TOWARDS A RICHER UNDERSTANDING OF SCHOOL-AGE CHILDREN’S EXPERIENCES OF DOMESTIC VIOLENCE: THE PERSPECTIVES OF CHILDREN AND THEIR MOTHERS

by

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July 2011

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ACKNOWLEDGEMENTS

Clinical training has been such a journey and one which I feel extremely privileged to have travelled. I would like to thank members of the course team for their support during training. A special thanks to Arlene Vetere, Susan Howard and Mary John who have guided and inspired me throughout. To all my placement supervisors I would like to say thank you for giving me such wonderful learning opportunities. I would also like to thank the clients I have worked with for all they have taught me.

This experience would not have been the same had it not been for a special few fellow trainees. Laura, Reena and Claire, I feel honoured to have gone through this journey with you and so unbelievably lucky to have made such amazing friends along the way.

Thank you so much to my family and friends for their love and support during training. Mum and dad, thank you for helping me to achieve my potential and for always believing in me. To my friends, thank you for making me laugh and keeping me sane.

Finally, I would like to say thank you to Matt. Words cannot describe how grateful I am for all the support, understanding, patience and love you have given me over this time. You are my rock and without you I would have been lost.
INTRODUCTION TO THE PORTFOLIO

This portfolio contains a selection of work completed during the Doctorate of Psychology (PsychD) clinical training course. This includes an academic dossier, a clinical dossier and a research dossier. Within each dossier, the work presented is in the order in which it was completed to illustrate the development of clinical, academic and research skills over the duration of training. This portfolio also demonstrates the range of client groups, presenting problems and psychological approaches covered during the course.

In order to maintain anonymity and confidentiality, all the names used in this report are fictitious and some of the details have been altered.

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Edition 20(5) of the Psychologist had a Picture on its Front Cover of the DSM IV Burning. What Issues Might this Raise for Service Users, Psychiatrists, Clinical Psychologist and You?

December 2008
Introduction

The Diagnostic and Statistical Manual of Mental Disorders (DSM) continues to be widely used by health professionals around the world as a tool for diagnosing individuals suffering from mental distress. However, despite its popularity, there has been a long standing debate regarding the appropriateness of psychiatric diagnosis and the use of such diagnostic tools. Recently, many of these concerns were brought to the fore in a special edition of 'The Psychologist' which presented a series of articles reviewing the reliability, validity and usefulness of diagnosis in mental health. In addition to the articles themselves, a further striking feature of this edition was a powerful and thought provoking depiction of the DSM-IV burning on its cover.

After reading the articles in the special edition and other related literature, I became aware that the image of the DSM-IV burning could be interpreted in many ways. In order to address the issues raised by this image, I felt it was imperative to consider what this image meant to me. My interpretation was that both the use of diagnostic manuals such as the DSM-IV and the whole concept of diagnosis in mental health were being challenged. In particular, I found myself becoming increasingly influenced by three overarching criticisms levelled not only against the DSM-IV, but also against the underlying approach that it implicitly supports. These three criticisms surround firstly the notion that the DSM-IV endorses a biomedical model of mental health; secondly the concept and construction of 'mental abnormality'; and finally the validity and reliability of the DSM-IV's classification system.

I feel that these three overarching criticisms, although interlinked, raise fundamentally different issues for a variety of professionals and individuals who use mental health services. Based on this rationale, the current essay will first introduce the DSM and briefly outline its role within diagnosis. The three criticisms described above will then be considered in turn, with particular reference to the issues each raises for service users, psychiatrists, clinical psychologists and myself. Finally, I feel it is important to end the essay by considering what can be done to address some of the issues raised. After all, the depiction of the DSM-IV burning raises many difficult questions, which cannot be easily addressed. The final section will therefore briefly discuss some of the alternative directions diagnosis might take in the future.
The DSM and its Influence

Efforts to classify psychopathology date back to Hippocrates, with the labelling of mania and paranoia, to which he attributed the imbalance of the four humours (Nathan, 1998). However, it was not until the 1950's that a uniform diagnostic manual was developed; it was branded the Diagnostic and Statistical Manual for Mental Disorders (DSM). Since the launch of the DSM, the number of disorders has steadily increased from 106 to 357 (Blashfield & Fuller, 1996). The most recent edition, the DSM-IV, was published by the American Psychiatric Association (APA) in 1994, and has since been revised to form the DSM-IV (APA, 2000). The DSM-IV (APA, 1994) claims to be a multi-axial system evaluating the existence of clinical disorders; underlying personality disorders or mental retardation; general medical condition; psychosocial and environmental conditions; and global assessment of functioning.

The DSM-IV, like its predecessors, has had a profound and widespread influence for several reasons. Not only is the DSM-IV used extensively in clinical settings around the world, but is also frequently used by both insurance companies to assess claims, and by teachers seeking to educate the public about psychopathology (Sarbin, 1997). Moreover, the DSM has introduced a standardised terminology used by professionals as a form of short hand (Seligman et al., 2001). Research has also benefitted greatly from the diagnostic criteria outlined in the DSM-IV, as researchers have been able to secure funding and design studies exploring the aetiology and treatment of specific mental disorders (Sarbin, 1997). Indeed, the DSM system is now so deeply entrenched within mental health, that some authors have suggested that in order to maintain credibility, practitioners must be seen to be using the DSM-IV diagnostic criteria (Sturkie & Bergen, 2001). Whilst I will refer primarily to the DSM, many if not all of the issues raised in the current essay are also applicable to other diagnostic manuals.

Having introduced the DSM, this essay will now present three overarching criticisms relating to the assumption of a biomedical model; the promotion of the concept of abnormality; and the poor reliability and validity of its classification system. Within each of these sections, the issues raised for service users, psychiatrists, clinical psychologists, and myself will then be discussed in detail.
A Biomedical Explanation of Mental Illness

Although the DSM-IV includes disclaimers which assert that no assumptions are made regarding the particular aetiology of disorders, many have argued that the language used within the DSM-IV promotes the biomedical model of mental illness. The use of terms such as 'symptoms' imply an underlying neurological or biochemical cause (e.g. Sarbin, 1997). Moreover the apparent disregard for what is happening in the wider social or family context is consistent with a reductionist biomedical framework. However, for psychological disorders there are no concrete biological tests which can provide a diagnosis similar to that of physical disorders such as HIV or cancer. Moreover, it is felt that the biomedical model has proved largely inadequate in explaining psychological distress (e.g. Boyle, 2007). Consequently, the DSM-IV has attracted criticism in recent years for adhering to an ideological premise which lacks the empirical data to support it (Double, 2003; Sarbin, 1997).

A biomedical explanation of mental distress can also be challenged by looking at the effectiveness of pharmacological treatment and the current direction of government health policies. With regard to pharmacological treatment of mental disorders, research has indicated that many service users fail to obtain little or any benefit from medication (e.g. Brown & Herz, 1989; Patten, 2004). Even when research has provided evidence that certain drugs used to treat mental disorders have toxic effects (Moncrieff, 1997) and cause abnormal brain states (Moncrieff & Cohen, 2006) they still continue to be prescribed. Nevertheless, government health policy appears to be shifting away from a biomedical approach. The National Health Service (NHS) Plan (Department of Health, 2000) places particular emphasis upon the social, economic and cultural context of health care; elements frequently neglected when diagnosing within a biomedical framework.

Issues for Service Users

The implicit endorsement of the biomedical model by the DSM-IV raises a number of issues for service users. Characterising mental disorders as biological could lead service users to believe they are powerless to do anything to overcome their distress. A biomedical characterisation could reduce the service user to a mere body in need of a 'biological treatment', and neglect the meaning of a person's distress within the context of their lives (Double, 2002). However, Thomas and Bracken (2004) point out that whilst some service users find a biomedical characterisation infuriating and disempowering, others find it somewhat comforting as it provides a concrete explanation of their distress. Given the
extent to which the biomedical explanation has filtered into the public understanding of mental distress, service users might feel pressured or obliged to accept drug treatments. Moreover, the recent criticisms of pharmacological interventions could also leave service users feeling confused about which treatment option to pursue and concerned about the long term adverse effects. The NHS Plan (Department of Health, 2000) suggests that service users should be considered as active agents of their distress within the context of their social and cultural system. If this is not implemented, service users could become disillusioned with professionals or services, and as a consequence, may avoid seeking help. It is therefore clear that for service users one of the most important issues raised is how they can have their distress understood in their own terms given that the dominant diagnostic manual continues to endorse a biomedical model.

**Issues for Psychiatrists**

The challenge levelled against a biomedical explanation of mental distress casts doubt over the future role of psychiatrists. Psychiatrists are primarily trained as medical practitioners to operate within a biomedical framework, which views diagnosis and pharmacological treatments as integral (Moncrieff & Cohen, 2006). It therefore appears that psychiatrists benefit from a biomedical explanation of mental disorders and thus have a vested interest in this explanation being maintained and promoted. However, confidence in the ability of a biomedical framework to predict and treat mental distress appears to be diminishing. Bracken and Thomas (2001) comment that psychiatry will need to evolve and take on board alternative perspectives of distress including putting a greater emphasis on psychosocial context. However, some psychiatrists have voiced growing frustration regarding the limitations of the biomedical approach in diagnosing and treating mental illness, and are beginning to look at alternatives to drug based interventions (Moncrieff, 2007). I therefore feel that for psychiatrists, the crucial issue is how they react to the criticisms raised as this could prove to be an exciting opportunity to transform their profession.

