September 2025

Child & Young Survivors of Domestic Abuse

A Trauma-Informed Approach for Health Professionals

Rising Sun

Ending domestic abuse. Together.

> **“Everyone should have a voice, not just the parents”**
>
> Girl, age 14

Acknowledgements

Thank you to Standing Together Against Domestic Abuse and the Whole Health Project, for commissioning Rising Sun to produce this guidance for Health Professionals.

With special thanks to the children and young people we consulted and who chose to share with us their experiences of being supported following domestic abuse. Their stories, ideas and experiences have shaped this guidance. Thank you in particular to the members of the Young People Steering Group - Baillie, Snow, Terry, Marion, Bailey and Roisin.

Thank you to the Rising Sun team, whose expertise in supporting children and young people over the last 40 years, have provided the strong foundation from which to shape this guidance.

Children’s Voices

Throughout this guidance, we have presented quotes, ideas, images and case studies that have come directly from children. These were collated via three routes:

- An initial focus group, involving 9 young children aged between 5 and 12 years, alongside their mothers. This was an arts-based activity, where children were invited to respond to the question: ‘What did you like about your support from your Mentor/ Counsellor?’
- A series of Young People Steering Group meetings, that ran alongside the creation of this guidance document and the supporting animation. This group of 6 young people, aged 17 to 23 years old and with experience of domestic abuse and mental health support from various agencies, shaped the concept of this guidance and gave us our focus.
- Our previous research (Orchard and Lyttle, 2022) funded by Kent County Council (KCC), which collected children’s voices through a series of interviews.

Where quotes and case studies have been included, pseudonyms have been used to protect the identity of children and families. Any identifying features have been removed or altered.

Collaborators

Rising Sun would like to thank the following organisations for their involvement and contributions.

Executive Summary

Aim

Whilst predominately aimed at health professionals, this guidance can be useful for anyone working within health, social care or education, who may encounter children who have experienced domestic abuse. It aims to provide a framework for developing responses to disclosures and for recognising signs of abuse. It also provides an overview of what coercive control-based domestic abuse looks like for child and young survivors, what some of the long-term impacts may be and explores how to promote and support recovery.

Key Messages

- Coercive control-based domestic abuse is distinctly different from parental conflict and anyone noticing conflict between parents/ carers should use professional curiosity to consider if there is, in fact, coercive control-based domestic abuse being perpetrated by one party over the other.
- Where domestic abuse is occurring within a household, the children are not merely witnessing the abuse, but are active agents within their homes, taking on a variety of roles such as a protector, help-seeker or as a confident to either the victim parent or the abuser.
- Domestic abuse does not end when a relationship between the adults has ended. The abuse often continues for years post separation, through means such as economic abuse, abuse of the family court process, harassment and coercive control of the children.
- Perpetrators of abuse frequently use a DARVO strategy, meaning Deny, Attack and Reverse Victim and Offender. This is where a perpetrator presents himself as the victim and uses the systems around the family to seek sympathy and support, further isolating the genuine victim and the children.

What do we mean by 'Domestic Abuse'?

Whilst the legal definition includes single incidents of violence or abuse, the most harmful form of domestic abuse, and the form this guidance focusses on, is coercive control. All domestic abuse involves those aged 16 years or over and who are 'intimately' related. In coercive control-based domestic abuse, one party seeks power and control over another, resulting in a denial of their human rights, degrading their dignity and self-esteem. Due to the intimate nature of the relationship between the perpetrator and the victim, the abuse is bespoke, targeted and humiliating, resulting in an eroding of a person's sense of self and evoking fear of punishment (see sections 3.1 – 3.2).

Children as victims in their own right

The Domestic Abuse Act (2021) recognises that any child of someone who is either perpetrating domestic abuse or is a victim, is also a victim in their own right and it is important that anyone working with child survivors understands why this is the case.

Children experience domestic abuse in much the same way as adult/ parent victims and often the whole family is targeted by the perpetrator. Therefore, children suffer the same ill effects as the adult/ parent victim. Children are actively engaged in the abuse they are subjected to. They interpret, predict and assess 'episodes', causing worry, often believing they are the cause of the problems and taking steps to protect themselves, their siblings and their non-abusive parent from harm (see sections 3.3 – 3.5).

The impact of this is widespread and plays a part in shaping a young person's experiences of the world and their relationships. The impacts include emotional/ psychological, neurological, behavioural and relational, affecting many, if not all, aspects of a child's life (see section 4).

What role do health professionals play in supporting child and young survivors?

Health professionals have a responsibility to be able to recognise and safely enquire about domestic abuse (see sections 5.1 and 5.2). In order to do this, they need to understand what coercive control-based domestic abuse is and how to recognise it. Any health professional who has contact with children and young people, has a responsibility to identify potential harm and take appropriate steps to safeguard children and their non-abusive parent or carer (see section 5.3 for responding to disclosures and section 6 for identifying and managing risk).

Support Strategies for Children and Young People

Depending on your role, there are a range of support options and strategies for supporting child and young survivors of domestic abuse. However, it is always necessary that an approach is trauma-informed. A trauma-informed approach prioritises creating safety, building trust, offering choice, working collaboratively, developing knowledge and empowering survivors, enabling them to make meaningful and lasting change towards recovery (see section 7).

The importance of multi-agency partnerships

Domestic abuse is a complex and multi-faceted issue that spans all aspect of a families' life. The importance of sharing information both internally, with other relevant healthcare services, and externally, with relevant agencies such as charities or social care, cannot be overstated. For key multi-agency partnerships and protocols, see section 9.

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1 Call to Action

This guidance underscores the pressing need for a multifaceted approach to address the complexities of domestic abuse and its profound impact on children and young people. As health professionals, educators, social workers, and members of the community, we all share the responsibility to recognise, respond to, and ultimately prevent domestic abuse. The voices of children and young people, as highlighted throughout this document, are a powerful reminder of the urgent need for change in our systems and practices.

- **Enhance Training and Awareness:** It is imperative that all professionals working with children and families receive comprehensive training on the signs and implications of domestic abuse. This includes understanding the nuances of coercive control, recognising the impact of trauma, and being equipped with the skills to engage sensitively with children who may be experiencing or witnessing domestic abuse. Training should be ongoing and incorporate the latest research and best practices, ensuring that all staff feel confident and capable in their roles.
- **Create Trauma Informed Spaces:** Professionals must prioritise creating environments in which children feel safe and therefore able to express their feelings and experiences. This means implementing trauma-informed care practices that emphasise empathy, active listening, and respect for the child's perspective. Establishing clear pathways for children to disclose their experiences, without fear of judgment or repercussion, is essential for early intervention and support.
- **Collaboration across Agencies:** A coordinated response is crucial to effectively address domestic abuse. Health services, educational institutions, social services, and community organisations must work together to create a comprehensive support network. This includes sharing information responsibly and ensuring that all parties involved are aware of the resources available to both the children and their non-abusive parents.
- **Engage Children and Young People:** Children and young people should be involved in the development and evaluation of services that affect them. Their input can provide invaluable insights into what support systems are effective and how they can be improved. Creating forums or advisory groups where children and young people can share their experiences and suggest solutions will empower them and ensure that their voices are heard in decision-making processes.
- **Advocate for Policy Changes:** Professionals should advocate for comprehensive policy reforms that prioritise the needs of children affected by domestic abuse. This includes pushing for legislative changes that strengthen protections for child survivors and ensuring that domestic abuse is recognised as a public health issue. Engagement with local and national policymakers is crucial to drive systemic change and allocate resources to support families affected by domestic abuse.
- **Support Research and Innovation:** There is a need for continued research into the impacts of domestic abuse on children and the effectiveness of various interventions. Funding should be allocated to studies that explore innovative approaches to support and recovery, particularly those that address the unique needs of diverse communities.

Collaborations between academic institutions, practitioners, and policymakers can lead to the development of evidence-based practices that enhance service delivery.

The gravity of domestic abuse and its impact on children cannot be overstated. As this guidance highlights, children are not mere witnesses to abuse; they are affected in profound ways that shape their emotional, psychological, and physical well-being. It is our collective duty to ensure that these young voices are not silenced, that their experiences are validated, and that they receive the support they need to recover and thrive.

By taking proactive steps to implement the recommendations outlined in this guidance, we can foster a culture of safety, respect, and empowerment for children and young people. Together, we can break the cycle of abuse, promote resilience, and cultivate environments where every child has the opportunity to flourish, free from the shadows of domestic abuse. The time for action is now - let us commit ourselves to being the advocates, allies, and champions for change that children deserve.

We hope this guidance is useful for anyone working with children and families affected by domestic abuse. For access to the online version and to the supporting animation, please visit www.risingsunkent.com/about-us/our-impact.

2 Introduction

2.1 Purpose of the Guidance

The publication of this guidance marks the end of a year-long pilot project, commissioned by Standing Together and Crossing Pathways, which sought to bridge the gap between health and domestic abuse services. Rising Sun, a domestic abuse service, used this pilot to employ a Mental Health Professional to train and support both internally and externally, resulting in improvements in Rising Sun's responses to mental health needs, alongside greater relationships and referral pathways to mental health teams.

In the aftermath of the COVID-19 pandemic and Socio-Economic Crisis, we are seeing a vast increase in demand for services.

What is clear from the outcome of this project, and more broadly from Rising Sun's work with children and young people, is that professionals working within Health, as well as those in Schools, Social Care and many other services, often do not have the tools or confidence when working with child survivors and their families. Domestic abuse is often conflated with parental conflict, with victims of abuse being labelled as 'just as bad' as the aggressor and children who are traumatised are frequently referred to as disruptive and difficult.

In the aftermath of the COVID-19 pandemic and Socio-Economic Crisis, we are seeing a vast increase in demand for services; domestic abuse-related crimes rose during the first lockdown, exposing children to more frequent and severe incidents.

We are grateful that the Domestic Abuse (DA) Act 2021 has provided a definition of domestic abuse which recognises children as victims in their own right; progress that was long overdue. And we also welcome the Domestic Abuse Commissioner (DAC) Report: 'Victim's in their Own Right?' (2025), which contains much needed recommendations for government, including the need to embed domestic abuse expertise into health settings and embark on a Public Health approach to domestic abuse, including a dedicated focus on the needs of children and young people. This guidance is therefore timely, and we hope it can be useful in supporting these recommendations.

Rising Sun have worked alongside Mid Kent Mind, Kent and Medway NHS and Social Care Partnership Trust and Canterbury Christ Church University to develop this guide for health, mental health, and other professionals to use. It aims to support anyone who may need to work with a child survivor, in knowing how to respond and where to turn. As children and young people have shown us in developing this guidance, the advice is extremely simple; to listen; give time and respond to what children share, even if that only means passing it on to someone else.

Figure 1: Boy aged 8 (2025) 'Amazing', poster paint on paper, 21x30cm

2.2 The role of health

Health Services play a key role in supporting children and young people who are experiencing domestic abuse. For women, we know that 80% will seek help from health professionals, often as their first point of contact (Webb, 2020). Children, however, will rarely directly ask for help, but will use other means to communicate their need for support.

All health professionals can learn to work safely with children who are experiencing domestic abuse, through an understanding of ongoing risk caused by coercive control-based domestic abuse, by using a trauma informed approach and by knowing how and when to safeguard children.

Children do not look at job titles or professional workloads when choosing who to disclose to. They are looking for a friendly face; someone they feel they can trust. Everyone working with children in health or social care, needs to be aware of the potential indicators that a child may be experiencing abuse, and know how to respond when they recognise the signs.

