Nottinghamshire Women's Aid
Survive & Thrive

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Health Report

Accessing Service Provision

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Overview of Survivor Accounts

How survivors come to be using services

The issues around health and well-being following a domestically abusive relationship were complex. Participants had often been in the relationship for months or years before exit. During that period, some respondents experienced physical abuse, whilst all survivors had experienced emotional abuse on an ongoing basis. Realisation that they were in an abusive relationship often came from some interaction with a third party, often a health professional, either during the relationship or following exit.

Indeed, an ongoing conundrum is that before survivors come to use health services, they must first recognise their need for some level of intervention. However, the very nature of coercive control means that it is difficult for survivors to recognise this need for support from health intervention. For some survivors, this was their first serious relationship; for others, they believed that behaviours were simply to do with their partner's personality and/or were their fault, i.e., due to something they had or had not done. Behaviours then became normalised. There were limited opportunities to recognise DA and to connect it to the relationship that survivors were in, due to the hiding or justifying of behaviors. Domestic abusers also heavily control access to family, friends, and service provision, so competing accounts, and questioning of the offender and relationship, are often limited.

In many examples of the discussions around healthcare, it might be that survivors went to their doctor in relation to another health issue, for example, pregnancy; postpartum care; or underlying health concerns; and were asked a question that prompted a revelation of domestic abuse. Often there is help seeking for physical or psychological conditions which are connected to the abuse – stress/insomnia, physiological conditions, i.e., Fibromyalgia.

Yet, the exercise of coercive control, or its aftermath, continued to affect access to health services and interactions with health care professionals. For example, a significant issue was around coercive control continuing to be exercised around and during health consultations and interactions with health professionals; women were often questioned about their health or condition whilst in the presence of the perpetrator. Some survivors, women in this round of interviews, described partners belittling their accounts of physical or psychological symptoms, both to them and to health professionals. Women described partners answering for them and/or querying their accounts and courses of action, their former partners had often described their symptoms as being imaginary or exaggerated because they were neurotic, or a hypochondriac. The predominant narrative being that survivors' accounts of their own feelings, health and symptoms were not to be trusted and that they were wasting the time of health professionals.

Breaches of confidentiality sometimes compounded the trauma of survivors who were undergoing medical procedures or other forms of treatment; meaning that coercive control or its aftermath, continued to frame health consultations. Whilst still in the relationship, survivors described encounters where they had been asked about domestic abuse in front of the perpetrator. This had happened for one of the respondents on more than one occasion when she was pregnant; in such circumstances, survivors were unable to respond. It is important to note that some survivors have

entered subsequent relationships, some positive, which helped them to recognise previous abuse and gain access to support, including health. Notwithstanding, some survivors described relationships or friendships, where the other parties accompanied them to appointments, including medical. It is important here that health professionals do not make assumptions about partners being supportive, given the dangers of assumptions.

Indeed, trauma-informed nursing and maternity care helped some survivors to recognise signs of abuse and access support earlier, or enabled survivors to feel comfortable after revealing abuse and/or associated trauma and illness, including episodes of self-harm. Health professionals, including midwives, often played a critical role where pregnancy and post-natal care created rare opportunities for safe disclosure, where professionals ensured that conversations about potential domestic abuse took place away from partners, demonstrating an awareness of power imbalances within relationships. Positive experiences with midwives and nurses were characterised by privacy, consistency, and safety-focused practice.

In contrast, an absence of these features could compound trauma and escalate risk. For example, two striking accounts of breaches of confidentiality compounding DA-related trauma stood out here, one from a woman and one from a man. In relation to the woman's account, she described being terrified that her former partner would gain access to her. She had CPTSD and had experienced nightmares and flashbacks for many years, resulting from the abuse of her and her children by her former partner. These nightmares and flashbacks resulted in feelings of panic that he was in her house and in her bedroom. Years after separating from the offender, with whom she had four children, two of whom were adults, she had been taken to the hospital after collapsing at her daughter's house. Her youngest child, a 13-year-old boy with special needs, was the only child who still had contact with his father; this child was emotionally vulnerable, and the mother described manipulation of him by his father.