**Issues for Clinical Psychologists**

Any shift away from a biomedical perception of mental illness, may have profound implications for clinical psychologists. Because they tend to be trained and work within a biopsychosocial model, which views distress in a more holistic way, their role may expand, with greater emphasis being placed on psychological therapies. This shift is illustrated by The New Ways of Working for Everyone agenda (Department of Health, 2007) which proposed that applied psychologists should provide management, leadership and research
and conduct less direct work with service users, taking on only those with more complex needs. Within this initiative, clinical psychologists are seen as integral to the implementation of this service innovation and are expected to lead in the implementation of new service models. As a result of this shift in emphasis, clinical psychologists may not only have to take on greater responsibility, but also have to adapt to the changing public perception, both of their role and of mental distress.

Issues for Myself

From my perspective as a trainee clinical psychologist, I feel that I have entered the profession at an extremely exciting time. The policy changes outlined above put clinical psychologists at the forefront of innovative change in mental health and I was struck by how important it is to be actively involved in this. However I am also apprehensive that the greater managerial responsibilities given to clinical psychologists as a result of government initiatives may place a considerable strain on existing resources. Consequently, I feel that it is important that adequate funding is made available both for the training and supervision of clinical psychologists and for the provision of continuing professional development. Moreover, I feel that the criticism raised above promotes a biopsychosocial model of mental distress. I therefore feel privileged to be training within a framework which looks at distress from a variety of angles, and advocates the views of service users. Conversely, I feel that the biomedical aspect of mental health should not be disregarded and that research and practice should be focused proportionately upon biological, psychological and social factors involved in the development, maintenance and treatment of mental distress.

The Concept and Construction of Mental Abnormality

Having considered the problems associated with a biomedical characterisation of mental distress, I will now critique the concept and construction of abnormality endorsed by the DSM-IV. The DSM-IV defines a mental disorder as “a manifestation of a behavioural, psychological, or biological dysfunction in the individual” (APA, 1994, pp. xxi-xxii). The use of the term ‘dysfunctional’ within this definition has been seen to imply that mental disorders are a distinct ‘abnormal’ phenomenon compared with the rest of the ‘normal’, ‘functional’ population (e.g. Widiger & Sankis, 2000). However, some authors have criticised the categorical conceptualisation adopted by the DSM-IV on the grounds that it is virtually impossible to know where to draw the line between supposedly normal and abnormal behaviours (e.g. Wakefield, 1997). For example, by omitting uncomplicated bereavement as a criteria needed to meet a diagnosis of major depressive disorder (APA,
there is a presumption within the DSM-IV that low mood as a result of a loved one dying represents a normal 'healthy' response to a negative event. However, Wakefield (1997) points out that there is no exclusion for low mood as a result of other similar uncomplicated negative life events. Thus, the categorical characterisation of mental distress as either normal or abnormal adopted within the DSM-IV, is inherently problematic.

One might expect the conceptualisation of mental distress in the DSM-IV as 'abnormal' to be based on rigorous scientific foundation. However, it has been suggested that rather than being derived from scientific methodology, psychiatric diagnoses are constructed to label individuals who display unwanted conduct, thus serving the political agenda of the time (e.g. Kutchins & Kirk, 1997; Sarbin, 1997). Each new edition of the DSM has seen an increase in the number of disorders; a trend taken by some critics as further evidence that diagnosis serves as a political tool rather than constituting scientific discovery (Rogler, 1997). The classification of homosexuality is perhaps one of the most compelling illustrations that DSM classifications are socially constructed (e.g. Kutchins & Kirk, 1997). Early editions of the DSM referred to homosexuality as a category of disorder, however in response to growing social acceptance, homosexuality was removed in 1974. Thus, it is apparent that the decision whether to include or exclude diagnoses from the DSM relies not on science but rather on beliefs and values evident in society at that time. Moreover, certain diagnoses appear to be culture specific, with many mental disorders in the DSM-IV reflecting intrinsic Western values (Widiger & Sankis, 2000). Kirmayer et al. (1995) suggested that in a Western society, a woman who is housebound could be diagnosed with agoraphobia, whereas, within a Muslim culture this might be considered normative behaviour. Therefore, the way in which we view behaviours as either normal or abnormal appears to be strongly influenced by cultural and social context.

Issues for Service Users

The categorical perception of so-called mental illness that is endorsed by the DSM-IV implies that service users are qualitatively different from the rest of the population. It is apparent that by treating mental distress as such, service users who have been diagnosed with a DSM-IV disorder are effectively being labelled as 'abnormal'. The labelling of individuals with mental health issues has previously resulted in stigma, which can lead to discrimination in terms of employment, housing, medical insurance and care (e.g. Holmes et al., 1999). Individuals or families can also be left feeling extremely disempowered, leading to shame, low self-esteem and self-fulfilling prophecies (e.g. Wahl, 1999). Service
users could feel that this conceptualisation contributes to the stigmatisation of their distress leading them to mistrust mental health services that work within a diagnostic framework. This notion could account for the findings that only one third of those with mental health problems seek treatment (Kessler et al, 1996; Hinshaw & Cicchetti, 2000). Indeed, this suggestion represents an interesting hypothesis for future research. Moreover, the historical inclusion of homosexuality as a DSM disorder raises the further issue of whether behaviours that are presently considered disorders will continue to be regarded as abnormal in the future. Being branded as abnormal due to the changing and questionable value systems within a society, is likely to leave some service users feeling extremely frustrated and cause or exacerbate distress.

**Issues for Psychiatrists**

The criticism against the concept and construction of mental distress could raise a number of ethical issues for psychiatrists. For instance, some authors have suggested that by labelling certain behaviours as disorders, psychiatrists are ultimately expanding their earning power (Kutchins & Kirk, 1997). In addition, the antipsychiatry movement (e.g. Szasz, 1974) proposed that psychiatrists use diagnosis as a method of expanding their treatment domain and that psychiatry is a medically camouflaged form of social control (Wakefield, 1997). These suggestions raise the issue of whether psychiatrists have a vested interest in psychiatric diagnosis that could impair their judgement and lead to exploitation of a client. Whilst these authors advocate extreme views, it remains unclear how psychiatric diagnosis will be conceptualised in the future and what role psychiatrists will play within this. It has been suggested that psychiatry will need to move towards ‘postpsychiatry’ which strives to use the conceptual criticisms levelled against psychiatry in order to develop new ways to categorise mental distress in the future (Bracken & Thomas, 2001). Psychiatrists may therefore need to re-evaluate the concept of mental abnormality and challenge the value systems behind the categorisation of mental distress.

**Issues for Clinical Psychologists**

For clinical psychologists, even if they refrain from assigning the diagnostic labels provided by the DSM-IV, they may use the language of diagnosis, possibly resulting in negative consequences for service users. This highlights the need for clinical psychologists to be mindful of the language they use when discussing a clients distress. For example, Horn et al. (2007) suggested a number of ways that clinicians could adapt their practice in relation to service users being diagnosed with Borderline Personality Disorder (BPD). These include
discussing diagnosis in a manner more constructive to the service user; externalising the diagnosis; clear communication that individuals do move on from the diagnosis; and letting service users’ views of their difficulties take priority over the diagnosis. For clinical psychologists, the issue arises as to how they manage a deeply engrained diagnostic system, within a profession which advocates formulation of distress rather than labelling.

Given the deeply entrenched use of DSM and diagnostic terminology within mental health, clinical psychologists face a difficult dilemma: On the one hand clinical psychologists wish to promote formulation, but on the other hand they have to work within the existing system, which may necessitate the use of DSM terminology to maintain credibility or secure funding. Indeed, I will discuss the importance of formulation in greater detail below when looking at the criticism levelled against the reliability and validity of the DSM-IV’s classification system. Finally, it is worth noting that for clinical psychologists the notion that DSM-IV disorders reflect Western values highlights the issue of whether applying Western diagnoses to individuals from other cultures is appropriate. It is apparent from the above criticism that mental health professionals need look beyond their own value and judgement system when assessing and treating service users.

Issues for Myself

The criticisms raised against the concept of abnormality leaves me feeling extremely undecided about diagnosing in mental health. On the one hand I have come into contact with a number of service users who report feeling comforted by being given a diagnosis that seemingly provides an explanation for their discomfort. However, my previous experience has also shown me that diagnosing can have significant negative implications for service users: Whilst conducting a self-harm reduction programme in a female prison, I noticed that health professionals and prison staff showed a reluctance to work with individuals who had been diagnosed with BPD, claiming that they were ‘difficult’ and ‘incurable’. This experience has left me particularly sensitive to the dangers of categorical diagnosis and the stigma attached to certain labels. Consequently, I now favour viewing mental distress on a continuum rather than as a categorical illness.