Children do not look at job titles or professional workloads when choosing who to disclose to. They are looking for a friendly face; someone they feel they can trust.

Many young people continue to be exposed to domestic abuse long after their parents have separated. The impact this has on their mental health is frequently minimised. We know that

more victims of domestic abuse die by suicide than are killed by the perpetrator (Woodhouse, 2025). Supporting the emotional wellbeing and recovery of children, along with their survivor parent, is critical and health professionals play a key role in enabling recovery from domestic abuse related trauma, supporting the child and their non-abusive parent to navigate complex feelings of love, hate, anger, guilt and shame.

2.3 Language and Scope of this Guidance

Domestic abuse is often referred to as a gendered crime. This is because the majority of those known to perpetrate domestic abuse are male and the majority of victims are females (ONS, 2025). Historic and ongoing gender inequality is broadly understood as both the cause and the exacerbating factor for this persistent trend. Two women a week continue to be killed by a male partner/ ex-partner (ONS, 2025) and the research in this area predominately focusses on mothers as victims and male partners/ ex-partners as perpetrators, also reflecting the need and demand within services.

We recognise that female to male domestic abuse can go undetected. One possible reason being that it is unusual in these cases for sexual abuse or high levels of physical violence to be present, making them less likely to meet threshold for documentation. Domestic abuse can occur between victims and their in-laws or other extended family, between adult children and their parents in either direction and it can affect LGBTQ+ people. Such cases, alongside other non-traditional relationships and families are often miscategorised and there is a risk that these families are not safeguarded effectively. We also recognise that stressors associated with belonging to a minority group, be it sexual, racial or otherwise, interact with domestic abuse to create or exacerbate vulnerabilities and add additional barriers to accessing support.

In creating this guidance document, we recognise that more needs to be done to support minoritised communities and more research is needed. However, we are also still in a climate in which women and children are at greatest risk from domestic abuse, both in terms of their physical safety and their mental health. As varying forms of domestic abuse manifest differently and are different in nature, to be inclusive of all would have prevented this guidance from being coherent or cogent. As such, the language and focus of this guidance is directed towards supporting mothers and their children as victims/ survivors, but it can be more broadly applied as needed.

2.4 Trauma-informed Approach

The term ‘trauma-informed’ is used throughout this document and some further details on trauma informed care is provided in section 7.

Trauma can have a long-lasting effect on survivors’ mental health and relationships. It can be caused by coercive control, amongst many other things, and can lead to behaviour which may seem harmful or counter-productive. A trauma-informed approach recognises this behaviour as a response to trauma and a coping mechanism. It prioritises creating safety, building trust, offering choice, working collaboratively, developing knowledge and empowering survivors, enabling them to make meaningful and lasting change to promote recovery.

3 Understanding Domestic Abuse

3.1 Definition of Domestic Abuse

Domestic abuse is an incident or pattern of incidents of controlling behaviour by someone aged 16 or over, towards another person aged 16 or over, with whom they are intimately related. There are many different forms of domestic abuse, and it isn't always physical or visible. In the majority of cases, domestic abuse is perpetrated by a partner or ex-partner, but can also be by a family member or carer.

Domestic abuse can include, but is not limited to, the following:

- Coercive control (a pattern of intimidation, degradation, isolation and control with the use or threat of physical or sexual violence)
- Psychological and/or emotional abuse
- Physical or sexual abuse
- Financial or economic abuse
- Harassment and stalking
- Online or digital abuse

The Domestic Abuse Act (2021) provides a cross-government statutory definition of domestic abuse and in section 3 of the Act, children are recognised as victims of domestic abuse in their own right. If they see, hear, or experience the effects of the abuse, and are related to, or fall under "parental responsibility" of, the victim and/or perpetrator of the domestic abuse, then they are also a victim.

"Non-physical forms of domestic abuse like coercive control have a significant impact on children and professionals focused on physical acts of violence may fail to understand the daily experience of victims and children, how it is affecting them, and the level of risk posed by perpetrators."

(Domestic Abuse Act Statutory Guidance, 2022)

It is widely reported that 1 in 5 children in the UK experience domestic abuse, often when still in the womb (For Baby's Sake, 2021). This crucial stage in a baby's brain development can be affected by high cortisol levels, which occur as a result of a father's coercive control-based domestic abuse, as well any physical harm a father may inflict on the mother, or potential self-neglect/ self-harming behaviours as a consequence of dad's abuse. This early experience of trauma affects the mother-baby bond from the very beginning of life and a baby's development will be impacted by their earliest experiences (Gerhardt, 2014).

3.2 Coercive Control-Based Domestic Abuse

The Home Office Statutory Guidance Framework describes coercive control as "an intentional pattern of behaviour that occurs on two or more occasions, or which takes place over time, in order for one individual to exert power, control or coercion over another" (Home Office, pp.13, 2023).

Coercive control consists of three elements (Fig 2):

- An intention of one party (the perpetrator) to take control over the other (the victim)
- Credibility of the threat made. These will be finely tuned to be effective against the victim, using an existing vulnerability or insecurity against them. One example of a threat could be, 'if you go out tonight with your friends, I will go out and cheat on you'.
- A negative perception, or experience of the controlling behaviour by the victim, resulting in them altering their behaviour, for example the victim decides not to go out with their friends.

Figure 2: Hamberger et al (2017) '3 Elements of Coercive Control'

Coercive control, or 'intimate terrorism' (Stark, 2007) results in denying someone their human rights, degrading their dignity and self-esteem. It is bespoke and targeted due to the intimate nature of the relationship between the perpetrator and the victim and whilst it can be accompanied by physical or sexual abuse, it isn't always. However, it still results in an eroding of a person's sense of self and evokes fear of punishment.

3.3 Coercive Control and Children

Historically, safeguarding policies have responded to domestic abuse as though it is dyadic in nature, with adults in the roles of 'victim' and 'perpetrator' and children merely witnessing abuse. If this was the case, children who did not see or hear incidents of violence, could be dismissed as unaffected. However, research shows us that this could not be further from the truth.

Children experience domestic abuse and coercive control in much the same way as adult/ parent victims do (Stark, 2007; Katz, 2022) and play a direct role within a context of coercive control and abuse (McLeod and Flood, 2018). Whilst their caregiver is typically the 'primary victim' and subject of the abuser's attempts to control, the whole family is usually targeted by the perpetrator. Therefore, children suffer the same ill effects as the adult/ parent victim.

Abusers often target the children directly as a way to control their adult partners. Sometimes this is the primary method, with some abusers intentionally seeking to "destroy" children in order to dominate their mothers. Stark (2007) describes this mistreatment of children as a "staged performance" directed toward the primary victim, his partner.

Figure 3: Anna Benner (2025) 'Not Just a Witness', still from animation

3.4 Distinguishing between Parental Conflict and Domestic Abuse

The terms 'parental conflict' and 'domestic abuse' are often used interchangeably, yet these are very different terms with different meanings.

In coercive control-based domestic abuse, one party will seek to dominate the situation, whilst the other is trying to survive, motivated by wanting the abuse to stop. The perpetrator seeks control and dominance, whilst the other changes their behaviour to comply and avoid punishment.

By contrast, parental high conflict occurs where both parties hold equal power and disagreements are expressed openly and mutually. Neither party is dominating the other.

Case Study

Dmitri, age 10

Dmitri was referred to a specialist domestic abuse service, with the referral citing 'parental conflict, with a history of domestic abuse' as the reason. The domestic abuse included an incident where dad had strangled mum and left marks on her neck. However, the Social Worker had focussed their concern on Dmitri's mother, as she was reportedly shouting at dad during handover.

During assessment, a long history of abuse was uncovered, which had escalated when Mum was pregnant with Dmitri. Dad would often call Mum 'mad' and say that if she ever left him, she would not get custody of the children. Mum left Dad because of the abuse, which had impacted her mental health. Her fear of Dad's threats prevented her from feeling able to access support. Handover was a particularly distressing time, whereby dad would subtly undermine her, making statements such as 'oh has mum forgotten this again', provoking a trauma response in mum.

For Dmitri, these handovers were confusing and extremely stressful. The domestic abuse worker recognised that to remove the harm to Dmitri, these fractious handovers needed to end and advocated for this with the Social Worker, initially by using a contact centre. As a result, mum's responses to the abuse from dad also ended. Dad however, continued to find other means by which to inflict harm on Dmitri's mother and therefore on Dmitri himself.

It is important in cases where there is history of domestic abuse, that we recognise who has the power to end the abuse, and who is responding to it. Only a perpetrator can end the abuse and therefore end the ongoing harm to children. Addressing the presence and actions of the perpetrator should be the focus when safeguarding children.

Parental high conflict can sometimes escalate into incidents of violence. This violence may, or may not, be severe or cause injuries. This kind of violence is a separate phenomenon to coercive control-based domestic abuse and should be dealt with by a different framework. Some researchers have called this 'situational couple violence' (Katz, 2022, pp.9-12).

If one party is making adjustments, such as reducing their social life or adjusting their hobbies, appearance, routines etc., then this should be understood as coercive control-based domestic abuse and specialist advice should be sought to assess the power dynamics and risks. It is this need to adjust behaviour over an extended period of time that causes psychological harm, and recovery for both the parent and their children is longer and more complex.

If you suspect parental conflict, it is important to exercise professional curiosity and consider the dynamics between the parents and whether one party holds power over the other. You should consider contextual factors, such as gender, sexuality, disability, immigration status, economic status, race, maternity and other intersecting identities. If one party holds and uses power and privilege over the other, then this apparent conflict should instead be understood as domestic abuse and appropriate steps taken to safeguard the children, through offering support to the parent whose power is being diminished.

"Practitioners should continue to be vigilant and confident there are no indicators of domestic abuse, including fear, imbalance of power and controlling behaviour."

(DWP, 2025)

In their parental conflict guidance, the Department for Work and Pensions (2025) state:

"Practitioners should continue to be vigilant and confident there are no indicators of domestic abuse, including fear, imbalance of power and controlling behaviour."

3.5 Children as Agents

Children are not only direct victims of domestic abuse, but also take active roles in their response to it. There are many ways in which children adapt their behaviours in order to manage the abuse. Some examples, taken from the Kent Phoenix Programme (www.phoenixgroups.uk) are:

The Peacemaker: Children may take on a role as pacifier, or mediator between the parents, in an attempt to de-escalate tensions within the family.

The Golden Child: Children may focus on ensuring that their own behaviour at school and/or at home is exemplary. This could be to ensure that they do not put any additional pressure on the survivor parent, to assume control over the aspects of their lives where it is possible for them to control, to provide themselves with a 'way out' of the family home through education or possibly to avoid punishment from the perpetrator.

The Caretaker: Children may take action to comfort the non-abusive parent, or to intervene in the abuse in order to protect them or their siblings from harm. SafeLives (2017) report this to be around 30 per cent of children.

The Scapegoat: Children may take the blame in the family, detracting blame away from their survivor parent, or taking responsibility for issues arising at home.

The Abuser's Assistant: Children may position themselves alongside the perpetrator, mimicking their use of insults or abusive language against other members of the family.

The Victim's Confidante: Children may position themselves in alliance with the victim/ survivor parent, enjoying a close emotional connection to them and enabling their parent to lean on them for support.