The woman explained how her ex-partner had been able to phone the hospital and obtain information about her admittance. He had then visited the hospital with her son, on the premise of bringing her son to see her, and managed to gain access to her room, even though he was not on the list of permitted visitors. No questions had been asked about whether he was allowed into the room as a permitted visitor. She described how she was feeling groggy from surgery and the effects of an aesthetic, seeing him in the room adopting a particular aggressive stance that she remembered from the relationship, feeling panic and fear, but thinking that she was having a nightmare or flashback. It was only after she recovered from the operation that she discussed it with her adult daughter and found out that her ex was in her hospital room, alone, with her and her son. Her daughter, realising that he was on his way to the hospital, had gone down in the lift to try to prevent him from entering, but simultaneously, the ex-partner was already in the hospital and on his way up in another lift, where he was admitted to the ward and the room. In this example, the woman explained how she was at her most vulnerable, following an operation, largely necessitated by the physical and mental effects of the abusive relationship, which had continued to affect her health for many years, when her ex-partner was still able to gain access to her hospital room, where she should have felt safe. Due to the dramatic nature and impact of this breach, the survivor went on to explain how the hospital had failed to protect her from a "*monster*".

A further very dramatic example involving breach of trust and confidentiality came from a man who was a survivor of domestic abuse. When he had eventually called the police after years of abuse, involving physical and emotional abuse of him, with his two children in the home, including a child with special needs, the perpetrator had been released, and he had been given misleading information from the police, which had resulted in him not pressing charges. He had been informed that if he did not press charges, he could obtain a non-molestation order, and it would be quicker and easier, and that he would not need to pay for this. The survivor was not in a position to pay for a legal response, as he had to care for his young children, and had given up work as the mother had abandoned them, and when she was put in a position to care for them for some hours, had been neglectful, leaving the young child with special needs for considerable periods of time alone in a bath. The father had taken action to look after his children himself, with some support from his family.

The police had provided no information on support services to this man. When it transpired that it was not straightforward to get a non-molestation order, in the way explained to him, he explained how he had felt completely alone and isolated after finally reaching out for help and support. In the wake of this response, after years of physical and mental abuse, feeling there was no point in carrying on, he had taken an overdose and ended up in hospital. He described how the nurses who cared for him in the aftermath were excellent, empathetic, supportive, and non-judgmental. Problems arose, however, when a doctor arrived in the ward to undertake an assessment and took him to another room. The nurses then assumed he was missing and had made a call to his parents, who had no idea about the domestic abuse or the suicide attempt. The survivor had not wanted his parents to know about it, although he had confided in his sister about his mental health, who had supported him previously. Having to deal with his parents had generated more anxiety and compounded the trauma for this man at a critical period, following a suicide attempt in response to the abuse he had endured. A recurring issue was that coercive control served to prevent or limit access to health professionals. Indeed, looking back over previous relationships after engagement with charitable and other services, survivors often had similar physiological and cognitive conditions, which in hindsight they related back to the coercive control and abuse that they had been experiencing, often for months or years.

Moreover, because of the abuse and nature of coercive control, they have often been delayed or prevented from obtaining a diagnosis for an underlying medical condition. Whilst these examples frequently involved partners controlling access to health services through threats and gaslighting, "*you are paranoid, not you again taking up staff tim*e, *you are not normal, you are a freak*, *you are weak and pathetic"*, it was also because the coercive control practices and the impact on survivors not only prevented support seeking, but masked underlying health conditions, meaning that survivors often went months or years, without a diagnosis. For example, one man, following years of abuse, obtained a diagnosis of ADHD, a long time after ending the relationship. His GP had examined his medical record and seen the number of different antidepressants he had been prescribed over a significant period, without anyone looking more holistically at what was going on. The survivor had attributed his symptoms of ADHD to his response behaviours in coping with the abuse, i.e., not responding, de-escalation, protection of his children, diverting attention from them, when in part, it was also part of his emotional cognition, due to ADHD. Following diagnosis and ADHD medication,

this survivor had an improved understanding of himself, enabling him to make more informed decisions around his own well-being.

It follows that medical consultations were often a route to getting support for recognising DA. There were some very good experiences with GPs, including the previous experience of the man who was diagnosed with ADHD. This survivor explained the enormity of the GP who looked at the "*bigger picture"* of what might be going on, and because he had believed the survivor's account of domestic abuse. As a man, he had thought his account would never be believed. He explained how his GP indicated that he could tell the emotional toll that these events were having on him from his physical demeanor when he was interacting with the GP. For this survivor, this approach had meant that the GP looked at the trail of anti-depressant medication to date, and realised that these were ineffective, because there was a context of domestic abuse, which was compounded by another condition.

