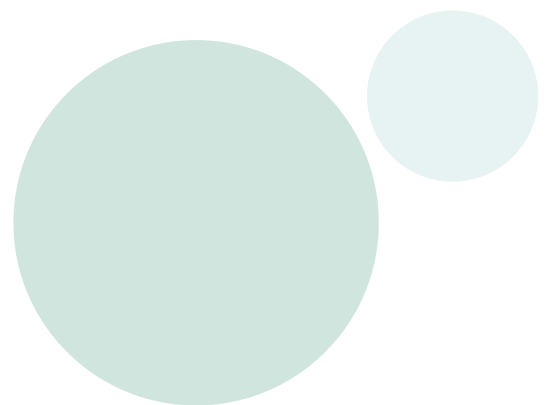
Some people with mental disabilities are especially sensitive to negative emotion and may be suggestible. They may respond to rough or persistent questioning by trying to please the questioner. Others may respond with tearfulness or panic and be traumatised by the legal process of cross-examination. For responses to be reliable, questions should be kept simple and non-threatening.

Advocates do not always have the necessary experience or understanding to know how to question appropriately a witness with a mental impairment. A judge should be ready, as necessary, to ask advocates to re-phrase their cross-examination, interject when there is clear potential for misunderstanding, and re-phrase questions for the witness. The ETBB sections on 'Limiting the length of cross-examination' and 'Questioning techniques to avoid' in relation to vulnerable witnesses are helpful in this regard. Please see ETBB, Chapter 2, paras 158-159 and 160-166.

Representation⁹²

Guidance on McKenzie Friends and lay representatives is set out in ETBB Chapter 1 para. 87. To meet the needs of a disabled party, a judge may facilitate representation in a form which might not otherwise have been permitted.

It may be helpful to seek assistance from anyone present in court who clearly has the confidence of the party in a way that stops short of representation but still assists the disabled person with parts of the court process, such as allowing a friend or family member to sit with the disabled person for support and allowing them to consult with each other.



References:

[92] Equal Treatment Bench Book - Courts and Tribunals Judiciary, Ch. 4, paras 66-68

PART F | Good practice in dealing with alleged perpetrators

F1 Good practice in dealing with alleged perpetrators⁹³

- ✦ The safety of potential or actual victims is the priority
- ✦ Be clear that abuse is always unacceptable
- ✦ Be clear that abusive behaviour is a choice and under the perpetrator's control
- ✦ Affirm/encourage any responsibility taken by the perpetrator for their behaviour
- ✦ Be respectful and empathic, but do not collude
- ✦ Be positive (hopeful that perpetrators can change) but do not equate intent with behaviour
- ✦ Be clear that you might have to speak to other agencies if children are at risk
- ✦ Tell the perpetrator that children are affected by living with domestic abuse, whether or not they witness it directly
- ✦ Tell the perpetrators that domestic abuse is about a range of behaviours, not just physical violence (see 'What is domestic abuse?' in Section B of this Guide)
- ✦ Do not expect an early full, honest disclosure about the extent of abuse
- ✦ Be aware of barriers to perpetrators acknowledging their abuse and seeking help (e.g. shame, fear of criminal or child protection proceedings, self-justification)
- ✦ Perpetrators may have used their own mental health as an excuse for abuse; mental distress, however, does not excuse domestic abuse
- ✦ Perpetrators may have used the mental health of the victim as a means to further abuse and control them; mental distress, however, is usually a consequence and never a reason for abuse
- ✦ Mental health issues can obscure and hide an underlying dynamic of abuse of power
- ✦ Services for women and children at risk should always be attached, or accessed alongside, work with perpetrators

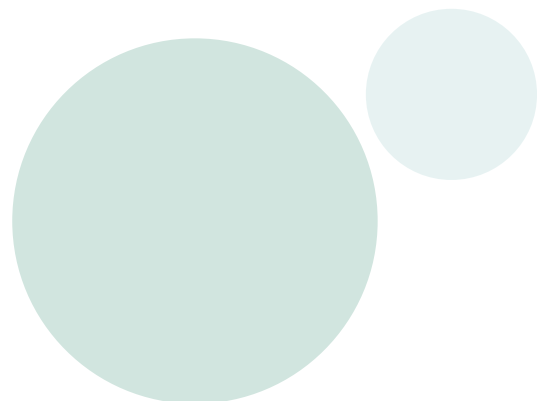
References:

[93] See <https://www.respect.org.uk> for key principles for work with perpetrators

PART F | Good practice in dealing with alleged perpetrators

F2 Safety issues

- ✦ If you are in contact with both parties to a family dispute, always try to see them separately when discussing abuse
- ✦ If information about the perpetrator's abuse comes solely from the victim, be mindful that challenging the perpetrator might jeopardise the victim's safety
- ✦ Do not suggest 'couple's work' as this is likely to be ineffective or dangerous
- ✦ Do not engage with anyone you know to be under the influence of drugs or alcohol



PART G | Children's mental health; children in Family Court proceedings

G1 Children's mental health

A child or young person (under 18) is a victim of domestic abuse if they are related to the perpetrator or victim and sees, hears or experiences the effects of the abuse.⁹⁴

Around one in five children in the UK experience domestic abuse during their childhood and this can have a negative impact on a range of health, social and developmental outcomes. Exposure to domestic abuse is associated with adverse outcomes throughout childhood and adolescence, including poor mental and physical health, lower academic achievement and poor social development.⁹⁵

Besides the trauma experienced during abuse (such as fear, inhibition, isolation, loss, anxiety and depression) there is a likelihood of longer-term trauma that affects physical and mental health, development, behaviour and emotional wellbeing. Negative psychological impacts of coercive control that children are likely to experience include a lack of security and safety, a reluctance to trust others and limited opportunities to choose, feel free and develop a sense of independence.

Of children exposed to trauma, about 50% will develop at least one symptom of PTSD, while 20% will meet the full criteria for the disorder.⁹⁶ Children who are victims both of direct abuse and as victims having witnessed domestic abuse show higher levels of trauma-related symptoms.⁹⁷

G2 Children in family court proceedings⁹⁸

It is recommended that family justice professionals should:

- ✦ Distinguish between risk and harm
- ✦ Understand the harm already caused to a child by a perpetrator
- ✦ Consider the impact of domestic abuse when making decisions about child arrangements, including interim orders, as well as future risk
- ✦ Acknowledge the need for specialist risk assessment

References:

[94] Domestic Abuse Act 2021

[95] Cafcass (Children and Family Court Advisory and Support Service)

[96] Alisic E, Zalta AK, van Wesel F, et al. Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: meta-analysis. *British Journal of Psychiatry*. 2014;204(5):335-340. doi:10.1192/bjp.bp.113.131227; McLaughlin KA, Koenen KC, Hill ED, Petukhova M, Sampson NA, Zaslavsky AM, Kessler RC. Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *J Am Acad Child Adolesc Psychiatry*. 2013 Aug;52(8):815-830.e14. doi: 10.1016/j.jaac.2013.05.011. Epub 2013 Jun 25. PMID: 23880492; PMCID: PMC3724231.

[97] Hultmann O, Broberg AG. Family Violence and Other Potentially Traumatic Interpersonal Events Among 9- to 17-Year-Old Children Attending an Outpatient Psychiatric Clinic. *J Interpers Violence*. 2016 Nov;31(18):2958-2986. doi: 10.1177/0886260515584335. Epub 2015 Apr 27. PMID: 25917005.

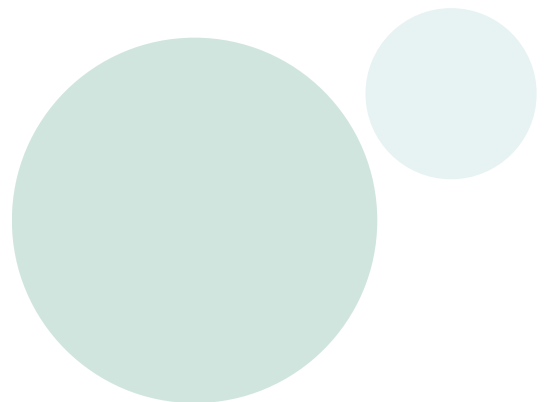
[98] Domestic Abuse Commissioner (2023) The Family Court & Domestic Abuse: achieving cultural change.