"Men's attacks on mothering and mother-child relationships are central in their exercise of control and domination"

(Lapierre, 2010)

In some families, siblings can become fractured and disconnected from each other, as they may take different roles within the home. For example, a perpetrator father may enforce rigid gender roles, and demand their sons to align themselves with him, subjecting their daughters to the same abuse as their mother.

Children may position themselves differently within the family, according to how they are used by the perpetrator.

3.6 DARVO

When a victim-survivor starts to speak out about what is happening and starts to seek support, it is usual for perpetrators to respond with a DARVO (Deny, Attack, and Reverse Victim and Offender) strategy:

- Deny or minimise the abuse
- Attack the credibility and character of the victim
- Reverse the narrative about who is the
- Victim and
- Offender, and who is the safe parent and who is the abusive parent to any children of the relationship.

(Freyd, 1997)

This tactic is often effective in confusing professionals and can result in further alienation and victimisation of the victim/ survivor and the family, as services are not able to recognise the coercion, or identify who has power in the dynamic between the parents.

> **"A perpetrator may manipulate the victim or those around them to make the abuse less visible or undetectable altogether. Perpetrators may also be particularly adept at manipulating professionals, agencies and systems, and may use a range of tactics to maintain contact with, and control over the victim."**
>
> (Home Office, pp.31, 2023)

3.7 Post separation abuse

Separating from an abusive partner is rarely the end of the domestic abuse. In fact, it can exacerbate the abuse and most domestic abuse related homicides occur once the victim has left or attempted to leave.

Post separation abuse, where the victim and perpetrator share parental responsibility for a child or children, is often ongoing and continues to cause harm to children. Handover of children can be a flashpoint for ongoing violence, intimidation and coercion to occur.

> **"Everyone ridicules the mum, asking things like 'you knew how unsafe it was, how did you not leave!?' But you should know that it is not safe for mums to leave an abusive man."**
>
> Girl, age 19

Katz et al. (2020) describe the various ways in which abusive fathers seek to maintain their control over the family post separation, often through a tactic of omnipresent fathering (Fig 4). This can be either by continuing the onslaught of abuse through means such as harassment, stalking, physical or emotional assaults and intimidation – dangerous fathering or by presenting himself as a loving father, who only cares about the welfare of his children, but often dominates the narrative, for example through the DARVO strategy (explained above in 3.6) – 'admirable' fathering. This could include reaching out to professionals, or other parents at the school to gain sympathy and further isolate the mother and children. Such fathers, however, will typically know very little detail about their children, such as their birthdays or their favourite hobbies. They may fight for contact through the courts and then neglect to take them to their extracurricular activities, further diminishing the child's rights and access to spaces that might enable the development of their own identity and sense of belonging.

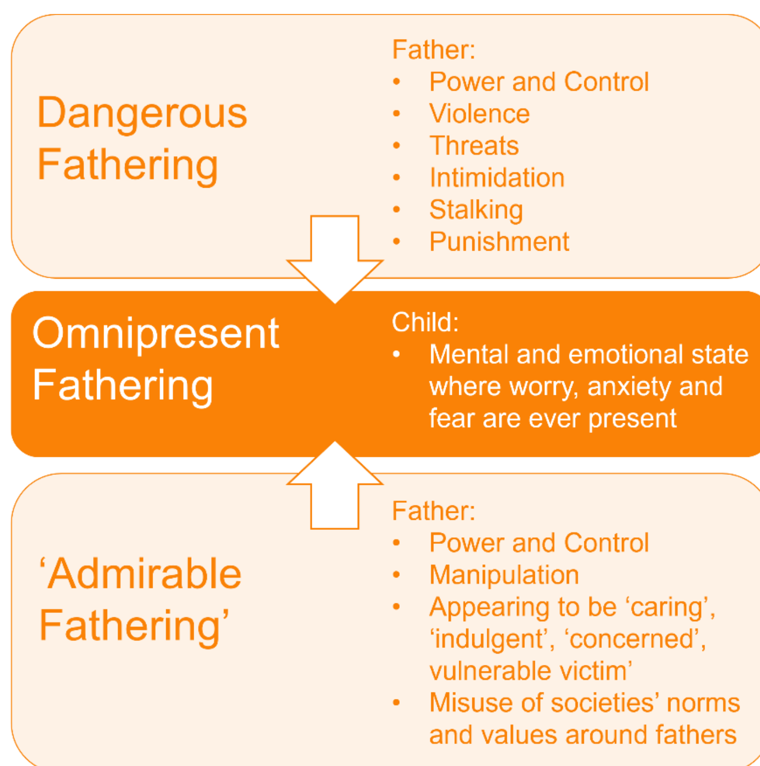

Figure 4: Katz et al. (2020) 'Omnipresent Fathering'

3.8 Economic Abuse

Economic abuse is a form of domestic abuse included in the Domestic Abuse (DA) Act 2021 definition. It involves the control of a partner or ex-partner's money, finances and resources such as clothes and food (Surviving Economic Abuse, 2025). It is a form of domestic abuse that often continues long after a relationship has ended and has long lasting impacts on children and young people (DA Commissioner, 2025). 78% of survivors experienced economic abuse during the cost-of-living crisis, with perpetrators controlling finances and limiting access to resources (Surviving Economic Abuse, 2022).

In children's lives, this can include refusing to pay child maintenance, such as by working cash in hand or not working at all in order to evade payment. It can include disrupting a mother's ability to work, through inconsistent/ unreliable child contact, leading the other parent to have to give up jobs or evening work for example. It could be taking out debts in both names, refusing to make mortgage payments or taking large sums of cash out of a joint account. It could also mean using the family courts to harass mothers and children, through frequently seeking to amend court orders, even if he then does not turn up for the contact he's been granted.

Children and their mothers can live with the impact of economic abuse for many years, leaving children in poverty with long lasting effects on their wellbeing. Survivors of economic abuse are 5 times more likely to experience long-term financial hardship (Refuge, 2023), further exacerbating the other psychological impacts of abuse.

Chloe, age 7 and Jack, age 9

Chloe and Jack were referred to a Specialist Domestic Abuse Mentoring Service, due to Chloe's anxious behaviour at school. Chloe was frequently running away at the school gates, refusing to enter the school and when she did manage to go in, was visibly distressed and struggling to remain in the classroom.

A few months prior to referral, Chloe had expressed ambivalence about visiting her dad, resulting in her dad excluding her from regular contact and from a family holiday, taking only her brother Jack. It was at this point mum felt that Chloe became more withdrawn.

Jack was having contact with his dad every other weekend, but would come back distressed, having 'meltdowns' and struggling to regulate his emotions. Mum felt that he was functioning as the intermediary between dad and his mum and sister, and the effect was a fracture in the relationship between the siblings.

In this way the family were unable to recover and move on as the perpetrator still had control and, although not physically present, continued to invade their home, which should have felt like a safe space once he was no longer living there.

4 Impacts of Domestic Abuse on Children

Children are actively engaged in the domestic abuse they are subjected to. They interpret, predict and assess 'episodes', causing worry, often believing they are the cause of the problems and taking steps to protect themselves, their siblings and their non-abusive parent from harm. This is exhausting work for a child or young person.

> **"Perpetrators / fathers demanded high level of attention from mothers at the expense of children."**
>
> (Katz, 2016, p. 52)

The impact of this is widespread and plays a part in shaping a young person's experiences of the world, their relationships and, to some degree, their neurological makeup (Gerhardt, 2014). However, it is also important consider this alongside the positive experiences and relationships in their lives, which may negate the negative ones.

4.1 Emotional and Psychological Impacts

Domestic abuse thrives in secrecy and silence. In the silence, children will typically default to a belief that they have caused the abuse, or that they should have done something to prevent it, leading to feelings of guilt and shame (Mills and Kellington, 2012). This is extremely isolating for children, and may cause them to become withdrawn, or struggle to form relationships with peers. Children may struggle to empathise with their peers, may be disruptive or have angry outbursts that further exacerbate their ability to form peer relationships. Unexplored feelings of shame also have links to self-harm and suicidal ideation, which can fluctuate as children move through developmental phases. For example, these risks could escalate in adolescence, even when the abuse took place in early childhood (Saotome, 2010). If silence and shame are not addressed, they can be repressed, leading to difficulties with mental health later in life, such as anxiety, depression and ongoing suicidal ideation.

4.2 Neurobiological Impacts

Evidence shows us that young people who grow up experiencing abuse will demonstrate neurological differences than children who do not grow up with adverse experiences (Teicher et al., 2016). These children need to continuously monitor and respond to threat and, just like the adult victim, will be 'walking on eggshells'. This constant vigilance means constant activation of their stress response system, which has an impact on brain development - their brain will develop to respond to threat more readily than under normal circumstances and can lead the child to develop an over-reaction to stress, impacting their ability to regulate their emotions and to cope with normal social interactions. Children could also experience developmental delays, in areas such as their speech, motor or cognitive skills.

This constant vigilance can be coined as Early Life Stress (ELS), a term used to describe traumatic events experienced as a child such as domestic abuse. ELS has been found to impair the brain's growth and development leading to potential longer term psychological and physiological repercussions. Neurologically, ELS can reduce the brain's hippocampal volume, resulting in impaired memory and emotional regulation, and can sensitize the amygdala,

leading to exaggerated fear and anxiety responses. It has also been found to disrupt the development of the prefrontal cortex, which is responsible for decision-making, impulse control and planning. This results in altered neurotransmitter systems, such as serotonin and dopamine, which influence mood and motivation. All of this can present in a child's behaviour, heightening the risk of anxiety, depression, and impulsivity (Jamil et al., 2025).

Figure 5: Anna Benner (2025) 'Shame', still from animation

4.3 Behavioural Impacts

Children who grow up in an environment of fear adapt their behaviour in response to that fear. Neuroscience suggests that the state of fear becomes a trait in that person (Perry et al., 1995), for example, a young person may develop a tendency to become over vigilant. However, it is also important to note that relationships, communities and culture play a role in this too.

Domestic abuse often results in inconsistent parenting due to unexpected absences of either parent, which could be due to parental separation, hospitalisation, imprisonment, or possibly due to unintentional neglect. As a result, they may develop a fear of abandonment and in some children, there is a greater difficulty in interacting sociably with siblings and peers. They are more likely to present with behavioural challenges such as anger and aggression in comparison to non-exposed children (Covell & Howe, 2009).

Being exposed to, and drawn into the dynamics of domestic abuse, can impact on a child's beliefs about family dynamics and intimate relationships. This can affect their own relationships in the future, not only with intimate partners and their own children, but also with peers. The effects of trauma can cause a child or young person to struggle with regulation, perceiving threat where there is none and over-responding, for example becoming violent or

> **"I love him and I hate him at the same time. I can't forgive or forget what he's done to us but he's my Dad. I hate not seeing him or having him around."**
>
> Girl, aged 15 years

aggressive in the classroom. They may struggle to concentrate, struggle to sleep, developmentally regress or turn to risk taking behaviours or substance misuse in order to cope with the effects of trauma caused by domestic abuse. They may learn to resolve conflicts with siblings and peers through copying their parents' behaviour and this may have an impact on developing crucial social skills (Cleaver, 2025).

4.4 Attachment

For secure attachment, children need to experience their primary care giver as a 'secure base' (Bowlby et al.,1956), learning as they grow and develop that this carer can meet their emotional and physical needs. Domestic abuse seriously disrupts this secure base with the primary care giver, as the perpetrator parent may frequently demand his own needs be met before the child's, resulting in the survivor parent focussing on the perpetrator's demands before the children's needs for fear of punishment against her and/ or the children. The impact of living in fear of an abuser, and managing his behaviour in this way, seriously disrupts her ability to provide a 'secure base' to her children.