Numerous survivors had either been prescribed or were taking antidepressants. The risk here is that prescribing of antidepressants can compound self-blaming, whilst obscuring, hiding and reinforcing the underlying context of abuse. The nature of domestic abuse means that survivors explain a repeated tendency to blame themselves, to think that what was happening was something to do with them, or their failings within the relationship, narratives which are also used by perpetrators to belittle and control. Research indicates that the internalisation of trauma-related shame and self-blame perpetuates abuse, contributing to the cycle of abuse, and preventing recognition and disclosure. For many survivors, it is only when they have exited the relationship, undertaken trauma-informed DA courses, like the Freedom Programme, wherein they begin to question their shame and poor self-esteem, and are able to relate it to the abuse. This often causes them to question the medical advice that they have been given, including the prescribing of antidepressants. By centering the focus of discomfort and anxiety with the survivor, the prescription of antidepressants without adequate trauma-informed assessment, including an emphasis on domestic abuse, can result in the constricting of emotional responses, including the numbing of feelings, meaning that questioning and detection of domestic abuse is less likely. Clearly, the challenge for clinicians is around the masking of domestic abuse, where survivors either do not recognise it and/or are fearful of revealing it; nonetheless, there was evidence from survivors of routine prescriptions of antidepressants in their experiences.

One survivor, a man who had been in a DA relationship with another man, had experienced a prolonged period of stalking and harassment, following the ending of the relationship. He explained how he had a drawer full of antidepressants, but that he was not willing to take them, without an overall medical plan, of how they were going to help, how long he would be expected to take them, and how they would align with other strategies; he felt that his experience with the GP and the NHS had been negative. This survivor felt that the approach to prescribing antidepressants was routine, perfunctory and uncoordinated without an overall holistic framework around domestic abuse. He explained that due to this lack of health coordination, he had felt let down and abandoned by the NHS and victim support system, and all he had left to show for his engagement, was a drawer full of antidepressants, which he was unwilling to take, in the absence of an holistic (trauma-informed) overall mental health plan. This survivor's account can arguably be expressed through the metaphor of using a sticking plaster to cover a hemorrhaging wound.

Positive examples of interactions with GPs

In addition to the positive example of consultations with GPs discussed above (ADHD survivor diagnosis), there were other positive examples of interactions with GPs. One woman, in a long cohabiting heterosexual relationship, explained how she went to see her GP to try to get her ex-partner, who was subjecting her to DA, some help for his negativity and bad moods. She had not recognised his behaviour towards her as DA at that moment in time. During the interaction with the GP, he suggested some treatment for the partner but asked to speak with the survivor. He informed her that he believed that she needed to seek support for DA, due to coercively controlling behaviour, and offered her support.

This survivor described her visit to the GP as a *'…catalyst…'* for getting support with the abuse she had been facing. The GP referred her for talking therapies, which, despite a long(ish) wait, *'…really helped…'* her. The GP also secured an appointment with a mental health nurse who organised for her to attend a group session about anxiety and loss of confidence. She was then invited back for a further health review with the GP:

> *'…My GP was wonderful for me. He was… he was really good and understanding…'*

What characterised these positive examples of interactions with GPs was that they exhibited some understanding of DA within patient interactions; they were looking potentially at the *bigger picture,* about what might be going on behind the reason provided for the consultation, as well as the presentation of the patient in the interaction. Two key attributes stood out from survivors' explanations of these encounters: empathy and professional curiosity. Whilst empathy has been highlighted as a key component of effective clinical practice, and features in patient satisfaction, it is critical for survivors engaging with health professionals in terms of disclosure of abuse. The survivors here reported positive interactions with their GP and described feeling both believed and unjudged. For these survivors, their GP consultation opened up a new level of understanding that the situation, and their symptoms, were neither inherent nor their own fault. In such situations, the GP appeared to see the survivor as a person, looking beyond their symptoms. The importance of this for those who have lived in or are living within a climate of DA cannot be underestimated. The broader context of disbelief from individuals and services compounds the coercive control and blaming strategies of perpetrators. Finding someone who believes in the face of such obstacles could be transformative.

For example, the following woman described an early transformative GP experience, located it within the overall context of embarrassment about going to the GP, and a wider environment of disbelief from previous individuals and services with whom she had contact:

> *'…You almost feel like did this even happen to me…'; '…I just wanted someone to believe me…'*

Not only does disbelief add to survivors' trauma, but it also makes them vulnerable to further manipulation from their abuser. This survivor spoke strongly about the potential power of being believed to counter this influence:

> *'…You need that guidance…'*

This woman, who had experienced rape and sexual abuse at a young age, before a domestically abusive relationship which involved young children, described an encounter with her GP at that time, which had resonated with her across decades:

> 'He said, you've been through hell, but you will come through. You will never be the person you were before, but you are not broken'.