The Reliability and Validity of the DSM-IV

The image of the DSM-IV burning not only symbolises challenges to the theoretical underpinnings of the DSM-IV and the wider concept of diagnosis, but may also be taken as a critique of the reliability and validity of the classification scheme outlined. For psychiatric
diagnosis to be reliable there would need to be diagnostic consistency across professionals. However, studies which have looked at the DSM-IV’s reliability have found that if clinicians are not on the same site then reliability is poor (e.g. Buysse et al., 1994; Zinbarg et al., 1994). In addition, the DSM-IV states: “The exercise of clinical judgement may justify giving a certain diagnosis even though the clinical presentation falls just short of meeting the full criteria” (APA, 1994, pp.xxiii). Given that the developers of the DSM-IV are striving for greater reliability, it appears contradictory that the APA advocates using the diagnostic criteria as mere guidelines to be informed by clinical judgement.

Questions have also been raised regarding the validity of the DSM-IV’s classification system. In other words, several authors have questioned the extent to which the taxonomy of supposed mental disorders accurately describes the mental distress seen in service users (e.g. Bentall, 2003; Boyle, 2007). In order for a classification system to be valid, one would expect two things; firstly that every person with psychiatric complaints would meet the criteria for a diagnosis; and secondly that they would only meet the criteria for one disorder, unless very unfortunate (Bentall, 2003). However, individuals are frequently given dual diagnoses such as depression with mild anxiety or attention deficit hyperactivity disorder in combination with bipolar disorder (Boyle, 2007). Furthermore, there is little empirical data to support the classification system outlined. Rather, classifications are based on professional consensus rather than on scientific research (Sarbin, 1997). Therefore, it appears that there is considerable subjectivity involved in deriving classifications.

Issues for Psychiatrists

The above criticism levelled against the DSM-IV, raises the question of whether anyone can ever be competent to diagnose using this manual, given the lack of consistency in assigning psychiatric diagnoses. This issue is particularly significant for psychiatrists as a large part of their role involves assigning DSM-IV diagnoses. In addition, the problems with reliability raise a potential ethical issue, insofar as diagnosis can be misrepresented. Danzinger and Welfel (2001) found that 44% of clinicians would, or had already changed a client’s diagnosis so that they would be eligible for managed care funding. It has been pointed out that the endorsement of subjective clinical judgement enables clinicians to rationalise diagnosing for convenience, which can lead to sidestepping restrictions and assigning more serious diagnoses so that the client could continue therapy (Sarbin, 1997). The use of the DSM by psychiatrists may therefore necessitate rigorous ethical guidelines.
Issues for Clinical Psychologists

Clinical psychologists are perhaps less affected by the DSM’s poor validity and reliability than psychiatrists, due to the dominant use of formulation in their profession. Formulation is a method used to relate theory to practice and should take into account cognitive, behavioural, affective and physiological factors as well as the social, cultural and historical context in which an individual operates (Goldfried, 1995). Nevertheless, clinical psychologists do still rely upon the DSM-IV classifications when conducting research and designing therapeutic interventions. Clinical psychologists are trained within a scientist-practitioner model (Shapiro, 1967), which posits that clinical practice should be informed by rigorous research and vice versa. However, the challenges outlined above might raise concerns over the interpretation of both the research findings and the treatment interventions derived. Thus, whilst clinical psychologists may promote formulation, they may be affected by the DSM’s poor reliability and validity in their role as scientist-practitioners.

Issues for Service Users

If unaware of the criticisms against the reliability and validity of the DSM-IV, service users could feel they have no choice but to accept the diagnosis they have been given even if it differs significantly from their own personal experience. It struck me that service users may rarely be adequately informed about the shortcoming of psychiatric diagnosis by professionals. Therefore I feel that it is questionable whether informed consent has truly been obtained from service users, insofar as they are not fully informed regarding the reliability and consistency of diagnoses. However, if service users resist a diagnosis they might not be offered the appropriate help due to mental health services and interventions being largely dominated by diagnostic classifications. It thus appears that service users may often have little recourse if they disagree with the diagnosis given by a professional.

Issues for Myself

The issues surrounding the poor validity and reliability of the classification system outlined by the DSM-IV has forced me to consider how I will approach conversations with service users if they ask questions about mental disorders described in the DSM-IV. On the one hand, I feel compelled to explain that the classifications have poor reliability, and that different professionals may offer different diagnoses. However, on the other hand I am concerned that such uncertainty may cause some service users to disengage from the therapeutic process. It is hard not to feel a little discouraged from giving a service user a
diagnosis based on the DSM-IV classifications in light of the reliability and validity issues. Given that the diagnostic labels we attach to service users are often accompanied by considerable stigma within society, I feel that diagnoses should not be offered where there is likely to be considerable disagreement between professionals. Moreover, I seem to agree with Wakefield (1997) that focusing excessively on trying to obtain reliable scientific diagnostic classifications is often to the detriment of contextual and personal information. Finally, whilst I appreciate that concise taxonomies of mental distress, such as that offered by the DSM-IV, may make experimental design easier; I believe that alternative classification schemes with superior reliability and validity may significantly improve the quality of research.

**Future Directions**

Having considered the three overarching criticisms above, this essay will now briefly discuss how some of the issues raised might be addressed. I feel that the biomedical conceptualisation of mental distress in the DSM-IV is inadequate and that future practice needs to move towards viewing distress in the context of an individual's environment, culture and community. This might be achieved in a number of ways including embracing a community psychology approach (Scileppi et al., 2000); focusing on a recovery model rather than symptoms (Repper & Perkins, 2003); and putting a greater emphasis on formulation rather than diagnosis (Bruch, 1998). In particular, the recovery model which promotes self-responsibility and empowerment appears to address a number of the problems associated with a biomedical explanation of mental distress.

Although there are a number of criticisms regarding the diagnostic categories used in the DSM-IV, diagnosis is still an integral part of mental health services. In reality, the popularity of the DSM diagnostic criteria suggests that the abolition of diagnosing in mental health is a long way off. However, the use of a diagnostic system that promotes mental distress as an abnormal phenomenon has led to service users having to face significant stigmatisation. It is for this reason that I feel strongly about promoting an alternative method of conceptualising mental distress. In particular, I feel that a compromise could be found in the form of a dimensional or continuum approach to diagnosis (Costello, 1992). Within this approach a dimensional element could be added to the DSM allowing clinicians to assess service users on a number of different dimensions. Consequently, clinicians would no longer be restricted to predetermined categories. From a service user's perspective, the
implementation of a dimensional approach would go a long way towards undermining the concept of normal and abnormal, potentially reducing stigmatisation (Mullen, 2003).

Throughout my experience within mental health and even whilst writing this essay, I have become increasingly aware of a shift in my attitude towards the DSM-IV and diagnosis. Initially I thought that diagnosis had its flaws but seemed a necessary part of mental health provision. However, I now question the values behind diagnosis and have come to believe that the categorical diagnostic system used by the DSM-IV is inadequate. I consider formulation a much more valid and empowering method of viewing an individual's distress, as it proposes a continuum between normal and abnormal and tries to account for an individual's actions and experience without labelling them as 'disordered'.

**Conclusion**

Having considered the image of the DSM-IV burning and the articles in the special edition of The Psychologist, I was struck by three overarching criticisms levelled against the DSM-IV and diagnosis. Using these three criticisms, I have explored a number of relevant issues raised for service users, psychiatrists, clinical psychologists and myself. I now believe that the shift away from a categorical, biomedical characterisation of mental distress will benefit service users, as their behaviours will be viewed within a more holistic context, thus placing greater emphasis on psychosocial factors. Moreover, a move to a more continuous or dimensional biopsychosocial framework will hopefully reduce the stigmatisation of mental distress. This shift will inevitably change the respective roles of psychiatrists and clinical psychologists. Psychiatrists may need to change their practices in order to incorporate such factors and to move away from a diagnosis driven approach. Conversely, clinical psychologists will need to accept more responsibility in light of recent government initiatives, and take a leading role in the development of a new characterisation of mental distress. Furthermore, I believe that a new approach based on these different underlying assumptions will not only demonstrate superior validity, but also greater reliability across practitioners.

With hindsight, I believe my initial reaction to the depiction of the DSM burning, may have underestimated the gravity of the issues at stake. At first sight, it is perhaps all too easy to conclude that it is merely the use of the leading diagnostic manual that is being questioned. However, whilst writing this essay it has become obvious to me that many of the questions being debated were more fundamental. Upon reflection, the criticisms and issues raised
within this essay have illustrated to me the importance of constantly reassessing concepts within mental health that are so often taken for granted.
References


Clinical Psychologists are Expected to take a Clinical Leadership Role in Mental Health Teams. What Themes and Approaches Might Inform our Understanding of a Clinical Leadership Position and its Usefulness to Others?