This increases the risk of an insecure attachment between child and carer, which in turn increases the risk of the young person struggling to form healthy and secure attachments in the future. Responses that focus on building safe and secure relationships with children and young people, informed by attachment theory, can therefore be an important aspect of recovery.

4.5 Adverse Childhood Experiences (ACES)

Domestic Abuse is listed as an 'Adverse Childhood Experience' (ACE) and often co-occurs with other ACEs, such as verbal abuse, physical abuse, sexual abuse, physical neglect, emotional neglect, parental separation, household mental illness, household alcohol abuse, household drug abuse and incarceration of a household member. We know that children growing up with multiple ACEs can be more likely to experience negative outcomes in adulthood (NHS England, 2025).

ACEs can present barriers to healthy attachment relationships that are formed for children and can increase the risk of future health problems including heart disease, cancer, violence and becoming a victim of violence as well as mental health difficulties. The risk of mental health difficulties increases the likelihood of anxiety, depression and post-traumatic stress disorder (PTSD), with 1 in 3 mental health diagnoses linked directly to ACEs (Bellis et al; 2014). However, we also know that a trauma informed response, which builds on and enhances protective factors, can reduce or negate the negative impact and has the potential to break generational cycles of abuse (Ford, 2017).

4.6 Children's Resistance

While we have focussed above on the negative impacts of domestic abuse on children, it is also important to remember that children have the potential to resist the impact of abuse and employ their own agency in order to build resilience in their response to domestic abuse. To do this, they need a safe and supportive network around them to enable positive outcomes.

The primary ways in which children resist the impact of abuse, are:

- Emotion focussed: Primarily used by younger children or children with SEND, a child may manage and reduce stress by withdrawing when abuse is occurring, distracting themselves by listening to music or playing with toys
- Problem focussed: Primarily used by older children, some children will attempt to change or manage the situation, for example, by intervening, distracting or summoning help

(Devaney, 2015).

> **"By focusing on children's capacity for conscious meaning making and agency in relation to their experiences of domestic violence, we highlight the importance of recognising its impact on children, and their right to representation as victims in the context of domestic violence."**
>
> (Callaghan et al., 2015)

These coping strategies protect children from some of the effects of abuse and are tools that can be further supported and developed in collaboration with non-abusive adults and peers. Resilience is built through safe community networks around the child and family, which all professionals play a role in.

Figure 6: Anna Benner (2025) 'Metaphor, still from animation

5 Safe Enquiry and Assessment

National Institute for Health and Care Excellence (NICE) Guidance recommends creating an environment which enables anyone to disclose domestic violence and abuse (NICE, 2014). This includes displaying signposting information, ensuring privacy, and providing training and supervision for staff. For children, the guidance requires services to ensure:

- Staff are able to recognise the indicators of domestic abuse and understand how it affects children and young people.
- Staff are trained and confident to discuss domestic violence and abuse with children and young people who are affected by or experiencing it directly.
- There are clear information-sharing protocols in place.
- Clear referral pathways to local services that can support children and young people affected by domestic violence and abuse.
- Staff know how to refer children and young people to child protection services.
- Staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse.
- Children and young people are involved in developing and evaluating local policies and services dealing with domestic violence and abuse.

Generally, it is not appropriate to ask children directly about domestic abuse. However, there are signs that you can look out for and ways to speak to children about their experience and to gather important information from them, from family members and from professionals around them, to better understand a child's experiences and any risks. We explore this further in sections 5.1 to 5.3 below.

5.1 Potential Indicators of Domestic Abuse in Children

5.1.1 Physical health indicators

When assessing any child or young person with emotional related physical health concerns, domestic abuse should always be a consideration. Some examples are:

- unexplained chronic gastrointestinal symptoms
- unexplained genitourinary symptoms, including frequent bladder or kidney infections
- chronic pain (unexplained)
- traumatic injury, particularly if repeated and with vague or implausible explanations
- problem with the central nervous system – headaches, cognitive problems, hearing loss
- repeated health consultations with no clear diagnosis

Additional concerns for older children or adults/ parents include:

- vaginal bleeding or sexually transmitted infections
- unexplained reproductive symptoms, including pelvic pain and sexual dysfunction
- adverse reproductive outcomes, including multiple unintended pregnancies or terminations, delayed pregnancy care, miscarriage, premature labour and stillbirth
- intrusive 'other person' in consultations including partner or husband, parent, grandparent or an adult child

(NICE, 2014)

There are often overlaps between domestic abuse and child sexual abuse, with some perpetrators of domestic abuse also sexually abusing children. Some signs could include:

- Bruises.
- Bleeding, discharge, pains or soreness in their genital or anal area.
- Sexually transmitted infections, including in the throat.
- Pain/soreness in throat
- Pregnancy.
- Difficulty in walking/sitting that are not usual for the child.

(NSPCC, 2025)

Every child is unique and knowing the child is important to understand what is normal or not normal for them. When completing assessments, professionals should gather information from a range of sources, in order to understand what is normal for an individual child, for example their school, any support workers and/ or parent.

Children with special educational needs and disabilities (SEND) may find it particularly difficult to express their feelings or may express them in different and unique ways. It is important to have a range of tools at your disposal to find the best way for a child to communicate, including working with other agencies where needed, who may have better specialist knowledge of the child's needs, or of the child as a unique individual (Domestic Abuse Act Statutory Guidance, 2022).

> **"The most important thing to me is to have someone to talk to about my fears and problems. Even if they don't have the answer I feel like being listened to helps me. Sometimes I have felt 'trapped' by how I am feeling, talking to someone and knowing they are listening helps me to let out what has been trapped."**
>
> Boy, age 19

5.1.2 Mental Health Indicators

5.1.2.1 Self-Harm and Suicide

If a child or young person presents with self-harming or suicidal ideation, again domestic abuse should be considered (NICE, 2022). This includes:

- symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- suicidal tendencies or self-harming
- alcohol or other substance use

Children who have been impacted by domestic abuse are at higher risk of suicide, with 31% of children who die by suicide recorded as having been living in households where domestic abuse was present (Woodhouse, 2025).

5.1.2.2 Attachment difficulties

NICE Guidance (2015) acknowledges that attachment difficulties often occur in children with experience of domestic abuse. Emotional development is based on attachment between parent and child, usually during the first year of life. Developing secure attachments is dependent on a safe environment, where a child's needs are met by a parent or carer. With a secure attachment, the child will grow with a sense of security and confidence in future relationships.

> **"Health and social care professionals should offer a child or young person who may have attachment difficulties, and their parents or carers, a comprehensive assessment before any intervention"**
>
> (NICE, 2015)

5.2 Safe Enquiry

5.2.1 Enquiring directly with children

Children need a safe space in which to share information, and it takes time to build trust with professionals in order to share these experiences.

Professionals should always introduce themselves and anyone else present, ask how a young person wants to be addressed (for example, their preferred name and pronouns), ensure you are friendly and welcoming and give plenty of time, including follow up appointments in order to build rapport and develop trust. It is important to always be child led, giving options on how a child or young person wishes to use the space and time available (NICE, 2021).

It is rarely appropriate to directly ask a child about abuse and leading questions should be avoided. Instead, it is helpful to be curious with children, following their lead and asking open questions such as:

- How do you feel when you're at home?
- Who makes you feel safe?
- Do you ever feel unsafe?

It can take many appointments before a child or young person feels able to open up and for some health and social care professionals, this may not be practical to offer. It could also be that a child will never feel able to disclose abuse, or that it could take years for them to work through and articulate their experiences. Therefore, professionals need to be equipped to notice signs, document them and pass on to safeguarding colleagues where necessary.

Figure 7: Anna Benner (2025) 'Blame', still from animation

5.2.2 Identifying the non-abusive parent

What do we mean by a non-abusive parent? In the context of domestic abuse, this can sometimes feel like a confusing question. It is not uncommon for the perpetrator to be the parent who is able to provide for the children's physical needs, such as a home, food and access to education. However, this could be the result of a mother having to flee with her children.

It could be that the perpetrator has maintained a secure job, a new relationship and presents as calm, caring and rational. In contrast, the victim/ survivor may have never worked, or have given up their job. They may present as lacking confidence, unable to articulate themselves, or perhaps as frustrated and angry. This could be the result of coercive control and resulting trauma.

When thinking about a non-abusive parent in the context of domestic abuse, we consider what children have told us about feeling safe. Children thrive when they are given time and space for their emotional needs to be met. They want to be able to develop peer relationships, hobbies and interests and to have their successes celebrated. They want a parent who listens and puts their needs above their own. Perpetrators of domestic abuse do not provide this, but

rather are intent on dominating the narrative at home, serving their own interests and not those of the family.

Working with domestic abuse services may be necessary to inform a decision about who the non-abusive parent is, in order to support the child. Respect have a tool to help make decisions about who to offer support to, which is available on their website: www.respect.org.uk/resources/19-respect-toolkit-for-work-with-male-victims-of-domestic-abuse. We would always recommend using this tool as part of a multi-agency approach, and alongside training on how to use it effectively.

Some features to look out for include:

Victim	Perpetrator presenting as victim
Presents as distressed	Presents as angry/ resentful
Has not filed and kept evidence in an ordered way	Has a file of evidence- sometimes including secretly made recordings of alleged abuse
Minimises abuse but knows details	Minimises events, vague in details and chronology
Takes responsibility and doubts self	Blames Partner
Empathy for partner	Focuses on own experiences
Ashamed of victimisation	Assertively claims victim status
Fearful/Confused	Not fearful; Overly confident

Professionals can also contact Men's Advice Line (mensadviceline.org.uk), the National Domestic Abuse Helpline (www.nationaldahelpline.org.uk) or a local domestic abuse agency for advice.

> **"Sometimes I got the impression from professionals that they didn't really care about me, it felt like they saw me as just a job to do. I was looking for someone who would listen and keep me in mind."**
>
> Boy, age 17

5.2.3 Direct Enquiry with Young People and/ or Parents

We recommend speaking to family members individually and not to enquire about domestic abuse in front of friends, partners or extended family, even if they appear to be supportive.

When asking about domestic abuse, it is best practice to start broadly, asking questions such as 'is there anything at home that might be causing you to feel stressed/ anxious/ afraid?' or 'how are your relationships at home?' If the answers are indicative of abuse being present, and it is safe to do so, questions can become more direct.

Examples of direct questions:

- Has anyone at home hurt you in any way?
- Do you feel controlled by your partner? For example, financially?
- Has anyone close to you threatened you?
- Do you fear for your safety? Tell me more about that.
- What do you think needs to happen in order for you to be safe?
- Are worried about work/the pets/the house/the children…?
- Have you experienced any kind of physical, sexual or emotional abuse in your life?

Giving or hearing a disclosure can be triggering. It is important to look after your own wellbeing and those of your team as well as the people you are supporting. No matter how much you try to detach yourself from situations or disclosures, it will have an impact. Use self-care tools or reach out for support for yourself if you feel you need this. Figure 8 provides some key principles for direct enquiry.