This recognition of the person beyond the abuse and the trauma had influenced the strategies that this survivor had used in the intervening years to come to terms with the abuse, and in her own terms, 'to heal', which will be examined shortly. Suffice to say here that, given how undermined and isolated many of these survivors had been within the context of domestic abuse, someone seeing them as a person and believing their account had been a revelation.

In addition to empathy, a further component, in these positive interactions with GPs, appeared to be professional curiosity, which meant that the health professionals were looking outside the symptoms of the patient, to the person they were, but also to the wider context that might be underpinning the consultation. The embodiment of these attributes by GPs resulted in a supportive environment for the survivor as a patient, shaping the quality of the interaction critically, enabling the GP to avoid assumptions and judgement, and ultimately, to find a more effective intervention around physical and mental health symptoms. For some of these survivors, their GP had been key to helping them to recognise DA, exit the relationship, and gain support with both physical and mental health. Discussions around the positive experiences of survivors expressed elements of trust in the GP, and ultimately, in their advice. To generate this, there is a need for GPs to place a level of trust in the account of the patient – trust where such encounters become reciprocal. Positive interactions with GPs were therefore characterised by empathy and trust, coupled with a professional curiosity, to go beyond inherent symptoms in a non-judgmental and sensitive way.

In contrast to these positive discussions of GP engagement, other survivors described poor interactions. A particularly troubling example, following a serious sexually abusive relationship, one survivor (who needed an intervention before the eight to twelve months that specialist rape services could provide) approached her GP:

> *'…I told them that I was feeling to the point where I could just go home that day and commit suicide. And they basically said to me I wasn't depressed or anything. I was just a bit sad, basically, was what they said…'*

In this case, the GP did not refer the survivor to other services but simply gave them a list of telephone numbers to call for further support. Her experience of such service is documented below.

> *'…it took a lot to go there and open up to them, and I really did want them to help me. And then coming away with that, it was, yeah, it didn't do me any good…'*

Positive examples of charitable service provision

There were positive experiences of Equation Support workers reported by survivors. Two men had been referred to Equation, one through his GP and the other after being referred to a psychiatrist; both men had attempted suicide following poor responses from the police after reporting their

abusers. These men had received information from the police about possible support services. One of these survivors, a man who identified as bisexual, who had been in an interracial homosexual relationship at the time, had a session with a psychiatrist at the hospital, who scored him very highly on the DA scale and told him that he had been experiencing domestic abuse:

> *"…it took a long time to get help, if I hadn't tried to kill myself, after that the psychiatrist did assist, and things started to fall into place".*

The psychiatrist had referred this man to Equation, whilst the other man had obtained a referral following intervention through his GP. These two survivors provided very positive reviews of Equation, stating the workers at the charity had provided invaluable support. Both survivors emphasised that what was important was to demonstrate belief and validate their experiences as men who had experienced domestic abuse. Additionally, it was stressed that an understanding of their cultural, sexual and gendered identities in relation to the abuse and its impact had been important for both men, one of whom had been in a homosexual relationship whilst the other was in a heterosexual relationship. The continuity of support was identified as critical. Both men praised their support workers at Equation for providing an empathetic and tailored response. However, both men described the continuity of the service as problematic, leaving them vulnerable when services had ended, including prematurely due to staffing issues. In one instance, the survivor felt he had fallen through the gaps and had to resort to funding his own private mental health care. Support workers at Nottinghamshire Women's Aid were also highly praised, but are discussed below, under counselling services. It should be noted that Equation does not offer counselling services.

Counselling

Discussions of counselling were very mixed both within and across survivor accounts. Many survivors had found some forms of counselling helpful at some points in their journey; others had not. Experiences depended on the timing of the counselling, the type that was offered, and the survivor's circumstances. What was very clear about counselling is that one size or type does not fit all.

Overall, whilst some survivors had found counselling helpful, albeit for a period, the short periods of time around the availability of counselling (4 – 6 sessions), or the lack of continuity in counselling and other services, were problematic. Positive descriptions of counselling were often due to examples which were more tailored to survivors and their backgrounds and circumstances, whereas negative examples were not. Largely, experiences depended on the timing of the counselling and the type that was offered. One woman noted that there had been quite a long waiting list (about 3 months) for talking therapy, but spoke positively about it, finding it helpful to speak about her experiences, and also valuable to try the techniques which were suggested for anxiety. She also appreciated having subsequent sessions as a reminder.