PART G | Children's mental health; children in Family Court proceedings

G2 Children in family court proceedings

Proceedings that are lengthy or delayed are harmful and traumatic to children. When courts uphold parental involvement, decision making rights, and/or contact with both parents over consideration of domestic abuse, a perpetrator's parental rights are prioritised over the welfare of both adult and child victims and in particular overlooks the safety and voice of the child.

Outcomes for children are worse when post-separation contact becomes a tool for continued domestic abuse. While children can recover from the impacts when they are in a safer environment, ongoing contact with the perpetrator can create difficulties for children's ability to recover or sustain recovery.



List 1 Getting support for those experiencing poor mental health

List 1.1 If your life is at risk right now

If your life is at risk right now (for example, you feel like you might attempt suicide or may have seriously harmed yourself) you need urgent medical help. Please:

- Call 999 for an ambulance
- Go straight to A&E, if you can
- Call your local crisis team, if you have their number
- If you can't do this by yourself, ask someone to help you.

Mental health emergencies are serious. You're not wasting anyone's time.

List 1.2 If you don't want to call 999

If you can keep yourself safe for a short while, but you still need urgent advice:

- Contact NHS 111 England or NHS 111 Wales. If you call 111, select option 2 to access a 24/7 helpline offering urgent mental health support.
- Contact your GP surgery and ask for an emergency appointment. Many GPs are now offering these remotely.

Do you need some urgent coping tools? Mind have some crisis resources that you can use right away, by yourself, wherever you are. Click [here](#) to access them.

If you need to talk right now whatever you're going through, there are people you can talk to any time. You can:

- Call Samaritans on 116 123 (UK-wide)
- Text 'SHOUT' to 85258 (UK-wide)
- Call C.A.L.L. on 0800 132 737 (Wales only)

List 1.3 GP and other services

Victims can speak to their GP, who may suggest medication and can refer to a counsellor or other NHS therapy.

Victims can self-refer to Talking Therapies (previously called IAPT) for a brief course of therapy. They can also refer themselves to domestic abuse or sexual abuse support services, which often have in-house counselling services. A lot of self-help information is available online and covered at the end of this booklet.

Victims can access a community psychiatric team or mental health service such as a Clinical Psychologist or Traumatic Stress Service, if referred by a GP. There is often a long waiting list for these treatments. There is also an option to access private treatment which can be quicker.

List 2 National mental health support

Organisation	What they do/How they can help	Website	Contact number
NHS	Your mental health is as important as your physical health. You will not be wasting anyone's time.	https://www.nhs.uk/nhs-services/mental-health-services/	If you or someone else is in danger, call 999 or go to A&E. If you need urgent help for your mental health, get help from NHS 111
NHS Talking Therapies	Talking therapies for anxiety and depression	https://www.nhs.uk/nhs-services/mental-health-services/find-nhs-talking-therapies-for-anxiety-and-depression/	Online referral or via your GP
Mind	Support and information for people living with a mental health problem, or supporting someone who is.	https://www.mind.org.uk/information-support/	Call our support line on 0300 102 1234 Call our Infoline on 0300 123 3393
Samaritans	Whatever you're going through, a Samaritan will face it with you. We're here 24 hours a day, 365 days a year.	https://www.samaritans.org/	116123
Hub of Hope	UK's largest mental health support directory	https://hubofhope.co.uk/	Online/app service
Shout	24/7 support for people in crisis	https://giveusashout.org/	Text 'Shout' to 85258
Rethink	Resource for information on mental illness, mental health laws, and guidance for carers.	https://www.rethink.org/	Online guides and directory