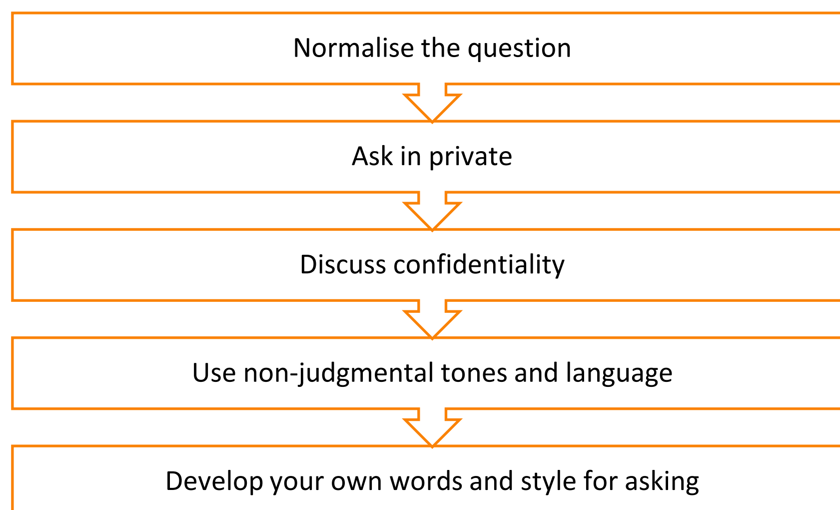

Figure 8: Key principles for direct enquiry

5.3 Responding to a disclosure

You should always document the question and the response, even if it is negative and understand that sometimes it takes time to build enough trust for someone to disclose domestic abuse.

The principles here are the same for children as they are for adults.

- Re-assure that it was a good thing to tell
- Thank them for telling you – it may be the hardest thing for them to do and saying it out loud or writing it down will feel huge and scary, especially if it is the first time saying it
- Let them know what you are going to do with the information
- Make a record of what has been shared
- Follow your internal safeguarding procedures
- Do not try to gather all the details
- At the end of the session, ask them how they are feeling
- Ensure they can access any immediate support they need

> **"Being listened to by my worker is the most important thing, if the worker is not listening to me it is like they are 'blind'."**
>
> Boy, age 19

It is important that you follow up with any disclosure of domestic abuse and that all domestic abuse involving a child is followed up as a safeguarding process. If a child or young person doesn't want you to tell anyone, explore why this is and what it is that they are worried about. It may be that there is a potential for further risk, and it is important to take this view into consideration when deciding with your Safeguarding Team what the next steps should be. However, this shouldn't prevent you from taking any action to safeguard a child or family from abuse. See Figure 9.

5.4 Looking after yourself

Working with cases where there is domestic abuse can be hugely upsetting, unsettling and can evoke a trauma response in any professional working with this subject, also known as vicarious trauma. It is important to make use of reflective spaces, such as supervision, to process these responses and to enable you to safely support others experiencing domestic abuse.

You may also need to make use of other resources offered by your employer, such as an Employee Assistant Programme. If the trauma symptoms persist, are affecting other areas of your life, or if you need support to process your own experiences of abuse, you could turn to your GP or private therapy to support you to process these experiences. The British Association for Counselling and Psychotherapy (www.bacp.co.uk/) may be a good place to start.

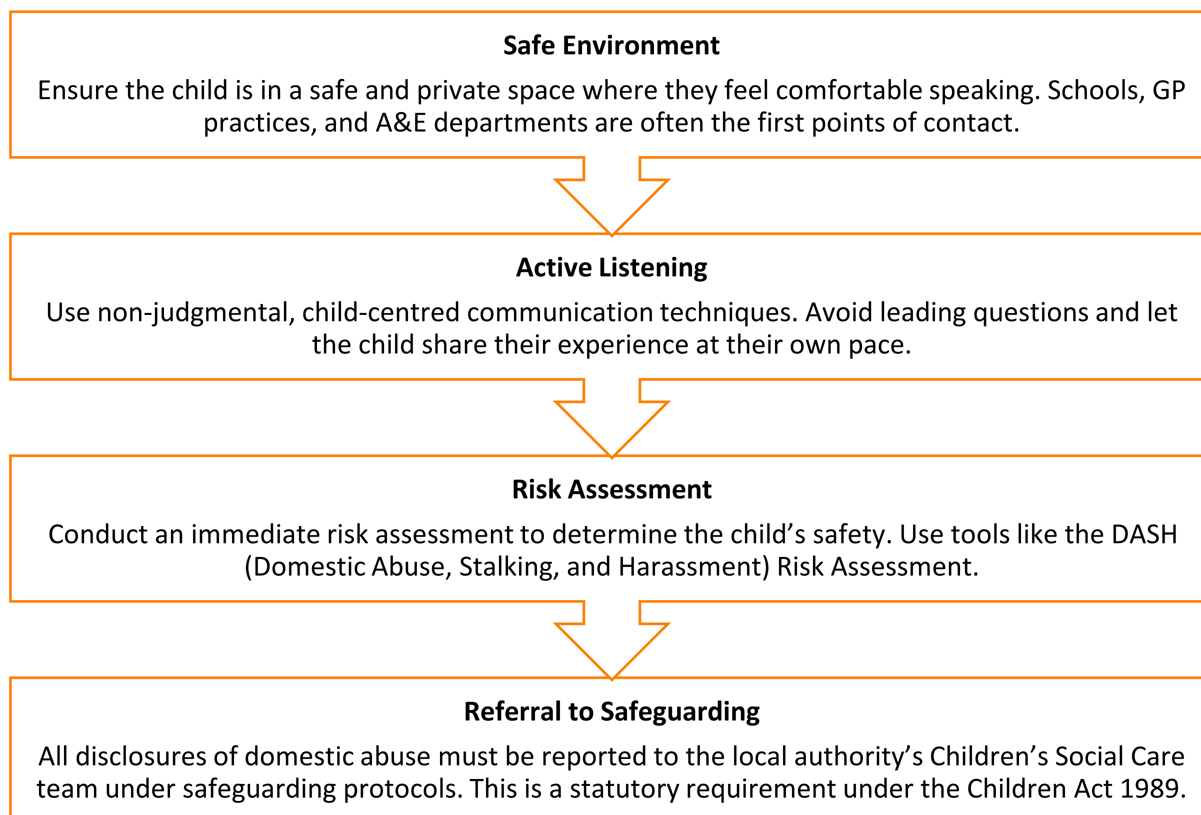

Figure 9: Responding to disclosures of domestic abuse

6 Identifying and Managing Risk

Working with child and young survivors often means working with ongoing risk of domestic abuse, particularly if the perpetrator is their biological parent. This can make risk assessment very difficult, and it can be tricky to navigate between what is known, what the family is sharing and what the child is saying.

Historically, risk assessment has focussed on risk of physical abuse from the perpetrator but increasingly risk of psychological harm and risks to a child's development are at the forefront of safe professional practice. A leading principle is that if someone is fearful, this should be acknowledged, and the fear needs to be believed and responded to as a form of harm in itself.

This also means listening to what a child or young person is telling you about any potential risks and keeping them in mind. If in doubt, speak to your safeguarding lead and consider the safest steps to take, to protect a child or other family members. Wherever possible, keep a child or young person informed about the steps you are taking and allow them space to share their thoughts or concerns.

6.1 Identifying Risk from Domestic Abuse

6.1.1 Risk from the perpetrator

Typically, risk assessment tools focus on the adult victim and are a good way of assessing risk to children. Some risk indicators to note, which may indicate high risk of harm to adult and child victim/ survivors are:

Separation. Have the adult perpetrator and victims recently separated?

Pregnancy. Is the adult victim pregnant?

Escalations. Are the incidents increasing in frequency and/ or intensity? Are there any threats to kill?

Cultural issues/ sensitivity/ isolation. Is the adult/ child victim particularly isolated due to their culture? For example, is there a lack of safe extended family? Language barriers? Or lack of recourse to public funds?

Stalking. Is the adult perpetrator stalking the adult victim/ family?

Strangulation. Has there been any incident of strangulation or choking?

Sexual assault. Is there any incident or history of sexual abuse/ assault?

If you are concerned that an adult is at risk from domestic abuse, ensure they are in a safe environment and then you can complete a DASH risk assessment with them directly (safelives.org.uk/resources-for-professionals/dash-resources). This tool can identify anyone at high risk of harm when used alongside professional judgement, and therefore when you need to refer to your local Multi-Agency Risk Assessment Conference (MARAC). If you are not confident in this process, you can call on support either within your organisation, from your local domestic abuse service or the National Domestic Abuse Helpline (www.nationaldahelpline.org.uk).

Domestic abuse should not be dealt with alone. A multi-agency response is needed and where children are in the home, or related to either the victim or perpetrator, then you will need to share information, ensuring their voice is presented and heard in the process. You will need to work with your local Multi-Agency Safeguarding Hub (MASH) and Social Care to coordinate support.

> **"You need to talk to the child about what you're planning to do. When my school counsellor told me 'I'm going to have to report this to Social Services', I was so scared. They didn't ask me about the risks, they just called my dad (perpetrator) straight away and he was so angry at me. Nobody thought to ask me what I wanted to happen, or listened when I said it wasn't safe to ring my dad. He just denied everything. After that, I felt a lot less safe. I was too afraid to share with anyone again."**
>
> Girl, age 19

6.1.2 Specific risk to children

As explored in previous sections, perpetrators of domestic abuse will often dominate the narrative at home, for example blaming the victim/ non-abusive parent for the abuse and making the child or young person feel that the safest place for them, is to be aligned with the perpetrator. This needs to be considered when exploring risks with a child directly, as it may impact the way in which they present their own assessment of risk.

Some indicators of ongoing risk are:

- Child/ young person is strongly aligning with their abusive parent
- Ongoing family court procedures
- Money is being withheld from the parent/ carer who is mainly responsible for the children
- Child/ young person does not have access to their usual clubs/ activities/ sports teams during contact time with one parent

- High conflict or violence apparently 'between' the parents (typically an indicator of coercive control-based domestic abuse, in which there is one perpetrator parent and one victim parent)
- Child/ young person engages in a pattern of abusive behaviours, eg. Emotional, physical or financial, towards their parent/ carer. This is sometimes referred to as CAPVA (Child and Adolescent to Parent Violence and Abuse)

To assess risk to older children experiencing domestic abuse, you can use a young person's DASH aimed at children aged 13 to 17 years using the same process as for adults (safelives.org.uk/resources-for-professionals/dash-resources).

6.1.3 Risk to self - Self-Harm and Suicidal Ideation

31% of under 18s who die by suicide were living in households where domestic abuse was present (Woodhouse, 2025). It is important for anyone working within mental health to have an understanding of domestic abuse, enabling better understanding of any underlying causes of suicidal ideation and self-harm.

Recent statistics show that more than 50% of people who die by suicide have had a history of consistent self-harm, with this being 2 – 3 times more common in females. Self-harm can begin at any age, and affects approximately 1 in 5 teens (Mental Health Foundation, 2025). It is important to remember that self-harm is a coping strategy and it is not reasonable to remove this before providing suitable replacement strategies for coping. If you are concerned a young person may be self-harming, you can ask direct questions, such as:

- Have you been engaging in, or felt like engaging in self-harm?
- Have you had suicidal thoughts or attempted suicide?
- What are your protective factors/what keeps you feeling safe?

William, aged 14 years

William's parents had separated three years ago, after many years of domestic abuse. During one incident, his dad physically assaulted his mum. William was referred to a specialist domestic abuse mentoring service due to poor school attendance, drug taking and violent behaviour towards his peers. School felt that this behaviour may be related to his previous experiences of domestic abuse.