For others, these talking therapies were not helpful. There was significant criticism from survivors, who felt that this form of counselling was inappropriate for survivors with more complex trauma, such as CPTSD. Indeed, traditional models of counselling and psychotherapy, often provided by the NHS, were criticised by some for a tendency to regard recovery as a linear process, which they felt was both unrealistic and inappropriate in DA:

> *'…trying to talk in chronological order is hopeless, and it's taken me a year to get over the trauma within the counselling'.*

Survivors interpreted some of these counselling experiences as judgmental, placing too much emphasis on Freud and formative early year relationships, with parents, often the mother, and insufficient attention to abuse within subsequent relationships. Such counsellors were often interpreted by survivors as patronising, perceived as using a rigid model of counselling involving a tick box approach. Survivors described these encounters as sometimes being repetitive, as compounding trauma without addressing it, and as being judgmental and blaming them both as people and for their pasts.

A key takeaway here was that counselling interventions in DVA should not be organised around a one-size-fits-all model. Rather than being wedded to more traditional models, there needs to be greater nuance in the interventions which reflect the complexities of the domestic abuse experience. Moreover, a key issue here is that mental health professionals need to be clear about their specialism and what is involved from the outset, in a language that survivors can understand, to enable them to make informed choices.

The survivor, whose GP had given her a list of support organisations, approached a general counselling service for 'talking therapy'. At her initial assessment, she scored very highly for depression, anxiety and PTSD, and so told the counsellor about the domestic abuse:

> *'…and they just basically said to me…we can't sit here and hear that. You need to report that to the police before our next session…'*

Although *'…scared…'* and *'…terrified…'*, she reported to the police, only to be told by the counsellor the next week that they did not *'…think she would do it…'*. Ultimately, the counselling lasted only four weeks, and, in the end, the service told her that the level of abuse she had endured was well beyond their experience. Unsurprisingly, this woman was deeply traumatised by her experience of counselling. She also had a very negative experience with the police:

> *'…a lot of the trauma then also came from what happened with the police. So yeah, it could have all been avoided…'*

Her trauma presented physically (in seizures) and in severe psychiatric illness, but the connection between the abuse, the secondary victimisation and her health problems was only made when she was eventually referred to a neurologist:

> *'…I think if I got proper counselling from the start and like when I went through the GP and told them how I felt, I feel like if they just listened to me from the start, I would have never had these seizures. I still have these seizures to this day…'*

Disbelief and skepticism were frequently prevalent in survivors, which accounts for poor experiences of GPs and counselling services. We have seen above that a woman told a GP she was suicidal but was told she was, in fact, 'just sad'. That same woman went on to have trauma-induced seizures, but some health practitioners even questioned her about whether they were real:

> *'… [they were] Saying at the same time, you're just, you're not, you're not having a seizure. You're fine, love. Just wake up. You're…e just pretending.*
>
> *'…it was like I was known in the department then for having seizures that they thought were fake….'*

Indeed, skepticism and disbelief from health professionals were described by some survivors, about both their symptoms and the extent of their engagement, including how many sessions they had had:

> *'I mean the psychologist turned round to me and said, 'Thirty-five sessions, that's a long time in therapy, why were you here for thirty-five sessions? And I said, 'Well, because she kept going, if I hadn't hurried it along, I'd still be there now'.*

Because of this, some survivors had discontinued their contact with some counselling services, including NHS, and had found alternatives, including paying for private counselling or using other types of counselling or self-help therapies.

For example, one survivor talked about engaging with a variety of counselling options over the years, and following some unsuccessful sessions, she undertook a counselling course to learn more about it. This survivor had engaged with different forms of counselling on the course and read books on the subject. Counselling that she had identified with was described as person-centered (embodied by Louise Hay and Karl Rogers), enabling her to *sit with her feelings, to be where you are at*. She explained that what had helped her heal was coming to terms with what had happened, believing these things had happened to her for a reason, and embracing energy work to create safety for herself by establishing boundaries. She had also drawn on spiritualism and had reframed the abuse and her previous life experiences.

Referring to a video of a woman on TikTok, she explained the different influences which helped her to understand that she had been abused:

> *'…she made me realise that the whole relationship, you know. I was being abused.'*

For this survivor, healing had been a long process. She had come to know herself and what worked for her along the way. She was happy with her current life and home, explained that she felt safe there, and that she was also involved in voluntary work and socialising.

This survivor explained how there were many professionals with whom she had come into contact, but that, her contact with them was often limited in terms of time periods and limitations in their role. Survivors described fragmented approaches, with some services providing practical support and others providing mental health support. Survivors felt that, owing to the complexity of survivors' needs, more joined-up and holistic support would help:

> *'…Like an IDVA but with experience in mental health…'*

For example, in the former quote, the survivor explains that whilst IDVAs were very important, she felt that they do not provide the talking point – *nobody to let out to,* so you almost need an IDVA but with that extra therapeutic input.