January 2010
Introduction

Leadership is thought to be central to the advancement of every aspect of transformation; from facilitating the drive for change, right through to sustaining change when it has taken place (Millward & Bryan, 2005). Within recent years there has been a realisation that mental health services are in need of development and investment (Department of Health [DoH], 2000). Effective clinical leadership is considered paramount to the success of this innovation and clinical psychologists are being invited to adopt these clinical leadership roles (DoH, 2007a). Commissioners hope that by putting clinical psychologists into leadership roles, it will “improve service delivery and the experience of service users and carers” (DoH, 2007a, p.17). The current essay aims to explore the themes and approaches that can inform our understanding of a clinical leadership position and how they may be useful to others.

Leadership has been defined in a multitude of ways and its influence within healthcare is complex (Millward & Bryan, 2005). Given this, I will firstly introduce the concept of clinical leadership and how it has been recently brought to the fore within clinical psychology. I will then go on to consider some of the main themes and approaches that might inform our understanding of clinical leadership positions. Following this, I will discuss how these themes and approaches may be useful for different stakeholders and the ensuing issues that are raised. Finally, I will reflect upon my relationship to the question and the topic of leadership from my perspective as a trainee clinical psychologist.

Clinical Leadership

Defining Leadership

A clear, shared and agreed understanding of the concept of leadership is considered central when exploring the usefulness of the approaches and themes that inform leadership positions (DoH, 2007a). However, the concept of leadership is vast, multi-faceted and has been defined in a multitude of ways (Millward & Bryan, 2005). Overall, leadership is thought to involve the ability to produce a collective shift or transformation in a group’s basic assumptions and principles (Schein, 1988). It is also thought to include the capability to influence and direct others in order to achieve goals, provide an environment that facilitates people in being optimally efficient and the ability to turn followers into leaders (NHS Modernisation Agency, 2005). However, it is has been suggested that a single definition of leadership is futile and is reliant upon the methodological and theoretical features of leadership being considered (Vance & Larson, 2002).
Leadership is notoriously related to positions of power or management within an organisation. However, it is important to acknowledge that it is not synonymous with these senior level positions (Millward & Bryan, 2005). Elements of leadership are involved in every interpersonal relationship and in principle anyone can be a leader without being officially recognised within a leadership role (Faugier & Woolnough, 2002). Leadership can be applied at every level; from within one’s own professional group, across different professional groups and between different organisations (Millward & Bryan, 2005). Indeed, within clinical psychology, leadership can extend from psychological thinking and therapies, through to strategic direction and innovative improvement of service user experience (Coak, 2006).

Defining Clinical Leadership

Although a broad definition of leadership has been considered, it is important to explore the meaning of leadership within a clinical setting. However, reaching a shared definition is difficult, not least because the concept of clinical leadership itself has been contested, with some viewing it simply as a means of accomplishing managerial goals (Edmonstone, 2008). Recent government literature has sought to operationalise the concept of clinical leadership. The essence of which has been defined by the DoH as the ability “to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being serviced” (DoH, 2007b, p.51). It pertains to the delivery of effective healthcare, evidence-based practice and improved service user outcomes (Millward & Bryan, 2005). Moreover, the importance of ‘front line’ clinical team members (doctors, nurses and other allied professions) in improving the organisation’s effectiveness has been acknowledged in the literature (Millward & Bryan, 2005).

It is worth noting that the idea of clinical leadership has previously been misinterpreted by some to indicate that there will become ‘too many chiefs’, resulting in a decrease in the efficiency of services (e.g. DoH, 2007a). However, this appears to be based upon an assumption that leadership is tantamount to a managerial position, which is not consistent with the definition considered above. Indeed, clinical leadership is not about power or authority, but rather about effective ‘front line’ health care (Lord Laming, 2003).

Clinical Leadership Brought to the Fore

Over the last ten years there has been a drive towards modernisation in the NHS, with effective clinical leadership at the heart (Millward & Bryan, 2005). Employees at all levels
are being driven to accept responsibility with regard to areas such as risk, professional development, audit and user involvement (e.g. Valentine & Smith, 2000). Moreover, high profile media cases such as the death of Victoria Climbié (Lord Laming, 2003), have highlighted major inadequacies within leadership practices and brought the issue of effective leadership into the public realm.

In recent years there has been a specific drive towards clinical leadership within mental health services, with increased focus upon Applied Psychologists (AP's) taking up these roles. One major catalyst to this drive was the NHS Plan (DoH, 2000), as it highlighted the need for investment and development in mental health services (DoH, 2007a). Following this, a number of important policies and initiatives were produced (e.g. The Ten Essential Shared Capabilities, National Service Frameworks, New Ways of Working and Increasing Access to Psychological Therapies). The role of AP's and the importance of good leadership were seen as paramount to the success of their delivery (DoH, 2004).

Given the climate of change and innovation within the NHS, it has been requested that health professions clarify their contribution to service delivery. AP's are considered to be a scarce but invaluable resource due to their extensive training in a broad range of psychological theories and practices (DoH, 2007a). However, AP's are seen by commissioners as expensive in comparison to other professionals, a factor which has heightened the importance of justifying AP's role within services. The New Ways of Working for AP's proposed that clinical psychologists should seek to promote their unique skills set and "develop their role in contributing to the improved effectiveness of services through process consultancy at systems level, peer consultation and supervision, [and] leadership" (DoH, 2007b, p.7). Within this initiative, clinical psychologists are seen as integral to the development of service innovation and are expected to lead in the implementation of new service models. Since leadership is fast becoming a fundamental part of clinical psychology, it appears vitally important to consider what might better inform our understanding of an effective clinical leader.

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1 It is acknowledged that the term 'clinical leadership' is not exclusive to clinical psychologists and can be applied to many other disciplines or AP's. However, for the scope of this essay, the focus will be solely on clinical psychologists.
Themes and Approaches

It is suggested that a number of approaches and themes need to be taken into account when considering effective clinical leadership within applied psychology (DoH, 2007a). A large amount of the literature is dominated by specific styles of leadership, the personal attributes thought to underpin effective clinical leadership and the conditions under which these attributes might be applicable (Millward & Bryan, 2005). Therefore, I will firstly consider specific leadership styles and models, followed by personal attributes and behaviours which have been indicated in effective leadership. Moreover, the strengths and weaknesses of these themes and approaches will be discussed throughout, in order to provide a basis for considering how useful they are to others.

It is worth acknowledging that the majority of literature surrounding clinical leadership stems from the nursing profession, which is unsurprising given they deliver around 80% of all healthcare (Millward & Bryan, 2005). However, this section will focus upon themes and approaches from a range of disciplines and discuss how they are most relevant to leadership within clinical psychology.

Leadership Styles and Models

The concept of transformational leadership has largely dominated recent clinical leadership investigation (Millward & Bryan, 2005). Within this leadership style, interpersonal skills are central and followers are constantly inspired by a shared vision of the future. Leaders who work within this style value communication, are highly visible and do not necessarily lead from the front (Clegg, 2000). The transformational leadership style is thought to be extremely applicable to clinical leadership as there is increasing evidence to suggest that this leadership style produces superior outcomes in health care settings (Clegg, 2000). Furthermore, transformational leadership is the model of choice within an NHS programme called ‘Leading an Empowered Organisation’ (NHS Executive, 2000).

In addition to transformational leadership, the DoH (2007a) cited three other main leadership styles applicable to clinical leadership and applied psychology; including transactional, servant and adaptive leadership. The idea behind the transactional leadership style is that when followers take on a job, they essentially consent to obey their leader (DoH, 2007a). The ‘transaction’ could be the money paid to the followers.

2 There are a plethora of themes and approaches that could aid our understanding of clinical leadership positions. However, due to the scope of this essay, I will highlight the ones that I consider to be the most appropriate and applicable to clinical psychologists taking up leadership positions within mental health teams.
(employees) by an organisation in return for their obedience and effort. This style of leadership is more synonymous with positions of management and therefore has related disadvantages. For example, there are few ways in which followers can improve their job satisfaction and it does not lend itself to creative or knowledge based work (Millward & Bryan, 2005). Nevertheless, transactional leadership remains the most common style used in organisations outside of the NHS. It has been argued however, that effective leadership is a product of combining elements of both transformational and transactional leadership styles (Proctor-Thomson & Parry, 2001).

Servant leadership refers to an individual at any position within an organisation, leading merely by meeting the requirements of their team (DoH, 2007a). Servant leaders are thought to be visionary and empowering, constantly striving to uphold their values and ideals. However, critics suggest that people who employ this style within competitive leadership situations are often overshadowed by people using other leadership styles (DoH, 2007a). On the other hand, adaptive leadership style is considered to be a process of mutual influence; whereby an individual dynamically influences their environment, whilst also adjusting to the circumstances they find. This is a broad style of leadership which encourages flexibility and innovation (DoH, 2007a). A major strength of this style is that it appears to promote the consideration of a diverse range of views before a final decision is made.