It took several weeks to build trust with William, which often included games such as Jenga and Uno. During these games, William talked and often expressed anger at his mum, blaming her for what had happened to him and focussing on the limitations of her parenting, such as her forgetfulness and the fact that she struggled financially, at one point referring to her as 'useless'.

William knew that the support was being provided by a domestic abuse service and after several sessions with his mentor, he started to share what he felt were the reasons he was referred for this type of support. He shared memories from early childhood and of how he manages his emotions, which included taking drugs to cope with difficult feelings. As he explored these memories, he started to frame them differently, recognising his dad's behaviour and the impact that this had on his mum and on himself.

Throughout the support, William continued to have confused feelings about his dad, which he often explored with his mentor, who simply listened and validated his feelings. William also seemed to have developed a stronger relationship with mum, opening up to her more at home, and mum reported feeling that their relationship had vastly improved. After 12 weeks, the support came to an end and the Mentor felt that William had gained a healthier relationship with himself, his emotions and his mum.

6.2 Risk management tools

6.2.1 Safety plans for managing risk from perpetrators

Children and young people who have experienced domestic abuse will have intuitively developed their own safety plans for managing risk. Therefore, the best place to start with any safety plan is by asking how the young person manages risk already.

You can then explore and build on what they have already developed for themselves, providing useful contacts and sharing ideas that have worked for others that they may wish to try.

It is important not to tell any victim/ survivor of domestic abuse what they should do, as they know the perpetrator best and know what is likely or not likely to aggravate the situation and risk further harm.

Some key areas to explore in a simple risk assessment are outlined below:

Who can I speak to about how I am feeling, or if I'm feeling unsafe at home?	Example: A teacher or a relative.
Place of safety: Where will I go if I feel unsafe at home?	Example: Somewhere in the house, or a neighbour's house
What distractions do I have to keep me feeling safe and calm?	Example: Music, toys, a sibling's bedroom
Phone numbers for local support services, which can help you. (Remember, always call 999 in an emergency)	Example: Childline (www.childline.org.uk)
Family/ friends who I can call in an emergency	Example: Grandparents, aunt/ uncle, neighbour

For the adult/ parent victim, there are more detailed risk assessment examples. For one example, visit the Women's Aid website: https://www.womensaid.org.uk/information-support/the-survivors-handbook/i-want-to-leave-my-relationship-safely/#makingasafetyplan

6.2.2 Safety plans for managing risk to self

Safety plans can be used to help children and young people feel a sense of control over how they manage their own safety. These need to be reviewed and amended regularly with the young person as situations and feelings can change over short periods of time. Encourage them to fill this out themselves in their own writing and make copies so they can use this no matter where they are.

A safety plan may consider the following questions:

What will help you right now?	
What calms you down or calms your situation down?	
What will make your situation safer?	
Who can you talk to? Who is in your support system? Who can you go to for safety?	
What services can support you?	
What are your coping strategies? What can you do to distract yourself?	

6.2.3 If working directly with the perpetrator

Do not try to act as a mediator between family members. Whilst the perpetrator parent may demonstrate remorse, it is almost never safe to act as a go between in cases of coercive control-based domestic abuse. Perpetrators will tend to minimise the abuse and/ or blame others for it. Do not rely on their account of the abuse for risk assessment purposes.

There are national organisations that support perpetrators, and you can look to refer the individual to these specialist services. Always think about safeguarding, by reporting to police, children or adult social care where domestic abuse is disclosed.

It is also important to recognise that a perpetrator who threatens suicide may also pose additional risk to his victims. For example, family wipe out cases are most commonly associated with perpetrators who threaten suicide.

6.3 Onward Referral Pathways for Immediate/ Risk Based Support

6.3.1 Domestic Abuse Support

Where domestic abuse has been identified, the priority will typically be to manage risk via the non-abusive parent. In this case, it is always recommended to encourage access to a domestic abuse service. You can call the National Domestic Abuse Helpline, run by Refuge on 0800 2000 247 (www.nationaldahelpline.org.uk) or visit your local authority web pages to find a local service.

They may wish to take legal protections, such as non-molestation orders or child arrangement orders to manage risks from an ex-partner. Finding Legal Options for Women Survivors (www.flows.org.uk) provides a list of legal options for women and Rights of Women (www.rightsofwomen.org.uk) are useful if a woman's access to legal support, or legal needs are more complicated, for example women with no recourse to public funds.

6.3.2 Acute Mental Health Support

If there is a disclosure relating to self-harm, encourage them to identify their thoughts and feelings prior to engaging in self-harm and look at more positive coping strategies to use instead, this can include harm minimisation techniques, distraction techniques, resources designed to support them reduce these urges such as apps, helplines, websites, etc. Reiterate the importance of how to keep objects they are using to harm clean and how to use first aid if the wound is deeper or more significant than intended to be. Use safety plans to encourage control over their urges.

If there is a disclosure of suicidal thoughts or suicide attempts, ask them clear direct questions to ascertain level of risk. Use the following questions:

- Have you planned to end your life?
- Have you decided when and where you will end your life?
- Do you have everything you need to end your life?
- Have you had suicidal thoughts before or attempted suicide before?
- Do you know anyone who has attempted or died by suicide?
- Do you have anyone that you can talk to about this?
- What stopped you from attempting suicide before?
- Do you have any plans in the future that you are looking forward to?
- What are your coping strategies? What helps to keep you feeling safe?

Refrain from using language that may be offensive, such as saying “I understand” or “committed/commit suicide”, use “attempted/attempt/died by suicide” instead. Refrain from using guilt or shame to prevent suicide and ensure that you listen non-judgmentally, reassure them that help is available and try to help them feel hope.

Remember that confidentiality never applies to suicide – if there is risk to life then ensure you follow safeguarding policies and don’t deal with this alone.

For further information and advice on supporting someone who self-harms or feels suicidal visit the Mind website (https://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/supporting-someone-who-self-harms/).

For immediate mental health support, you can contact:

- Children and Young People Services (CYPS) Crisis Teams: In England, 24/7 Mental Health Crisis Assessment Hub, Mental Health Direct, and crisis teams provide 24/7 support for children and young people with acute mental health needs. This includes risk assessment, de-escalation, and short-term interventions. Contact number for all areas is 111 option 2.
- Emergency Services: If the child is at immediate risk of harm (e.g., self-harm, suicidal ideation), contact emergency services or take the child to A&E for urgent psychiatric assessment.

If there is an immediate risk of danger to life, call 999 or go to the nearest A&E department or call 111 option 2 for crisis triage support.

6.3.3 Long-Term Follow-Up

Alongside protecting the short-term safety of the child or parent, it is best to also consider the follow up options, particularly as waiting lists are often long.

For ongoing child/ young person support: Ensure the child is referred to Children and Adolescent Mental Health Services for long-term mental health support, including trauma-focused therapy (e.g., TF-CBT or EMDR).

For School-Based support: Work with schools to implement support plans, such as Individual Education Plans (IEPs) or access to school counsellors.

Monitoring and Review: Regularly review the child's well-being through multi-agency meetings, such as Child in Need (CIN) or Child Protection (CP) plans.

7 Support Strategies for Health Professionals

In February 2022, Kent County Council (KCC) commissioned Rising Sun to carry out research with children and young people and publish a report outlining their views on the support they wanted to receive around domestic abuse. The strongest theme in this research was that children and young people want to talk about their experiences with someone they can trust (Orchard and Lyttle, 2022)

This aligns with NICE guidance, which states that providers should:

- Address the emotional, psychological and physical harms arising from a child or young person being affected by domestic violence and abuse, as well as their safety. This includes the wider educational, behavioural and social effects.
- Provide a coordinated package of care and support that takes individual preferences and needs into account.
- Ensure the support matches the child's developmental stage (for example, infant, pre-adolescent or adolescent). Interventions should be timely and should continue over a long enough period to achieve lasting effects. Recognise that long-term interventions are more effective.
- Provide interventions that aim to strengthen the relationship between the child or young person and their non-abusive parent or carer. This may involve individual or group sessions, or both. The sessions should include advocacy, therapy and other support that addresses the impact of domestic violence and abuse on parenting. Sessions should be delivered to children and their non-abusive parent or carer in parallel, or together.
- Provide support and services for children and young people experiencing domestic violence and abuse in their own intimate relationships.

(NICE, 2014)

If a child is still living with the perpetrator, or still has a high level of contact, then we do not recommend attempting to explore the impact of abuse, and the practitioner should focus instead on managing the risk via the adults and supporting the child with distraction techniques. Once risks have been managed, it may then be safe to explore things further with the child.

> **“When I first met my worker we did some sessions in a room at a children’s centre but I didn’t feel comfortable there. My worker asked me what I needed and we agreed to meet outside to walk and talk. My worker was able to find the middle ground where I felt comfortable and we were able to do the work we needed to do.”**
>
> Boy, age 19

7.1 Trauma Informed Care

Trauma-informed approaches should always be used to support child/ young survivors of domestic abuse to avoid re-traumatisation. This includes creating a calm environment, validating the child's feelings, and avoiding unnecessary physical contact. Children have told us that what they want from their support is a space in which they are given time to build trust with non-abusive adults, using creative ways to express themselves at their own pace.

Trauma can have a long-lasting effect on child survivors of domestic abuse; on their mental health and their relationships. It can be caused by coercive control, amongst many other things, and can lead to behaviour which may seem harmful or counter productive. A trauma informed approach means recognising this behaviour as a response to trauma and a coping mechanism. The approach focusses on creating safety, building trust, offering choice, working collaboratively, developing knowledge and empowering survivors to help them make meaningful and lasting change to promote recovery.

> **"I found it easier to express myself whilst walking and moving my body in this way. In the past when I have met professionals in more formal environments indoors I have felt very uncomfortable. Sitting in a room and seeing just a plain room with a table and chairs makes me feel like I am being interrogated and I get a thought of "oh no I have to talk about something I don't want to talk about" I am really put off by this. I will then start having thoughts like "what is wrong with me?" "Why am I here?" "Why am I like this?" "Why can't I be normal?""**
>
> Boy, age 17

7.2 Creative Therapeutic Approaches

Tools such as creative therapy are effective, trauma informed disciplines that can support children in their recovery. Techniques that incorporate creative approaches can be used by anyone working with children, even those with the tightest restrictions on their time.

7.2.1 Forms of Specialist Creative Therapy

Creative therapy is a specialist form of psychotherapy and is effective in supporting child survivors of domestic abuse, often with complex trauma, due to long term exposure to coercive control and traumatic events in early years. Many of these professions are registered with the HCPC, or similar bodies and have protected titles. These include:

Art Psychotherapy or Art Therapy: Art therapy uses art as the primary mode of expression, alongside talking with an art therapist. It aims to reduce distress and improve social, emotional

and mental health by promoting insight, self-compassion and a sense of agency and selfworth (baat.org).

Dance Movement Psychotherapy (DMP): DMP recognises body movement as an implicit instrument of communication and expression. DMP is a relational process in which client(s) and therapist engage creatively using body movement and dance, as well as verbal and nonverbal reflection (admp.org.uk).

Play Therapy: Play Therapy is a type of therapy where play and art materials are used as the main way for people to express themselves. Using play in therapy helps people to express themselves in their own way; especially if they are struggling to understand how they are feeling, or are finding it hard to put their experiences into words (playtherapy.org.uk).