List 2 National mental health support

Organisation	What they do/How they can help	Website	Contact number
Saneline	Practical information, crisis care and emotional support to anybody affected by mental health problems.	www.sane.org.uk	0845 7678000 (charged at local rates) 1pm – 11pm every day
Calm	Suicide prevention line	https://www.thecalmzone.net/	0800 585858 5pm - midnight
Turning Point	Reliable support from experienced professionals when facing depression, anxieties, relationship issues, PTSD, and other mental health conditions.	https://www.turning-point.co.uk/	Online contact
Specialist : Support for women			
Wish	Support for women's mental health	https://www.womenatwish.org.uk/	Online support
Specialist : Support for men			
Andy's Man's Club	Men's suicide prevention charity, offering free to attend peer-to-peer support groups across the United Kingdom and online.	https://andysmanclub.co.uk/	Find groups online or email: info@andysmanclub.co.uk
Specialist : Children and young people			
Papyrus – Hopeline	Prevention of young suicide	https://www.papyrus-uk.org/papyrus-hopeline247/	0800 0684141 Text: 88247
Young Minds	Practical advice and helping you find support	https://www.youngminds.org.uk/young-person/	

List 2 National mental health support

Organisation	What they do/How they can help	Website	Contact number
Kooth	Free, anonymous support: our chat service is free, and you don't even have to give your name.	https://www.kooth.com/	Sign up online – live chat/message
Childline	Provides support for all under-19s in the UK	https://www.childline.org.uk/	0800 1111, open 24/7
LGBTQ+			
Switchboard	Information and support	https://switchboard.lgbt/contact-us	0800 0119 100, open 10am–10pm every day
Mind Out	Mental health service run by and for lesbian, gay, bisexual, trans, and queer (LGBTQ) people.	https://mindout.org.uk/get-support/	Online support
Black, Asian and Minority Ethnic Communities:			
Black Minds Matter UK	Free, one to one, culturally appropriate talking therapy for Black people in the UK	https://www.baatn.org.uk	Online referral
The Black, African and Asian Therapy Network (BAATN)	UK's largest independent organisation to specialise in working psychologically, informed by an understanding of intersectionality, with people who identify as Black, African, Asian and Caribbean	https://www.baatn.org.uk/	Online directory
Disability:			
Scope	Providing information and support; transforming attitudes to disability, tackling injustice and inspiring action.	https://www.scope.org.uk/	Free Disability Helpline Helpline <u>0808 800 3333</u> Monday - Saturday 10am - 5pm

List 3 Local mental health support

(Bristol, Bath and Northeast Somerset, North Somerset, Gloucestershire and South Gloucestershire)

Organisation	What they do/How they can help	Website	Contact number
24/7 Support & Connect – Talking Therapies	A free NHS confidential 24/7 helpline for people who live in Bristol, North Somerset & South Gloucestershire.	https://vitahealthgroup.co.uk/nhs-talking-therapies/bristol-north-somerset-and-south-gloucestershire/	0800 0126549 – 24/7
BaNES Talking Therapies	A non-urgent service for people registered with a GP in Bath and North East Somerset, offering one-to-one therapy and online or in-person courses.	https://www.awp.nhs.uk/our-services/talking-therapies/self-refer-today/banes	01225 675150
Gloucestershire Talking Therapies	Cognitive Behavioural Therapy for those in Gloucestershire	https://www.ghc.nhs.uk/our-teams-and-services/letstalk/	0800 073 2200 or online referral
Bristol Mind	Local mental health charity serving Bristol and South Gloucestershire.	https://bristolmind.org.uk/	0117 980 0370
Bath Mind	One-to-one and group community mental health support	https://bathmind.org.uk/	01225 316199
Somerset Mind	Local mental health charity serving Somerset	https://www.mindinsomerset.org.uk/	01935 474875 01823 334906 01278 228269 01643 353115
Swindon and Gloucestershire Mind	Local mental health charity serving Swindon and Gloucestershire	https://www.sgmind.org.uk/	Online referral
Missing Link	Women's MH support services	https://missinglinkhousing.co.uk/	0117 925 1811 Mon to Fri 9am – 5pm

List 3 Local mental health support

(Bristol, Bath and Northeast Somerset, North Somerset, Gloucestershire and South Gloucestershire)