Although each leadership style has advantages, it is suggested that no one individual style can underlie the basis of effective clinical leadership. Rather, it is thought that effective leadership is about knowing how to utilise different styles depending on the situation (Moiden, 2002). This involves the ability to use evidence, theory and judgement to anticipate what is required and respond appropriately using effective interpersonal and clinical skills (Moiden, 2002). It seems that policy has also reached the same conclusion, stating that although the leadership approaches mentioned above may be individually successful, there is no one correct leadership style that suits all situations (DoH, 2007a). Indeed, the DoH (2007a) proposed situational leadership as an important approach for AP's. Within this leadership style an individual takes into account the organisations environment, the followers' culture, experience and skills, the type of work being carried out and is able to adapt their style according to the situation they find themselves in (DoH, 2007a). It depends "on the practitioner's ability to apply assessment and formulation skills to the leadership aspects of their role” (DoH, 2007a, p.18). It is worth acknowledging that
situational leadership entails a fine balancing act of skills, something which is not straightforward in practice (Millward & Bryan, 2005).

Diversity

On reflection, I was surprised by how many of the approaches discussed above seem to support a 'fixed' leadership style. This does not necessarily appear to be aligned with the diverse and pluralistic culture of the NHS (Attwood et al., 2003). It has been suggested that "a key leadership challenge seems therefore to develop processes whereby people can listen to and respect each other’s perspectives across divides of history, tradition, culture, education and so on" (Edmonstone, 2008, p.294). Therefore, approaches which value followers' culture, experience and skills (e.g. situational leadership style), seem to be extremely advantageous in a pluralistic organisation such as the NHS (Edmonstone, 2008). 3

Personal Attributes and Qualities

Given that the concept of clinical leadership is diverse and difficult to quantify, it seems inadequate to solely focus upon collective styles of leadership. An alternative approach has been to determine the most effective individual qualities and attributes possessed by leaders (Coak, 2006), and as such this will be explored below. In addition, the influence of context and wider systemic factors will also be discussed.

Leadership Qualities

The Leadership Qualities Framework (LQF) was produced with the aim of providing a template of key attitudes, characteristics and behaviours expected from clinical and managerial leaders within the NHS (DoH, 2007a). The framework was created from 150 in depth interviews with chief executives and executive directors and found fifteen personal qualities which clustered into three areas: personal qualities, setting direction and delivery of the service. The ‘personal qualities’ cited within the framework include self-belief, self-awareness, self-management, drive for improvement and personal integrity. With regard to ‘setting direction’, an effective clinical leader was thought to possess intellectual flexibility and political astuteness, whilst being able to seize the future, drive for results and lead change through people. Within the final cluster, ‘delivery of service’, effective leaders were considered those who could empower others, work collaboratively and use effective strategic influencing and broad scanning skills.

3 Issues relating to diversity and difference will be discussed further in the section ‘Usefulness and Considerations’.
The LQF presents individual leadership qualities as a list of how leaders 'ought' to behave. This method seems to oversimplify the concept and complexity of leadership by assuming that it resides within the individual rather than being influenced by the relationships between people (Edmonstone, 2008). In an organisation such as the NHS where clinical leaders generally work within a broad range of settings and multidisciplinary teams, the rigidity of the LQF seems to have certain practical downfalls. One of which appears to be the lack of recognition of diverse leadership qualities spanning across areas such as culture and education (Edmonstone, 2008).

In response to the premise that leadership qualities are fixed and prescriptive, there has been growing support for the authentic leadership approach. It advocates that an effective leader is able to draw upon the strengths that they already possess, rather than advocating the existence of 'fixed' leadership qualities (DoH, 2007a). Moreover, an authentic leader possesses superior levels of self awareness and introspection; personal qualities that are illustrated in their ability to understand and utilise both their strengths and weaknesses flexibly (DoH, 2007a).

**Context and Systems**

When focusing on effective clinical individual leadership, it is important to take into account specific personal qualities and attributes in relation to the experience of working within a system and a particular context (DoH, 2007c).

Psychological services offer a unique and complex environment and therefore, an effective leader would need to possess certain personal attributes that make them adept at handling this unique context. It has been cited that within the context of psychological services, an effective leader would need to possess advanced critical analytical skills and be able to draw upon a vast theoretical knowledge base (DoH, 2007a). Moreover, an effective clinical leader is thought to have awareness of the wider political and financial climate and be able to strategically apply this knowledge at the appropriate time (Coak, 2006). These skills were deemed necessary so that no matter what situation arose, the leader could make an informed critical appraisal, choose an appropriate leadership style, and act accordingly (Moiden, 2002).

As such, leadership is not an isolated process. For someone to lead there must be followers, therefore creating a system in which the leader operates. A range of skills are thought necessary for an individual to be able to effectively lead, whilst taking into account wider
systemic issues (DoH, 2007a). These skills include the ability to interact with a wide range of individuals, create lasting relationships with them, navigate existing systems and set up novel ones in order to keep others informed (DoH, 2007a). The role of a clinical leader has been conceptualised within the literature as one of managing relationships between professionals, between the team and the organisation, between the leader and the team and between the team and the service user (Millward & Bryan, 2005). These skills may be particularly important for clinical psychologists given that their leadership positions may be informal (not connected to a particular leadership position). Informal leaders may need to utilise more tentative influencing skills compared with formal leaders (DoH, 2007a).

Usefulness and Considerations

A number of different themes and approaches informing our understanding of clinical leadership positions have been considered above. These appear to have a number of associated strengths and weaknesses, which provide the underpinning of how they may be useful for others. This section will elaborate on how useful these approaches may be to different stakeholders, in the context of clinical psychologists taking up leadership positions. Furthermore, the ensuing issues that are raised will be considered.

It is acknowledged the usefulness of the above clinical leadership approaches and themes could be discussed in relation to many different people or groups. However, due to the constraints of the current essay, I will only discuss the usefulness for the main stakeholders.

Usefulness and Considerations for Different Stakeholders

Clinical Psychologists

The themes and approaches discussed above are useful for clinical psychologists taking up leadership roles for a number of reasons. The general consensus that no one style or attribute can underpin effective leadership is useful as it highlights flexibility and multi-perspective thinking; factors that are paramount to clinical psychology. Clinical psychologists are trained to integrate a range of perspectives and be adaptive to different stakeholders and environments. This is aligned with the notion that desired leadership styles or skills should flexibly adapt depending upon both the particular context and the surrounding systems (DoH, 2007a).

The drive towards clinical psychologists taking up leadership roles and the salience placed upon this could be somewhat daunting, especially for those who have gone into the profession wanting to solely pursue the ‘therapist’ route. However, I feel that clinical
psychologists already possess a number of the skills central to the themes and approaches discussed above. For example, it is thought that clinical psychologists are "well suited to leadership roles because of their skills in formulating and reframing situations, their tendency to be good listeners and empathic concerning the needs and concerns of others...[and their use of] core skills of assessment, formulation, intervention, and evaluation" (DoH, 2007a, p.29). Therefore, the themes and approaches discussed above appear to be useful for clinical psychologists in reframing clinical leadership as a fundamental part of their already existing role.

It is apparent that leadership is fast becoming a central part of the role of AP's. It has been acknowledged that in order for clinical psychologist's to effectively lead multi-professional staff groups, it will need to be ensured that they possess effective leadership qualities and skills (DoH, 2007a). Therefore, when selecting and interviewing for places on the doctorate in clinical psychology, courses will need to place increased emphasis on successful candidates possessing potential leadership qualities. The personal attributes and qualities involved in effective leadership (explored above), provide a useful framework for courses to assess leadership skills. However, as discussed previously, the personal attributes involved in clinical leadership are not fixed and largely dependent upon the context in which an individual is leading. Doctorate programmes would need to be mindful of this when selecting and interviewing potential candidates.

Doctorate programmes would also need to develop trainee clinical psychologist's leadership potential throughout training, to ensure they qualified with the required leadership competencies (DoH, 2007b). The suggestion that effective leaders are able to draw upon their unique strengths and acknowledge their weaknesses (e.g. authentic leadership style), might be something programmes could consider. If this is taken on board, the syllabus would need to be geared towards highlighting and nurturing trainee's existing leadership skills and fostering awareness of weaknesses.

**Mental Health Teams and Allied Professionals**

Successful leadership within mental health teams has been repeatedly positively associated with team functioning and negatively associated with burnout amongst professionals (Corrigan et al., 2002). It has also been found that positive leadership ratings were linked with staff adopting and practicing evidence-based practice (Aarons, 2006). It is likely that in the future, clinical psychologists will fill increased amounts of leadership positions within mental health teams. Therefore, the way in which clinical psychologists are selected for
these positions and their resulting leadership styles, will have a major impact upon mental health professionals and the success and practices of the team as a whole.

The literature suggests that leaders and their followers are inherently bound, and that it is the quality of this relationship which has the most impact upon staff behaviours, attitudes towards their work and overall staff performance (Haslam & Platow, 2001). Successful leaders are thought to be capable of turning ‘you’ and ‘me’ into ‘us’ (DoH, 2007c). A number of the themes and approaches discussed above value the leader-follower relationship and highlight skills involved in enhancing relationships (e.g. transformational leadership style). If this leader-follower relationship is in fact paramount to successful outcomes, then clinical psychologists who carefully consider ‘followers’, might prove potentially beneficial for mental health teams.