Dramatherapy: Dramatherapy is a form of Psychotherapy. Dramatherapists are both clinicians and artists that draw on their knowledge of theatre and therapy to use as a medium for psychological therapy that may include drama, story-making, music, movement, and art; to work with any issue that has presented itself (badth.org.uk).

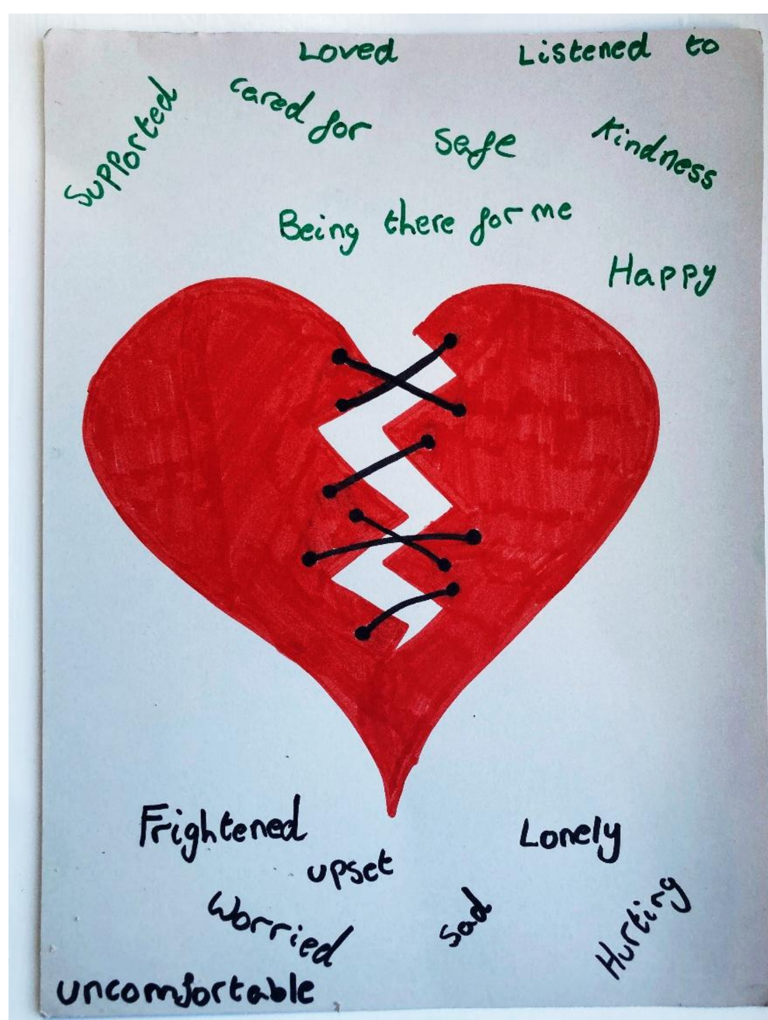

Figure 10: Girl aged 12 (2025) 'Support', felt tip on paper, 21x30cm

7.2.2 Embedding creative approaches to your support

Anyone can use creative techniques in their support with children and young people. For example, you could:

- Bring a supply of toys, such as animals or dolls for children to access
- Supply paper and crayons/ felt tips so that children can draw as they talk
- Use books and stories
- Use bubbles or sensory toys to distract and/ or sooth
- Have a sensory bag to hand, with things to touch, smell or listen to
- Bring a ball, to throw and catch, or take outdoors
- Have games like Jenga or Uno to hand

These tools can facilitate children to explore their feelings and develop a trusting relationship with professionals.

Figure 11: Anna Benner (2025) ‘Breathe’, still from animation

7.3 Distraction Techniques or Re-directive Techniques

Whilst working with the underlying causes of emotional distress can help in the long term, we know that children will not always be safe or ready to do this work and tools that can help with emotional regulation are also needed to help manage the neurological effects of trauma.

Some examples of distraction techniques can be:

- Breathing exercises
- Puzzles
- Music
- Drawing/ art
- Dance
- Exercise
- Television

These can be offered to a child as well as, or instead of other types of support. A child may not ever be ready or in the right space to explore their feelings around domestic abuse and it should never be forced.

Case Study

Amit, 6 years old

Amit used the process of play to explore his experience of domestic abuse through superhero figurines. The story played out week after week and featured fights, with the 'villain' attacking people and with people dying as a result. The villain was so strong that nobody could defeat them. The counsellor supported Amit over 12 weeks.

Throughout the support, the fights became increasingly intensive, however in the latter sessions, the villain started to lose. Towards the very end of the support, the fights stopped and Amit's play became calm. It was at this stage that Amit was able to verbalise his fears around going to his Dads house. He expressed how scared he was. The Counsellor completed a social services referral and they advised Mum not to send Amit to contact.

Case Study

Marta, 7 years old

Marta expressed her fears around her Dad through play. She would introduce a game where there was a family of bears. There was a scary Daddy bear and everyone would run and hide from him. Mummy bear was safe and everyone felt safe with Mummy bear in the game.

The key worker returned to this game each session, allowing Marta to lead the sessions, working always at her pace. After several weeks, she began to speak directly about her own feelings, until eventually, after around two months of working with her in weekly sessions, she shared that she hates her Dad; he shouts and she doesn't like visiting him.

8 Recovery Support for the Family

8.1 Support for the victim parent

Risk from domestic abuse can be complex, subtle and long lasting, which is why support from a domestic abuse service with specialist knowledge of domestic abuse and coercive control is always recommended to enable long term recovery. However, anyone can support a survivor of domestic abuse, so long as you are able to listen, empathise and take any risks seriously. If working therapeutically with a domestic abuse victim/ survivor, it is crucial to ensure the service and workforce has a strong understanding of intersectionality and oppressive power structures. Supervision is also essential to explore potential biases and barriers to empathy.

> **"Mother's and children's recoveries were deeply intertwined. When children made progress with their recoveries… then the children's progress also helped mothers to move forward… Similarly when mothers received support… these supports benefitted not only them but the children too."**
>
> (Katz, 2022, pp. 302-303)

8.2 Support for the perpetrator parent

If an abuser discloses their behaviour, acknowledge that disclosure is an important first step towards stopping abusive behaviour, and affirm any accountability shown by them. Their behaviour is a choice, and they can choose to stop. Be respectful and empathic, but do not collude. Acknowledge that any form of domestic abuse is wrong. Ensure this is clear and consistent. Remember that domestic abuse is a crime and needs to be taken seriously due to the high level of harm.

Perpetrators may try to avoid responsibility for their actions. They may blame their partner, stress, substance or alcohol use, etc. Be clear that violence and abuse is always wrong. Be aware that perpetrators may deny what is happening or they might minimise the level of the abuse. Do not rely on their account for risk assessment purposes.

Seek out specialist support for the victim of abuse if their partner is accessing a perpetrator programme (see safelives.org.uk/resources-library/supporting-families-practice-briefing-for-multi-agencies). You can also refer to Men's Advice Line (mensadviceline.org.uk).

8.3 Support for the whole family

In Emma Katz' (2022) proposal of the mother-child being considered as co-victim/ co-survivors, it also follows that there is rationale for both to be supported together, as a unit. Similarly, because of what we know about the perpetrator seeking to fragment the family unit, working with the whole family in their recovery is often beneficial. Whilst the perpetrator of abuse should not be included in this support, the facilitator should be trained to recognise and

shift the blame back to where it belongs: with the perpetrator's abuse tactics and behaviour, and not with the victims of abuse.

Non-abusive parents can also be brought into support in other ways, such as through joint assessments and review sessions with the child. Due to the nature of coercive control and its intention to fracture the mother-child bond, as a minimum, you should have these tactics in mind when working with children, and support the child's ability to also bring them to mind, shifting the blame and shame away from the abuse victims.

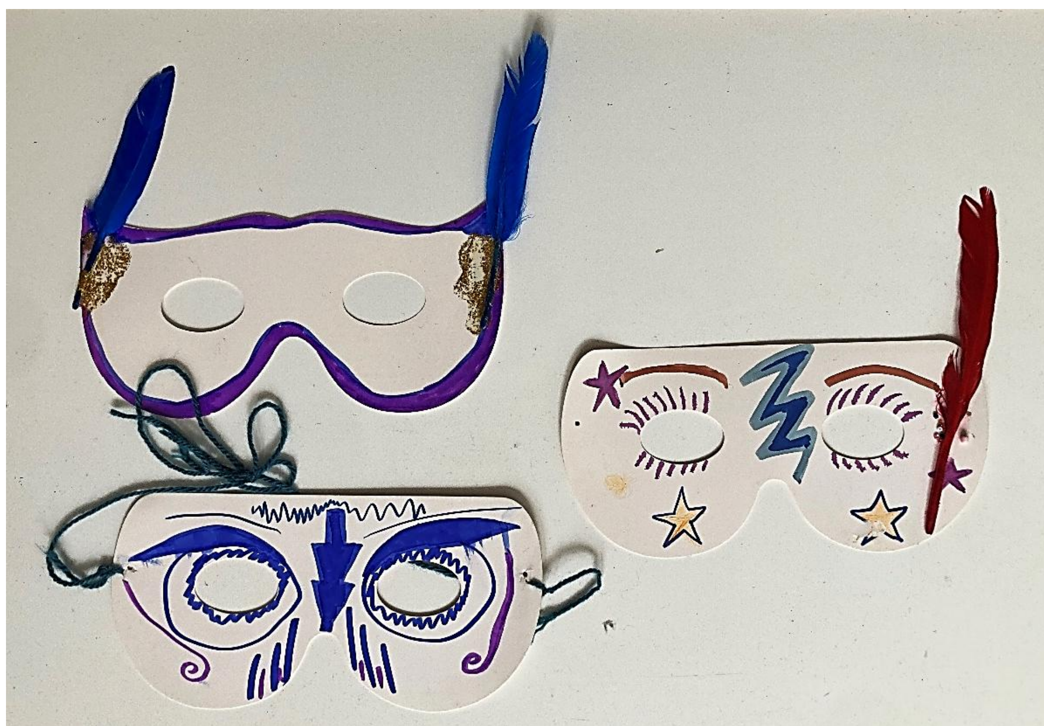

Figure 12: Left: Boy aged 7, 'Powerful', right, Mum, 'Super Mum'. String, feathers and felt tip on card, mixed sizes up to 21x21cm (2025)

9 Multi-Agency Collaboration

No single agency can respond to domestic abuse in isolation. Domestic abuse is a complex and multi-faceted issue that spans across all aspect of a families' lives. It will affect children and their parents differently and siblings will have unique experiences and needs in recovery from the abuse. The importance of sharing information, both internally with other relevant healthcare services and externally with relevant agencies such as charities or social care, cannot be overstated. Standing Together (2020) identify the importance of responding to the diversity of survivor needs through a coordinated response. They propose that a multi-agency response is the only way to address the intersecting needs of a child and their family.

9.1 Importance of a Coordinated Response

It is recommended that any health professional who receives a disclosure of domestic abuse shares this information with the patient's GP and considers if it is relevant to share with any other healthcare professionals involved in their care (Dheensa, 2020). It is often appropriate to refer to a specialist domestic abuse service, who can assess risk and consider further onward referrals. However healthcare professionals can also refer to safeguarding agencies, such as Children's Social Care, Adult Social Care or MARAC (Multi-Agency Risk Assessment Conferences) even without consent if concerned about the patient's safety. It is important to be familiar with local protocols and if in doubt, always record concerns and check them with the local safeguarding lead.