The above quotation is indicative of a point raised by numerous survivors included women and men in the sample, namely, that mental health services are too disjointed and need to be better integrated.

What is evident from the findings is that whilst some survivors did have positive experiences of mental health professionals and interventions, including counselling, which aided in their recovery, negative experiences compounded trauma and delayed or prevented healing. An additional point is that survivors suggested that having a supportive person to discuss their experiences of health intervention, without judgement, including when interventions are perceived as unhelpful and compounding trauma, would be beneficial.

Summary of Key Findings and Recommendations

Features of positive experiences, seeing the person, demonstrating belief and empathy, professional curiosity, going beyond the symptoms and considering the *bigger picture.*

Poor experiences, disbelief and skepticism, resort to antidepressants without a trauma-informed approach, lack of an overall care plan and time periods for intervention.

Some good experiences of counselling, talking therapies valued by some, more tailored examples were good, but not available for all, positive experiences of CBT and EMDR counselling provided by many.

Some survivors felt that traditional models sometimes felt inappropriate for DA, particularly CPTSD. Survivors described negative experiences, *tick-box* experiences where they felt judged, disbelieved, and patronised.

Overall, services were inadequately resourced, resulting in poor coordination and fragmented services and experiences.

Survivors often described a gap between practical service support and mental health, which sometimes felt arbitrary and felt that such services should be better integrated.

Some survivors felt there was more scope for life coaching, person-centered counselling and spiritual approaches.

Health and Wellbeing Following Domestic Abuse

Positive Professional Encounters: What Made the Difference

Across survivor accounts, positive encounters with health and counselling professionals shared a small number of consistent characteristics, regardless of professional role. Survivors described these encounters as pivotal in helping to identify abuse, seeking support, and begin recovery.

General Practitioners (GPs)

Positive GP interactions were marked by belief, empathy, and professional curiosity. Survivors described GPs who looked beyond presenting symptoms, considered the wider context of domestic abuse, and trusted survivors' accounts. Being believed by a GP was frequently described as transformative after encountering years of gaslighting and self-blame.

Key aspects of positive experiences of GPs include asking sensitive questions in private, recognising the psychological impact of coercive control, and avoiding premature reliance on medication alone. In several cases, GPs' holistic assessment led to appropriate referrals, greater understanding and identification of underlying conditions, and validation that survivors' experiences were *not their fault.*

Some survivors had been referred by their GPs to NHS talking therapy for anxiety and depression, which they had found helpful in the short term.

Midwives and Maternity Services

Positive experiences with midwives were characterised by privacy, consistency, and safety-focused practice. Survivors valued midwives who ensured conversations about domestic abuse occurred away from partners, who respected confidentiality, and demonstrated awareness of power dynamics within relationships.

Trauma-informed maternity care helped some survivors to recognise signs of abuse and access support earlier. These professionals played a critical role in which pregnancy and post-natal care created rare opportunities for safe disclosure.

Service Provision

Survivors also discussed engagement with a range of health professionals, including GPs, Midwives, hospital staff (including nurses) and NHS and Private counselling services. The women survivors in this report had been engaged with support services from Nottinghamshire Women's Aid, either in the recent or distant past. The men survivors had received support through Equation.

Service Provision at Nottinghamshire Women's Aid

Nottinghamshire Women's Aid provides a free, time-limited counselling service for women survivors of domestic abuse within women-only settings. Counselling may be delivered face-to-face, by telephone, or online, according to the survivor's choice and safety needs. Counselling models are person-centered and integrative, prioritising empathy, non-judgement, validation, and survivor autonomy. While structured clinical therapies such as trauma-focused CBT or EMDR are not delivered in-house, survivors requiring specialist trauma processing are supported through referral pathways to NHS mental health services.

Service Provision at Equation

Equation is a Nottingham-based specialist domestic abuse charity providing the only accredited domestic abuse services for men in Nottingham City and Nottinghamshire County. Key Services include Men's Domestic Abuse Helpline, a free, confidential helpline for men experiencing domestic abuse. Additional support includes emotional support, advice and signposting. Men can also access one-to-one support from qualified IDVAs, including safety planning, advocacy and practical support. The Gateway Domestic Abuse Recovery Program is an eight-week recovery program for male survivors of domestic abuse, focusing on healing, wellbeing and rebuilding confidence. Stalking Advocacy Service provides specialist support for men experiencing stalking outside of a domestic abuse context.