Mental health teams can benefit practically from exploring successful leadership approaches. For example, documents such as the LQF can provide a useful tool in facilitating individual leadership development, evaluating leadership abilities and where appropriate, aiding recruitment into leadership positions (Edmonstone, 2008). Given the clear association between good leadership and positive outcomes, it seems essential to have some way of fostering and monitoring leadership. However, it is also worth acknowledging that approaches such as the LQF support a fixed form of leadership and reject the notion that leadership is intrinsically bound to culture, context and systems (Edmonstone, 2008).

**Service Users and Carers**

It has been found that particular elements considered central to effective leadership (e.g. innovation and effective running of patient services), can equate to quicker patient recovery rates, increased patient quality of life and even the difference between life and death (NHS Leadership Centre, 2005). Therefore, whether or not a mental health team is being successfully lead, will have major implications for the individuals who are receiving their services and the people who care for them.

Government policy has put the voice of service users and carers at the heart of the NHS reform. It was recommended that “service users and carers should be involved in the commissioning as well as design, delivery and evaluation of psychological services.” (DoH, 2007a, p.22). AP’s who take up leadership roles are essentially responsible for making sure that service users and carers are involved within service development. The themes and
approaches discussed above place varying emphasis on whether diverse views are considered and taken up by the leader. An adaptive leadership style is thought to promote consideration of multiple views, which may prove extremely useful for service users and carers. However, I am aware that certain leadership styles (e.g. transactional) may not be useful to service users and carers as they are primarily focused upon capital gain. I feel that clinical psychologists need to be particularly cautious of adopting leadership styles that may lead to the views of service users and carers being neglected.

Other Considerations

Diversity

Within the NHS we work with individuals from a range of different cultures, ethnicities, traditions and backgrounds, who hold different personal and professional values and beliefs. It is suggested that organisations which value and utilise different beliefs and values, tend to be more vibrant and innovative (Heititz & Laurie, 1997). In addition, the DoH (2007c) commented that “a team of people who are simply clones of the leader will be neither effective nor innovative” (p.40). Therefore, it appears extremely important to consider issues of diversity when exploring themes and approaches which may inform clinical psychologists taking up leadership positions.

During the process of writing the essay I became particularly aware that clinical psychology is a profession is largely dominated by females. The literature suggests that on average, women use a more transformational, democratic style of leadership compared with their male counterparts (Workman, 2008). As a result, women have been found to be more popular with ‘followers’ but can neglect to take more directive action when it may be needed (Workman, 2008). Therefore, the diversity of leadership styles between genders is something which needs to be considered by both male and female clinical psychologists taking on leadership roles.

It is apparent that an individual’s own ‘diversity’ will inevitably be brought into their leadership style; however what seems important is the ability to be able to recognise and reflect upon this and act accordingly. It has been recognised that as a profession, clinical psychologists consciously reflect upon their own diversity in relation to themselves and others (DoH, 2007a). Reassuringly, this is considered one of the factors which make clinical psychologists well placed to take up leadership positions in the NHS (DoH, 2007a).
Power

Clinical leadership literature stresses that leadership is not necessarily tantamount to formal positions of leadership, but rather about clinicians leading from the front (Lord Laming, 2003). Nevertheless in practical terms, for clinical leaders to build professional credibility, their role will need a managerial component (DoH, 2002). Therefore, it seems that regardless of position or approach, the relationship between leaders and their followers is laden with complexities relating to attributions of power, control and authority (Millward & Bryan, 2005). However, what seems important for clinical psychologists taking up leadership roles is the ability to be able to recognise, acknowledge and use these complexities, in a way that is constructive for the follower and the organisation.

Overall Reflections

I found the notion of clinical psychologists leading mental health teams particularly salient for a number of reasons. As a trainee, I have been able to directly see the increasing emphasis placed on leadership skills within the doctorate training (DoH, 2008). However, I feel that due to practical constrains, there will be little opportunity to practice and develop these leadership skills whilst on placement. Consequently, I feel slightly daunted about the prospect of taking up a leadership role in a mental health team once qualified. This made me reflect upon issues relating to power and leadership. As a reasonably young trainee, I have considered the issues that may arise from younger clinical psychologists taking up leadership positions in mental health teams. As such, I wonder how senior mental health professionals feel about the suggestion that clinical psychologists will be taking up an increasing number of leadership roles in teams and whether this will lead to any ensuing resentment.

Finally, I have been able to experience firsthand the importance of good leadership and the positive difference it makes to ‘followers’ and the team as a whole. I am currently on my child placement and feel that the team functions particularly well under the current manager who is a clinical psychologist. I have noticed that this manager is able to adapt their leadership style to suit whoever is being addressed, which seems to be consistent with a situational leadership style. In addition, the manager also seems to place a lot of value on the followers; for example, personally praising individual achievement or effort. I feel that this has ultimately led to increased team satisfaction and cohesion. Throughout writing this essay, I have been continually enthused by the notion of developing my own leadership
style so that one day I may be able to inspire a team the way that I feel this manager has done.

**Conclusion**

It is apparent that in the future, clinical psychologists will be taking up increasing numbers of clinical leadership positions in the NHS. As such, this essay has highlighted a number of different themes and approaches that may inform a greater understanding of effective clinical leadership. By exploring separately both the leadership styles and personal attributes involved in effective leadership, it is apparent that there is not a 'fixed' or correct way to lead. Rather, effective clinical leadership can take many forms and is greatly influenced by the context or system surrounding the leader. Moreover, when applied to clinical psychologists in leadership positions, these themes and approaches differ in their usefulness for different stakeholders. For example, mental health professionals might benefit from leaders using a style which carefully considers 'followers'; whereas, service users may benefit from a leader who take into account a range of different perspectives. For clinical psychologists, the challenge will be how they integrate this information so that they can become effective leaders within mental health teams.
References


The Relationship to Change

March 2009
The PBL Exercise

The original Problem Based Learning (PBL) task was titled 'the relationship to change'. The task required trainees to work in their personal and professional development groups and explore their interpretation of this title, decide upon an approach to the title and then demonstrate these ideas in a presentation.

The Group Process

In order to own my perspective in this process, this reflective account will be written in first person.

Prior to meeting my group I felt apprehensive about how the group would function as a team. I wondered whether we would all be able to work effectively together and what roles each person would take. During the first session, the group discussed the allocation of the role of chair and "scribe" (Wood, 2003). The group collectively felt that the role of chair and "scribe" should be rotated so that everyone would be able to gain the experience of these responsibilities. This initially decreased my anxiety as it seemed to reflect a sense of equity in the group right from the beginning. I volunteered to be the chair during the first group meeting as I felt that it would be an exciting and challenging opportunity for me to try and help manage initial group dynamics. Our group facilitator was present during the first session and aided the group process by ensuring that we adhered to the appropriate learning objectives and provided gentle guidance for our initial ideas (Wood, 2003). The group did not explicitly set any 'ground rules' but rather these appeared to exist naturally. I felt that this was a positive development as it seemed to reflect our natural respect of each other.

This title initially presented as vague and ambiguous to me. I was unsure what direction the presentation would take as it seemed that there were an unlimited number of avenues that could be explored in this exercise. After discussing the title, the group considered how change is a constant phenomenon which can seem all encompassing. We decided to explore what our relationship, as trainees, was and will be to change within the context of our role, our wider profession and society. Over the sessions leading up to the presentation, the group developed initial brainstorming ideas into five topics. These topics included; control and power within change, collaboration and involvement in change, clarity and information sharing when implementing changes, the role of clinical psychologists within change, the evaluation of change and diversity issues within change.
The group recognised how perceptions of these five broad areas have changed significantly over time and how people appear to have a choice in whether to be an active agent or passive recipient in future change.

Given the time constrains, there were growing concerns in the early stages of the exercise that we needed to narrow our focus in order start planning the presentation. I feel that the facilitator presence aided the group in narrowing these ideas and finding a focus in which to move forward towards planning the format of the presentation. This appears to support the assumption that more direction will be required from the facilitator during the early stages of the group process (Wright, 1989). Nevertheless group discussions appeared to be open and forthcoming and I felt reassured that we would work well and productively as a team.

**My Role**

Given the rotating nature of the role of chair and “scribe”, each group member appeared to develop their own unique role within the group process. I feel that initially, my role within the group was that of a ‘negotiator’. I feel that I adopted this role with the intention of facilitating compromise when group members had conflicting views. Upon reflection I feel that I may have also embraced this role in order to reduce my apprehension regarding possible group conflict. However, as it became clear that our group was not experiencing any noticeable conflict, it appeared that my role changed and I became an ‘organiser’. This role consisted of organising the presentation material in the sessions prior to the performance. It has occurred to me after the presentation that my initial desire to avoid or resolve conflict might be something I would need to be mindful of within therapeutic relationships. Thus, it has been noted that within cognitive therapy, a good therapist will notice and pursue high affect rather than avoid it (Kuehlwein, 2002).