Organisation	What they do/How they can help	Website	Contact number
The Sanctuary Bristol (part of Second Step)	Mental health support space in Bristol	https://www.second-step.co.uk/our-services/community-and-wellbeing/the-sanctuary-bristol/	07709 295 661 Thursday to Monday (closed Tuesday and Wednesday) between 3pm and 11pm.
CAMHS	Specialist service that helps children and young people who are struggling with their mental health issue in B&NES	https://livewell.bathnes.gov.uk/young-peoples-mental-health-and-wellbeing-support-services/child-and-adolescent-mental-health	01865 903 889
CAMHS Bristol	Community child and adolescent mental health services (CAMHS) across Bristol, North Somerset and South Gloucestershire	https://www.awp.nhs.uk/services/children-and-young-people	Online referral
CAMHS Gloucs	Provides a comprehensive range of specialist emotional wellbeing and mental health services for all children and young people aged under 18	https://www.ghc.nhs.uk/our-teams-and-services/children-and-young-people/camhs/	0300 421 4899 Monday to Friday 9am – 5pm
Mothers for Mothers	Maternal mental health and emotional wellbeing support, advice and information to women, birthing people and their families in Bristol, North Somerset and South Gloucestershire	https://mothersformothers.co.uk/	0117 9359366 Mon- Fri 10:00am to 9:00pm

List 3 Local mental health support

(Bristol, Bath and Northeast Somerset, North Somerset, Gloucestershire and South Gloucestershire)

Organisation	What they do/How they can help	Website	Contact number
Mental Health Directory (Bristol and S. Gloucs)	A list of local, current MH services	https://www.wellaware.org.uk/	Online
Mental Health Directory (B&NES)	A list of local, current MH services	https://livewell.bathnes.gov.uk/supporting-adults-live-independent-lives/health-and-wellbeing/mental-health	Online
Mental Health Directory (Gloucs)	A list of local, current MH services	https://www.bewellgloucs.org.uk/category/mental-health-support/	Online
Mental Health Directory (Somerset)	A list of local, current MH services	https://healthysomerset.co.uk/health-and-wellbeing-topics/support-with-your-mental-health/	Online

List 4 National domestic abuse support

National domestic abuse organisations that can help:

Organisation	What they do/How they can help	Website	Contact number
FearFree (Wiltshire)	Services for victims of Domestic Abuse and their families	https://www.fearfree.org.uk/refer/wiltshire/	01225 775276
GALOP (LGBTQ+)	Support for LGBT+ people who are victims of domestic abuse	https://galop.org.uk/	0800 999 5428
GDASS (Gloucestershire)	Domestic abuse support for all, including LGBTQ+	https://www.gdass.org.uk/	01452 726 561 support@gdass.org.uk
(The) Iranian And Kurdish Women's Rights Organisation (DA, FORCED MARRIAGE, HONOUR BASED VIOLENCE)	Support for domestic abuse, forced marriage and honour-based violence	https://ikwro.org.uk/	0207 920 6460
Karma Nirvana	Honour based abuse	https://karmanirvana.org.uk/	0800 5999 247
ManKind	Men's support	https://mankind.org.uk/	0808 800 1170
Men's Advice Line	Men's support	https://mensadvice.org.uk/contact-us/	0808 8010 327
Nextlink	Support for women victims of domestic abuse	https://nextlinkhousing.co.uk/	0800 4700 280
Nilaari	BAME/ Mental Health network For People Of Colour	https://nilaari.co.uk/	0117 952 5742

List 4 National domestic abuse support

National domestic abuse organisations that can help:

Organisation	What they do/How they can help	Website	Contact number
One 25	Support for women victims of domestic abuse	https://one25.org.uk/about-us/how-one25-help-women/	0117 909 8832
Opoka	Support for women victims of domestic abuse – specifically in the Polish community	https://www.opoka.org.uk/	Polish – 0300 365 1700 English – 0117 427 0012
Paladin	For victims of stalking	https://www.paladin-service.co.uk	0203 8664107
Refuge (National Domestic Abuse Helpline)	Support for women victims of domestic abuse	https://refuge.org.uk/i-need-help-now/how-we-can-help-you/	020 7395 7700
Rights of Women	Support for women victims of domestic abuse	https://www.rightsof-women.org.uk/	020 7251 6575
Safelink	Support for women victims of domestic abuse	https://safelinksupport.co.uk/improving-access-to-domestic-and-sexual-violence-services-for-lgbt-communities/	0333 323 1543
Sarsas	Support for women victims of domestic abuse	https://www.sarsas.org.uk/resources/domestic-violence/	0808 801 0456
SDA (Somerset)	For anyone who needs advice about domestic abuse	https://somersestdomesticabuse.org.uk/	0800 69 49 999