Counsellors and Therapeutic Practitioners

It should be noted at the outset that survivors' experiences with counselling services are often individualised, with some examples proving more helpful than others. Indeed, several different approaches may be utilised in a survivor's journey. Indeed, survivors had usually engaged with a range of counselling services through Nottinghamshire Women's Aid, NHS services, including talking therapies, or paid for their own counselling.

From the discussions about the range of counselling, it appeared that there were broadly three types: person-centered therapy focused on survivor feelings and identity, i.e., Carl Rogers, CBT focused on thoughts and behaviours (working on negative thought patterns, anxiety, depression, associated behaviours) – providing the survivor with practical tools for rethinking, reframing and countering anxiety, overthinking and self-blame). Finally, trauma therapy, including processing and dealing with trauma memories (e.g., EMDR).

It should also be acknowledged that there is often a tension between the theoretical underpinnings and individual response to different types of counselling

Person Centered Counselling

Perceived benefits included a sense of agency, meaning-making, emotional grounding, and safety at times when statutory or clinical services felt inaccessible or overly medicalised. Person-centered counselling is often offered at an early stage of a survivor's recovery journey.

The benefits of person-centered therapy include empathy, non-judgmental acceptance, unconditional positive regard and compatibility with the therapist. The main idea here is that people have the capacity to heal but need the right environment to access it. Survivors described this form of therapy as not treating them as broken or as the abuse being due to something that they had done or as being related to their upbringing or past. Person-centered therapy helps to counter the loss of confidence and identity following domestic abuse. Impact of coercive control, confusion about your own thoughts (doubting your account), loss of identity and self (feeling unsafe about self-expression). Some women explained how this form of intervention had helped them in numerous ways, namely because they were listened to without correction or judgement, because they (the survivor) set the pace of discussion and what they wanted to discuss, rather than this being pre-framed, there were no forced timelines, women were able to process trauma at their own pace and the sessions were less structured, there was no pressure to 'fix' things, women were able to process what they felt ready for.

This meant that survivors often found that the process felt safer for them; it was less overwhelming and more respectful of them as a person, validating their experiences. Women described an environment where they felt safer to engage both emotionally and psychologically, because the space was calm and they could predict and control the disclosures, as there was no pressure to disclose too quickly, and they maintained control over what they talked about. This provided a space for survivors to exercise autonomy through a non-directive way where they regained control, processed their own experiences, made their own meaning of them, helping to rebuild confidence and independence; this was deemed critical for some women, following domestic abuse where their identities and voice had long been suppressed, and decisions had been taken away from them. Because of this, survivors felt that such sessions helped them to rebuild a sense of self following the effects of abuse, where they had long doubted their own thoughts, minimised and suppressed their own feelings and needs, and internalised blame, viewing themselves as the problem, and thinking they were defective in some way. The therapist's emphasis on validity and empathy helped survivors reframe self-criticism and shame, building a sense of self-worth and compassion. In the longer term, survivors were able to reconnect with their feelings and with themselves, recover their self-identity, and regain trust in their own narratives and decisions.

However, person centered therapy is not always enough on its own for everyone. Some people may find it too open and insufficiently structured. CBT was considered helpful by many survivors through providing practical tools to reflect and reframe on thought patterns and behaviours, but it does not address deep trauma.

For severe trauma symptoms (flashbacks, panic attacks, PTSD), which many survivors had experienced, approaches including trauma-focused CBT or EMDR were often found to be helpful. These approaches are more guided and structured, helping the survivor to process specific memories, recurring as flashbacks, nightmares, body-based fear responses and 'stuck' traumatic memories. In this way, they help survivors with reliving past events. Trauma-focused CBT and EMDR were often experienced as intense forms of therapy, and the survivor needs to be ready; timing is crucial. Although many survivors found this kind of therapy intense, they found the sessions very helpful when dealing with the flashbacks, panic attacks and PTSD that often follow domestic abuse, sometimes for years.

Hence, key differences in the aims and format of these counselling processes are that person-centered counselling provides a safe environment focused on understanding the survivor, CBT focuses on changing thought patterns/behaviours, and trauma therapy focuses on processing what has happened to change how it affects the person.

Usually, these different forms of counselling will be offered at different stages in the survivor journey through a combination over time. In the early stages, person centered, builds a feeling of safety, reduces self-blame and shame, restores a sense of identity, Middle Stage, is focused on change, challenging self-blame and building coping tools, and trauma stage for deep trauma, involves EMDR or trauma therapy to process deeper trauma and reduce triggers

Spiritual and Holistic Approaches to Healing

Some women described drawing on spiritual, holistic, or reframing-based practices as part of their recovery from domestic abuse. These included the use of crystals, energy work, mindfulness, spiritual belief systems, and reframing life narratives. For some survivors, these approaches were experienced as empowering and supportive of identity reconstruction.