**The Presentation**

From our initial ideas, it was decided that the presentation would loosely imitate the format of ‘A Christmas Carol’ (Dickens, 1843/2004) by having a trainee clinical psychologist as the Ebeneza Scrooge character and a supervising clinical psychologist mimicking the role of The Ghost of Christmas Past, Present and Yet to Come. Based on this format, the presentation depicted the past, present and possible future of clinical psychology to the trainee clinical psychologist, guided by a supervisor with the aim of helping the trainee to decide their own relationship to change.
The past, set in the 1980's, was presented first in the form of a slide show. It depicted the closing of the asylums (Barham, 1992) and the emergence and growing popularity of Cognitive Behavioural Therapy (Beck, 1967). To convey the present, the audience was shown a video of a Primary Care Mental Health Service Team (PCMHT). The video aimed to depict the new government initiatives in mental health such as New Ways of Working for Everyone agenda (Department of Health, 2007), growing service user involvement and the demands placed upon trainee clinical psychologists within their new role. The future was divided into two parts: one where clinical psychologists had not taken an active role in change and another where clinical psychologists had taken an active role in change and had expanded and developed their role within mental health.

**Reflection on the PBL Exercise**

Initially after the presentation I felt an overwhelming sense of relief and achievement. I perceived that the presentation had gone well and that we had worked well as a team in terms of forming the initial ideas, bringing all the separate parts of the presentation together and performing the final presentation. What initially struck me after the presentation was that it seemed that our group had experienced less conflict leading up to the presentation compared with other groups. Thus, by looking at our group process within the developmental model of group processes (Tuckman, 1965), our group seemed to have bypassed the 'storming' phase of the group process. 'Storming' is described by Tuckman (1965) as the phase after the group has formed and is characterised by conflict and polarization around interpersonal issues. Upon reflection, I think that there were subtle differences in opinion. However, there appeared to be a collective group attitude that we needed to complete a task and that compromise could be reached in the event of two competing ideas.

Once time had passed and I had time to reflect upon the presentation and the process leading up to it, I identified that there were areas of our preparation that could have been improved upon. Our group had decided to use a number of mediums for presenting the information in our presentation. This initially felt unique and exciting to me. However it practically posed a number of technical problems which meant that in the hours leading up to the presentation, a few group members, including myself, had to find alternative methods to convey our presentation. During subsequent discussions, the group acknowledged that our ambitious choice of presentation medium was something we could take into account for any subsequent tasks. This discussion did not place blame but instead
felt open and generated constructive feedback. I felt that this way of working suited my personal style and I went away feeling proud to be part of the group.

It also struck me after the presentation that our group did not include any folk theories of change, but instead focused upon the changes within clinical psychology and the implications of being involved in future change. To begin with I felt apprehensive about the lack of any folk theories of change in our presentation. However, after reflecting upon the process and speaking with some of the audience, it occurred to me that the presentation had been more salient because of the approach our group had taken. I have subsequently been able to relate this insight to my therapeutic style and, where appropriate, steer clear of jargon when speaking with clients. Consequently, after the presentation I have found myself increasingly embracing a client-centred approach to therapy, which has involved relating to the client in a congruent way rather than trying to fit the client's concerns to a theory (Rogers, 1951).

Moreover, I felt that it was not only my therapeutic style that had been influenced by the exercise, but also my personal attitude towards change. I think that I had always taken change for granted and had never really embraced my relationship towards it. I subsequently found myself asking what my role would be within the future of clinical psychology. By looking at change over time, I was able to see the advances that have been made since the 1980's. These included; increased interest of mental health and psychological therapies, greater diversity within clinical psychology (Hall, 2006) and recent government initiatives which have pushed mental health to the fore (Department of Health, 2007). However, the presentation illustrated that there is still so much that could be done to improve mental health services and access to these services, especially for underrepresented groups in society such as black and minority ethnic communities (Department of Health, 2008). I think the exercise made me realise the importance that clinical psychologists play in the changing nature of mental health. As a result of this presentation I now feel a deeper desire to play an active role in future developments and changes within mental health.

Although the whole group process appeared to be a positive one, the initial anxiety I experienced before meeting the group raised a few important issues for me. Firstly, I have subsequently attributed the rapid decrease in my initial anxiety to the sharing of roles and responsibilities within the group. I feel that the group addressed any fear of power differences by taking this stance. Secondly, by joining a new group of people at the start of
a new course, I was undertaking significant changes myself. Although I perceived these changes as positive, they still appeared daunting and anxiety provoking. On reflection I have been able to liken this experience to that of a client beginning therapy. I can imagine for some clients, the start of therapy signifies a considerable change for them. I have subsequently been able to apply the positives of subtly addressing the power differences within our group to that of the start of a therapeutic relationship. Indeed, authors have stressed the importance of establishing a collaborative therapeutic relationship (Kuehlwein, 2002), part of which could be seen as addressing the inevitable power differences that exist between client and therapist.

Summary

From the initial group meeting, I feel that I have become part of a group that works collaboratively and effectively. Initially perturbed by the ambiguity of PBL exercise, I have found myself increasingly interested in my relationship to change. My group took the stance of looking at change in clinical psychology over time and the decision of whether to be an active agent or passive recipient of change. From completing this exercise, I have considered my own role within change and now feel a growing desire to be an active party in change within mental health. I have also been able to explore how the insights that I gained from the group exercise could be related to my therapeutic relationships. Thus, I feel that taking a collaborative stance within a therapeutic relationship can go a long way to redressing the power differences that inevitably exist.
References


How do we Know IAPT is Working?

March 2010
Introduction

The Problem Based Learning (PBL) task required each group to prepare a consultancy report on how the effectiveness of the Improving Access to Psychological Therapies (IAPT) programme could be assessed. The groups were given the task of considering what future evaluation questions needed to be asked; the methodologies, designs and analyses that could address these questions; how certain evaluations might be valued by different stakeholders; and how the findings might be transferred into policy and practice.

Within this account, I will firstly discuss the group process, including the format of the group, the different roles and the final presentation. I will then go onto discuss my overall reflections of the PBL exercise relating to the content and process of the task. Throughout, I will discuss how the PBL task has impacted upon my clinical practice within the NHS.

The Group Process

The Group Format

Initially I felt a bit perturbed by the task as I had certain preconceptions about IAPT services taking a rather narrow view towards evaluation. However, I was also aware that I had never worked in an IAPT service and therefore wanted to keep an open mind. I felt quite apprehensive about working with more experienced third year trainees and wondered about my own contribution to the group given that I had little experience of directly working within an IAPT service. This has made me reflect upon how difficult it may be for clients to access a new service and begin therapy, especially if they are unfamiliar with the approach being used.

For every group member, the PBL task coincided with many different assignments and deadlines. I felt that this context impacted upon the way we decided to tackle the PBL task. During our first meeting, there was a general consensus amongst the group members that we needed to be particularly efficient with time and come to a quick agreement on what idea and format to chose for the final presentation. Moreover, everyone in the group had quite negative feelings towards the current methods of evaluation used in IAPT services. This meant that a lot of time was taken voicing these opinions. It was felt that previous evaluations only used symptom-based measures, which neglected to explore what it was about the services that worked and did not take into account the views of different stakeholders involved in IAPT.

In order to own my own perspectives in this process, the reflective account will be written in first person.
Initially I felt a sense of group cohesiveness and walked away from our first few meetings feeling quite lucky to have been placed with this group. According to Yalom (2005), during the beginning stages of group formation, group members often spend time searching for similarities, which if found can provide part of the foundation for group cohesiveness. Moreover, it is suggested that when there are performance goals, groups often find it easier to gel and become more cohesive (Roback & Smith, 1987). I feel that the consensus about how the task was going to be tackled and the negative feelings about previous IAPT evaluation, contributed to the sense of group cohesiveness that I felt in those first few meetings.

After a few meetings the group seemed to move into a ‘storming’ phase, whereby the group shifted from a preoccupation with shared interest, meaning and structure into a preoccupation with dominance and control (Tuckman, 1965). I feel that this was largely connected with the roles that were taken up by different group members, which will be discussed below.

Roles and Contributions

The absence of a nominated facilitator meant that this role needed to be negotiated amongst our group. Interestingly, there was no explicit conversation regarding how this might be dealt with, but there was a sense that the third year trainees were much more willing to take facilitator type roles. During the first group meeting it seemed that each person had quite an equal part in discussions. However, as time went on there was a definite sense of a power imbalance between the second year and the third year trainees. I feel that during our third group meeting, a leadership role was taken on by one third year trainee in particular.