List 4 National domestic abuse support

National domestic abuse organisations that can help:

Organisation	What they do/How they can help	Website	Contact number
Sign Health	Support for deaf people	https://signhealth.org.uk/	020 3947 2600
Sistah Space	Support for African and Caribbean women victims	https://www.sistahspace.org/	020 7846 8350
Southside (Bath)	Support for victims of domestic abuse	https://southside.org.uk/	01225 331 243 Enquiries@southside.org.uk
Switchboard	National LGBTQIA+ Support Line	https://switchboard.lgbt/	0800 0119 100
We are Hourglass	Support for elderly abuse victims	https://wearehourglass.org/	080 8808 8141
Woman Kind Bristol	Mental health support for women victims of domestic abuse	https://www.womankindbristol.org.uk/	0345 458 2914 or 0117 916 6461
Women's Aid	Support for women victims of domestic abuse	https://www.womensaid.org.uk/information-support/	Online Chat https://chat.womensaid.org.uk/

List 5 References

1. For more information, the following web links may be useful:
[Department of Health and Social Care - GOV.UK](#)
[Home | The Health Foundation](#)
[Policy and campaigns | Suzy Lamplugh Trust](#)
[Home - For Baby's Sake](#)
2. [Equal Treatment Bench Book - Courts and Tribunals Judiciary](#).
3. Stark, E. (2007). Coercive control: How men entrap women in personal life. Oxford University Press.
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List 7 Glossary of key terms

This glossary provides definitions of key concepts used throughout this guide.

Abusive Litigation / Litigation Abuse

The use or misuse of court applications, correspondence, complaints or procedural mechanisms to continue controlling, intimidating or exhausting a victim after separation. A common form of post-separation coercive control.

Adult Victim / Survivor

A person aged 16 or over who has experienced domestic abuse.

The term victim is used for legal clarity; survivor is often used in advocacy and therapeutic contexts.

Child Victim (Domestic Abuse Act 2021)

A child is a victim in their own right if they see, hear or experience the effects of domestic abuse. This includes overhearing abuse, witnessing aftermaths, or experiencing coercive control directed at the safe parent.

Child's Lived Experience

A trauma-informed approach focusing on how a child has directly experienced harmful behaviour, rather than relying solely on adult reports, allegations or counter-allegations.

Coercive and Controlling Behaviour (CCB)

A pattern of acts designed to dominate, isolate, monitor or regulate another person's daily life. Includes psychological, emotional, financial and reputational harm. Coercive control is understood as the foundation of domestic abuse, not merely an optional subtype.

Complex Trauma / Complex PTSD (C-PTSD)

A trauma response caused by prolonged or repeated abuse from which escape is difficult. Features may include:

- Difficulty regulating emotions
- Shame, guilt or feelings of worthlessness
- Difficulties trusting others or maintaining relationships
- Dissociation or emotional numbing

Dissociation

A trauma response where a person becomes detached, blank, numb or mentally "checked out". In court, dissociation may appear as confusion, flat affect, slow responses or difficulty recalling information.

List 7 Glossary of key terms

Domestic Abuse (DA)

Abusive behaviour between people aged 16+ who are personally connected, including:

- Physical, sexual or emotional abuse
- Coercive or controlling behaviour
- Financial or economic abuse
- Threatening or intimidating behaviour
- Defined in the Domestic Abuse Act 2021.

Domestic Abuse Protection Orders (DAPOs)

A new protection tool enabling courts (including Family Courts) to impose restrictions on a perpetrator, such as exclusion zones or electronic tagging.