9.2 Collaboration with the non-abusive parent

When working with any child or young person, it is important to work alongside their non-abusive parent wherever possible. When working with cases of child abuse and neglect, NICE Guidelines (2017) recommend joint assessments with the non-abusive parent, maintaining a child centred approach, with consideration of all family members. Where there has been domestic abuse, it could be tempting to exclude physically absent perpetrators from risk assessments, particularly when abuse is felt to be non-recent or 'historic', as the parents have separated. This tends to focus safeguarding responses on mum's parenting, without considering the context of abuse and trauma.

"If the perpetrator is hellbent on maintaining control, they don't need the victim in physical proximity: they can control them through the system."

(Katz, 2022, p.199)

We know that parenting in the context of domestic abuse leaves a mother in a serious dilemma, with difficult choices to be made. It may lead to unintentional neglect, due to a mother's own trauma and her turning to coping mechanisms with unintended consequences, such as substance misuse. Her own mental health will inevitably be impacted as a result of abuse and blaming her for this, instead of holding responsibility with the perpetrator, is not helpful to the children and could impede the family's

ability to recover. Therefore a supportive, strengths based approach is needed to safeguard the family and provide additional support to promote recovery for the family unit.

Domestic abuse fractures the non-abusive parent and child relationships, therefore working to increase communication and understanding between the two is crucial for improving the emotional wellbeing of both.

9.3 Key Multi-agency Partnerships

There are a number of partnerships and protocols set up to support a multi-agency response and information sharing in cases of domestic abuse. There will be some variations across different regions, however the following are available country wide:

Multi-Agency Safeguarding Hubs (MASH): These hubs bring together professionals from health, social care, police, and education to coordinate responses to child safeguarding concerns.

Early Help Assessments: For less acute cases, an Early Help Assessment (EHA) can be initiated to provide coordinated support across agencies.

Information Sharing: Ensure information is shared securely and in compliance with GDPR and local safeguarding policies to protect the child's privacy and safety.

Multi-Agency Risk Assessment Conferences (MARAC): For high risk or suspected high risk cases of domestic abuse, bringing together key agencies including Police, Children's Social Care, Health and specialist Domestic Abuse services for a coordinated response.

9.4 Key Protocols and Frameworks in England

Working Together to Safeguard Children (2023): Statutory guidance on inter-agency working to safeguard and promote the welfare of children. Available here: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

NICE Guidelines (NG76): Recommendations for domestic violence and abuse, including identification, risk assessment, and referral pathways. Available here: https://www.nice.org.uk/guidance/ng76

CYPMHS Tiered Model: A four-tiered model of mental health support, with Tier 3 and Tier 4 providing specialist and crisis interventions. Available here: https://www.england.nhs.uk/wp-content/uploads/2018/04/mod-camhs-tier-2-3-spec.pdf

THRIVE Framework: Sets out a multi-agency approach to responding to individual needs of a child or young person in relation to their mental health and wellbeing. Available here: https://implementingthrive.org/about-us/the-thrive-framework/

Glossary of Terms

ACEs: An acronym for Adverse Childhood Experiences, meaning traumatic events occurring before the age of 18, including domestic abuse that can have long-lasting effects on health and well-being.

CAPVA – An acronym for 'Child and Adolescent to Parent Violence and Abuse' describing when a child or young person engages in a pattern of abusive behaviour towards a parent or carer

Child Protection Services: Government agencies responsible for ensuring the safety and welfare of children, particularly in cases of abuse or neglect.

Coercive Control: A pattern of controlling behaviour that restricts a partner's freedom and autonomy, often involving psychological manipulation, intimidation, and isolation.

CYPS: Children and Young People's Services.

CYPMHS: Children and Young People Mental Health Services.

Domestic Abuse: A pattern of controlling behaviour and abuse by one partner towards another in an intimate relationship, which can include physical, emotional, psychological, financial, and sexual abuse.

DARVO: An acronym for "Deny, Attack, and Reverse Victim and Offender," a tactic used by perpetrators to manipulate situations and portray themselves as victims.

DASH: An acronym for "Domestic Abuse Stalking Harassment", this is a risk assessment tool used to assess level of risk posed by the perpetrator to a victim, undertaken through answering a series of questions.

ELS: An acronym for Early Life Stress, a term used to describe traumatic events experienced as a child such as domestic abuse.

Emotional Abuse: A form of abuse characterised by behaviour that undermines an individual's sense of self-worth or emotional well-being.

Economic Abuse: A form of domestic abuse where one partner controls the other's access to financial resources, limiting their ability to support themselves.

MARAC: An acronym for 'Multi-Agency Risk Assessment Conference'; a meeting whereby any cases assessed to be high risk due to domestic abuse is discussed and actions assigned to various agencies.

Mental Health Crisis: A situation in which an individual experiences severe mental health symptoms that may pose a risk to themselves or others.

Mental Health Indicators: Signs and symptoms that may indicate a child or young person is struggling with their mental health, including anxiety, depression, and self-harm.

Multi-Agency Collaboration: Cooperative efforts among different organisations and professionals to address complex issues, such as domestic abuse, ensuring a comprehensive response to the needs of those affected.

Neurobiological Impacts: Changes in brain development and function resulting from exposure to trauma, which can affect emotional regulation and behaviour.

Non-abusive Parent: The parent or caregiver who is motivated to put the child's interests first, often before their own and who takes an interest in the child's interests and needs.

Perpetrator: The individual who commits acts of domestic abuse or violence against another person.

Post-Separation Abuse: Ongoing abuse that occurs after a victim has left an abusive relationship, often involving harassment or manipulation of custody arrangements.

Safeguarding: The action taken to promote the welfare of children and protect them from harm, including abuse and neglect.

Trauma-Informed Care: An approach to treatment that recognises the impact of trauma on individuals and seeks to create a safe and supportive environment.

Victim/ Survivor: An individual who has experienced harm as a result of domestic abuse or violence.

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List of Support Services

BACP
British Association for Counselling and Psychotherapy is a professional association for members of the counselling professions in the UK: www.bacp.co.uk

Childline
Free national counselling service for children and young people: www.childline.org.uk

FLOWS
National organisation providing legal options for women survivors of domestic abuse: www.flows.org.uk

Men's Advice Line
National support for male victims of domestic abuse: www.mensadviceline.org.uk

Mind
National organisation to support anyone with their mental health: www.mind.org.uk

National Domestic Abuse Helpline
National helpline for any survivor of domestic abuse, professionals or third parties needing support: www.nationaldahelpline.org.uk

Phoenix Group
Support groups for survivors of domestic abuse based in Kent: www.phoenixgroups.uk

Respect
National organisation to support male victims and perpetrators of domestic abuse: www.respect.org.uk

Rights of Women
National organisation providing legal advice, information and support for women including domestic abuse, family law and immigration: www.rightsofwomen.org.uk

SafeLives
National organisation that provides training, tools and resources for risk assessment and management of domestic abuse: www.safelives.org.uk

Women's Aid
National organisation campaigning and developing resources to support survivors of domestic abuse and prevent future abuse: www.womensaid.org.uk

Authors

Ingrid Sanfey, Head of Children and Young People Services, Rising Sun

Ingrid has worked as Head of Children and Young People Services at Rising Sun for over 4 years and is an HCPC registered Art Psychotherapist, graduating from Goldsmiths University (MAAT) in 2024. She has worked in the Violence Against Women and Girls (VAWG) sector for 15 years in various roles including as a qualified Independent Domestic Violence Advisor (IDVA), IRIS Advocate Educator and as VAWG Coordinator for a London Borough. Her previous roles with children and families range from overseeing the implementation of a whole school approach to mental health across Derby City council and more recently as an Art Psychotherapist working with children, adolescents and parents.

Claire Cortez, Senior Primary Care Mental Health Practitioner & Independent Nurse prescriber, Canterbury North and South PCN

Claire is an experienced mental health professional with a career in both secondary and primary care settings. She currently serves with the Kent and Medway NHS and Social Care Partnership Trust (KMPT) and within primary care mental health services across GP practices. Claire holds a Master of Science in Deprivation of Liberty Safeguarding (MSc DoLS) and a Master of Science in Advanced Clinical Practice (MSc ACP), alongside a Postgraduate Diploma in Psychotherapy. She is also a qualified Registered Mental Health Nurse (RMN), with a foundational degree in Mental Health Nursing. She has postgraduate training in mental health and ADHD, with a special interest in Neurodivergence and women's health.

Kristina Massey, Senior Academic Tutor for Psychology, Canterbury Christ Church University and Rising Sun Trustee

Kristina graduated with an MSc (Hons) degree in Forensic Psychology 2004. After completing her MSc (Hons) in Addiction Psychology and Counselling she worked for the NHS as a Highly Specialist Alcohol Therapist and is a Senior Accredited member of the British Association for Counselling and Psychotherapy. A large part of her work for the NHS involved facilitating therapy groups for women that have experienced sexual and domestic abuse. Since 2012 she has researched with Professor Horvath of University of Suffolk and coauthored "Basically... porn is everywhere" An assessment of the Effects of Pornography on Children and Young People, funded by the Office of the Children's Commissioner in 2013. She was part of the Operation Soteria Team, an end to end exploration to police responses to rape allegations which is currently changing the way the police investigate rape and serous sexual assault. She trains Kent Police in effective ABE interviews, how to best support victims of sexual violence, Jane Monckton Smith's 8 Stage Homicide Model in Domestic Abuse.

Chantelle Willows, Services Manager, Mid-Kent Mind

Chantelle started working with Mid-Kent Mind as a Wellbeing Coach and now as a Services Manager, supporting children, young people and adults with their mental health and wellbeing. Chantelle completed a BPS accredited Psychology BSc with first class honours,

and also a MSc in Foundations to Clinical Psychology at Canterbury Christ Church University. Her previous experience includes supporting and teaching children and young people with Down's Syndrome, focusing on communication, wellbeing, and smiLE therapy. During her BSc, Chantelle was recruited as a research intern in Public Health to conduct a scoping review on how lockdown impacted the mental health of children and young people, focusing on marginalised communities. Chantelle has a keen interest in trauma-focused care, understanding how the brain can impact behaviour particularly in young people and their neurodevelopment.

Peer Reviewers

With thanks to the following individuals for their honest feedback, valuable suggestions and precious time.

Dr Emma Katz, Senior Lecturer in Criminology, Edge Hill University

Joanne Baldwin, CYP Service Manager, Oasis Domestic Abuse Service

Robert Barton, Primary Care Mental Health Practitioner, Canterbury Primary Care Network

Children and Young People Team, Women's Aid

Dr Christopher Ellis, General Practitioner39, Northgate Medical Practice

Sue Mullin, Children's Mental Health Commissioner, NHS Kent and Medway

Nikki Naziri, Head of Domestic Abuse Safe Accommodation Support Service for Children and Young People, SALUS

Ben Sims, Physiotherapist, Canterbury Primary Care Network

Tamara Whiting, Advanced Liaison and Diversion Practitioner, Liaison Diversion and Reconnect Service (KMPT)

Tim Woodhouse, Kent and Medway Suicide Prevention Programme Manager

01227 452852

admin@risingsunkent.com

risingsunkent.com

Rising Sun

PO Box 1229, Canterbury, CT1 9TZ

Charity Number 289253

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