Perceived Risks and Tensions with Counselling Services

Tensions emerged where such approaches were dismissed or misunderstood by practitioners. Risks include spiritual bypassing, reinforcement of self-blame, or avoidance of trauma processing if used in isolation from therapeutic support. A further potential risk is a reluctance to engage with services.

Implications for Practitioners

Survivors were sometimes reluctant to disclose use of spiritual practices with health professionals. Practitioners should approach holistic practices with professional curiosity rather than judgement. Trauma-informed support involves understanding how these strategies function for the survivor and how they may sit alongside, rather than replace, therapeutic intervention. There is a need to avoid pathologising survivors' beliefs or practices.

Summary and Overview: Supporting Survivors of Domestic Abuse

Positive Professional Encounters: What Made the Difference

Survivors consistently described positive encounters with professionals as those characterised by belief, empathy, professional curiosity, safe enquiry, and respect for survivor autonomy. These principles applied across GP, midwifery, and counselling contexts.

Therefore, effective practice across GPs, midwives, and counsellors were defined by the following features: believing survivors' accounts, creating private, safe opportunities for disclosure, demonstrating professional curiosity beyond presenting symptoms, and avoiding judgement or rushed interventions.

Trauma-informed approaches that recognise coercive control, respect non-linear recovery, and prioritise survivor autonomy were highly praised for reducing secondary victimisation and improving engagement.

Attention to confidentiality was important; practitioners should be alert to the risks of confidentiality breaches, particularly in hospital and maternity settings, and ensure clear documentation and visitor controls are upheld.

How these features manifested in relation to different professionals are considered below:

General Practitioners (GPs)

Positive GP encounters involved believing survivors, asking sensitive questions in private, recognising coercive control, and avoiding sole reliance on medication. Being believed by a GP was repeatedly described as transformative.

Midwives and Maternity Services

Midwives who ensured privacy, respected confidentiality, and demonstrated awareness of power dynamics enabled safer disclosure during pregnancy and post-natal care.

Counsellors and Therapeutic Practitioners

Positive counselling was linked to trauma-informed, non-linear approaches and explicit domestic abuse expertise. Continuity of care and cultural or identity attunement further strengthened engagement with counsellors and support workers.

Key Findings

- ⇒ Obtaining an early referral for counselling was important; sometimes opportunities were missed, i.e., police did not provide generic victim support or information on domestic abuse services and support.
- ⇒ Positive professional encounters were defined less by role and more by belief, empathy, and curiosity.
- ⇒ Belief and empathy were more influential than professional role in enabling disclosure and recovery. Being believed by GPs, midwives, and counsellors enabled recognition of abuse and engagement with support.
- ⇒ Fragmentation, rigid models and lack of DA expertise undermined survivor wellbeing and recovery.
- ⇒ Survivors valued counsellors who did not require linear recounting of abuse, avoided judgement or blame, and worked flexibly with complex trauma, including CPTSD.
- ⇒ It was felt that CPTSD was very different to PTSD and consequently, for survivors with this condition, it was rarely possible to recall events in a linear fashion as required in some more traditional counselling sessions.
- ⇒ Positive counselling experiences were linked to practitioners with explicit domestic abuse expertise and trauma-informed approaches.
- ⇒ Trauma-informed and gender-aware practice reduced secondary victimisation and improved outcomes.
- ⇒ Cultural understanding, shared identity, or specialist knowledge of coercive control enhanced trust and therapeutic effectiveness.
- ⇒ Continuity of care (and counsellor) and clarity about therapeutic models, practice, purpose and boundaries also made a critical difference.

Recommendations

1) Police must ensure that advice on victim support and specialist Domestic Abuse providers is given to people reporting domestic abuse.
2) Mandatory domestic abuse and trauma-informed training for GPs, midwives, hospital staff, and counsellors.
3) Clear communication of counselling models and DA specialisms at referral and assessment stages
4) Continuity of Counselling staff and reduction in asking survivors to keep repeating accounts
5) Health systems should value professional curiosity and holistic assessment alongside clinical protocols.
6) Expand trauma-informed and DA-specialist training across health and counselling systems
7) Integrated advocacy and therapeutic models should be prioritised through improved integration between advocacy, counselling and mental health pathways
8) Practitioners should approach holistic practices with professional curiosity rather than judgement, understanding how these strategies function for the survivor and how they may sit alongside, rather than replace, therapeutic intervention
9) Support survivors to process harmful professional encounters as part of recovery.