DAPOs may be applied for by the police, the victim, or a third party, including friends or family members.

Fact-Finding Hearing

A hearing where the court determines whether alleged incidents or patterns of domestic abuse occurred, based on the balance of probabilities. Required where findings are necessary to make welfare decisions.

Harm (Cafcass Three-Stage Approach)

A structured framework in which practitioners:

1. Identify harmful behaviours
2. Understand the impact on the child
3. Assess how this should influence recommendations and decisions

Hypervigilance

Constant awareness of potential danger, commonly arising from trauma.

May affect concentration, memory, decision-making, and the ability to participate fully in legal processes.

IDVA / ISVA

- Independent Domestic Violence Adviser (IDVA): Specialist advocate supporting high-risk victims with safety planning, criminal justice processes and multi-agency work.
- Independent Sexual Violence Adviser (ISVA): Specialist advocate supporting victims of sexual violence.

List 7 Glossary of key terms

Parental Alienation (Allegations of)

Claims that one parent has intentionally influenced a child to reject the other. Courts must assess these allegations carefully and avoid their misuse in cases where domestic abuse is present.

PD12J

A Practice Direction requiring the Family Court to identify and consider domestic abuse when making decisions about child arrangements. Establishes expectations for risk assessment, fact-finding and safe contact arrangements.

Post-Separation Abuse

Abuse that continues after a relationship has ended.

Common behaviours include:

- Misuse of child contact arrangements
- Surveillance or monitoring
- Financial pressure
- Reputational harm
- Litigation abuse

Protective Factors

Circumstances or supports that reduce the likelihood of further harm, such as stable housing, supportive relationships, therapeutic intervention or community resources.

Secondary Trauma / Vicarious Trauma

Emotional and psychological impact experienced by professionals or family members exposed to traumatic material or disclosures.

Relevant for judges, Cafcass officers, social workers, police and practitioners.

Special Measures

Adjustments made to support victims or vulnerable witnesses to participate safely, including:

- Screens
- Video-link evidence
- Separate waiting areas
- Intermediaries
- Adjusted questioning style

List 7 Glossary of key terms

Trauma Bonding

A strong emotional attachment created by cycles of abuse and intermittent kindness or apology. The pattern increases dependency and can make leaving an abusive relationship difficult.

Trauma-Informed Practice

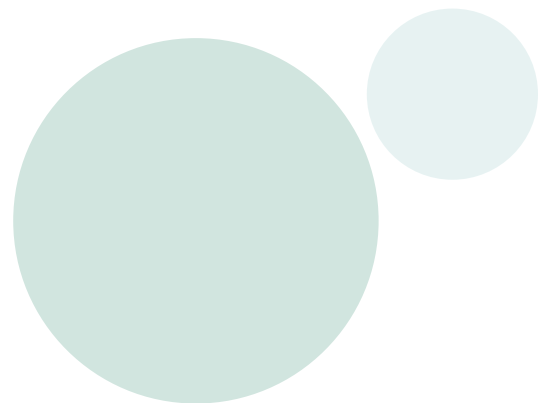
An approach recognising that trauma affects memory, thinking, emotional regulation and behaviour. Principles include:

- Safety
- Predictability
- Respect
- Avoiding re-traumatisation
- Understanding behaviour through a trauma lens

Window of Tolerance

The zone in which an individual can stay regulated enough to think clearly, engage socially and process information.

Trauma narrows this window, making hyperarousal (fight/flight) or hypoarousal (freeze/dissociation) more likely.



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Thank you

Thank you for taking the time to read this guide. We hope it has provided you with the information, insight, and practical understanding needed to better support those going through the Family Court process, particularly where mental ill health and experiences of domestic abuse may affect vulnerability, participation, and decision-making.

If you found this guide useful, you may also wish to read our first guide: [Guide to Family Court Proceedings for those who have experienced domestic abuse](#).

Feedback

If you have any suggestions or feedback about this guide, we would greatly appreciate hearing from you. Please contact Emma.Whewell@uwe.ac.uk, as your input helps us improve and better support others in need.