For myself I was unperturbed by the third years taking on more dominant roles. I felt able to challenge any decisions made and often put forward my point of view. However, I noticed that one second year trainee had tried to put across another idea for the presentation, which was seemingly dismissed by the more dominant third year as “too complicated”. I felt concerned for this group member by the outright dismissal of their idea and therefore tried to encourage the other group members to incorporate some of the ideas into the final presentation. This made me reflect upon leadership styles. I feel that this third year took on a ‘transactional’ leadership style, whereby the leader is in charge and followers are expected to obey the decisions of their leader in order to reach a shared goal (Department of Health [DoH], 2007). However, this style does not lend itself well to
follower satisfaction and group cohesiveness (Millward & Bryan, 2005), which I felt was consequently reflected in our next few group meetings.

I feel that as our meetings progressed I adopted a mediator type role. I initially adopted this role due to feeling that some of the second year group members were not being heard. On reflection, I noticed that I had taken on a slightly different role from the first PBL task. Previously, I took on a role which aimed to avoid group conflict. However, during this task I found myself actively promoting the ideas of more passive group members, which might have resulted in conflict between myself and the more dominant third year. This made me wonder what it might be like for clients who find it difficult to put forward their views to professionals or other clients. I feel that my role within the group has influenced my clinical practice as I believe I am better able to promote the views of clients and handle conflict in group situations. For example, I am currently on my child placement and have been able to use these skills to mediate heated discussions between children and their parents and in some cases been able to reach an agreed compromise.

The Presentation

Our initial agreement regarding the pitfalls of previous quantitative IAPT evaluation seemed to shape our presentation. It was decided that our presentation would put forward both a qualitative and quantitative approach to assess the effectiveness of IAPT from the viewpoint of a number of different stakeholders. The presentation seemed to be successful and I feel the group did well to highlight the importance of taking into account the views of clients, carers and professionals regarding the service.

Looking back, I think our presentation went well because the group regained a cohesiveness that had been lacking since the early group meetings. I feel that this happened due to the group having a last minute crisis and consequently pulling together in order to achieve our shared goal. The more dominant third year, who had quite a significant part in our presentation, was absent on the day we were due to present. I feel that our group was able to effectively pull together and share the absentee’s role.

Overall Reflections

Content

Initially, I found it quite difficult to not become too polarised as a result of my personal feelings about IAPT. However, the PBL task motivated me into looking deeper into IAPT and as a result my opinions began to shift. Although I could see that the current methods of
evaluation were far from perfect, I could also recognise that IAPT has produced some positive results, such as improved mental health. Looking back, I feel that I had also overlooked what IAPT was actually trying to achieve. IAPT's statement of intent refers to decreasing stigma associated with mental health, making evidence based psychological therapies more available and providing seamless person-centred care (DoH, 2008). I feel that by carrying out this task I have been able to reconnect with the positive aspects of IAPT, whilst still retaining a critical stance towards it.

Moreover, this has made me reflect on how changes in the NHS are constantly occurring and it may be easy for professionals and clients to become focused upon the negative aspects rather than looking at the bigger picture. For example, my current placement is going through reconfiguration, which has meant that a number of staff members are being relocated. In some cases, the impending move has been handled less than sensitively, with employees being given less than a day's notice before they had to move. I have noticed that these staff members have become extremely polarised around the negativity of the move, but have lost sight of how this reconfiguration will hopefully lead to the service becoming more accessible and seamless. Driskell et al. (1999) found that high levels of stress in teams can lead to a narrowing of team perspective, which can negatively impact on the team’s performance. This has made me think about how change is handled in mental health teams and the importance of trying to reduce and manage the stress that may occur.

**Process**

Once the PBL task was over, I started reflecting on my own assumptions about the initial similarities in the group. Although we were all of a similar age, ethnicity and had similar ideas about tackling the task, there were differences in terms of gender, background, values and styles of working. It seemed these differences were not fully acknowledged and valued within our group, which may have been due to time pressures, other academic demands and possibly the 'transactional' leadership style employed by one of the third year trainees. However, I feel that this may have contributed to the lack of group cohesiveness and satisfaction at times. Indeed, greater personal satisfaction has been associated with groups that value and encourage discussion of their member's diversity (Keyton & Beck, 2008). This has made me think about how frustrating and disempowering it must be for clients if issues relating to diversity are not considered. I have since been able to apply this insight on my current child placement, taking particular care to adapt my practice to suit
each client’s age, gender and level of cognitive development using aids such as puppets, games and cartoons.

Looking back, I wondered how my mediating role impacted upon the individual group members and the group as a whole. Initially I felt that I had enabled the second year trainee’s views to be heard. However with hindsight, I wondered whether I had intervened too quickly and taken away an opportunity for the second year trainee to make their own voice heard, leading them to feel disempowered. This made me reflect upon how it may feel for clients when they are not given the space to make their own voice heard. Consequently, this has highlighted a continuing learning need for me. On my current placement I am trying to be particularly mindful of stepping in too quickly in order to resolve or mediate conflict. Indeed, a good therapist needs to be able to notice and tolerate high affect, without necessarily intervening (Yalom, 2005).

**Concluding Thoughts**

Although I initially felt quite apprehensive about this PBL task, it has enabled me to reconsider my opinion of IAPT. I have been able to reflect upon how different group members' roles impacted upon the sense of group cohesiveness and how my role may have impacted upon others. Indeed, looking back I feel that I need to be mindful of jumping in too soon without leaving time for group members to advocate their own views. Throughout the PBL task, I have seen how taking a more task focused stance can mean that the richness and innovation that comes with valuing diverse styles is lost. Finally, I feel that the insights gained from this PBL task have gone some way to shaping and developing my clinical practice within the NHS.
References


Summary

September 2009
Introduction: The Personal and Professional Discussion Groups offered an opportunity to discuss and reflect upon professional, ethical and organisational issues. I approached this account by discussing the development of group process over the first year of training and what I leaned during this time.

Group Format: I outline how the group format appeared to develop. It seemed that with the development of group members' knowledge and practical experience, we were able to become more flexible with the group format. For instance, in the latter part of the year the group engaged in sharing Genograms and discussing a range of professional issues.

Roles and Contributions: I consider my interpersonal style in group settings generally, how group members may have perceived me and the implications of certain roles upon group cohesiveness. For example, I considered my role as a 'negotiator' and how this may have inhibited any conflict to emerge within the group.

Learning from the Group: The influence of the group on my personal and professional development is discussed. I reflect upon how the group process shaped my clinical practice, enabling me to build theory-practice links and learn from other group members.

Final Reflections: I conclude with reflections on the group process as a whole and my overall experience of the group. I believe that my engagement with the group has enabled me to maintain a critical stance, formulate in different approaches and consider difference styles of interaction within a group setting.
PERSONAL AND PROFESSIONAL DISCUSSION GROUP PROCESS ACCOUNT – YEAR 2

Summary

July 2010
Introduction: Over the last two years of training, the Personal and Professional Discussion Groups offered an opportunity to discuss and reflect upon pertinent professional, ethical and organisational issues. I approached the account by exploring group structure, roles and learning throughout the second year.

Group Structure: I begin by discussing how the structure of the group matured within the second year. The group explored a more flexible and reflective style compared with the first year. The benefits and limitations of these changes in the group structure are discussed.

Group Roles: I reflect upon my changing role within the group, taking on a more active 'leadership' style compared with the first year. I discuss the roles of other members and reflect upon how certain roles may have impacted on different group members.

Group Development and Learning: I discuss the difficulty posed of having a group member experiencing high levels of personal distress and how this impacted upon group conversations about clinical issues. I explore the benefits of discussing placement experiences and how this enabled me to reflect upon issues relating to difference and diversity.

Concluding Thoughts: I conclude by considering how the development of a more comfortable group structure seemed to foster enhanced group cohesion. I reflect upon my 'leadership role' within the group and consider how to develop this within the final year of training.
OVERVIEW OF CLINICAL EXPERIENCE

Summary of Experience Gained Through Placements

October 2008 – September 2011
Adult Mental Health Placement - Year 1

Setting: Community Mental Health Team, Acute Inpatient Unit
Clients: Adults between the ages of 18 to 65 years
Theoretical Models: CBT, CAT, mindfulness based cognitive therapy (MBCT)
Presenting Difficulties: Depression, anxiety, health anxiety, phobia, PTSD, panic, agoraphobia, bipolar, anger, OCD, psychosis and relationship difficulties
Clinical Experience: Assessment, formulation and intervention with clients and couples, co-facilitation of CBT group for anxiety and depression, co-facilitation of MBCT group for depression, psychometric and neuropsychological assessments, attendance at risk management meetings
Service Evaluation: Evaluation of a dialectical behaviour therapy service
Teaching and Presentations: Teaching to multi-disciplinary team regarding MBCT and presentation at a county wide psychology meeting regarding service evaluation outcomes

Child and Adolescent Placement - Year 2

Setting: Child and Adolescent Mental Health Service (outpatients, client homes, schools)
Clients: Children and adolescents between the ages of 4 to 17 years
Theoretical Models: CBT, behavioural, systemic and psychodynamically informed work
Presenting Difficulties: OCD, anxiety, depression, anger, self harm, school attendance difficulties, family relationship difficulties, feeding problems, ASD, parenting difficulties
Clinical Experience: Assessment, formulation and intervention with clients and families, joint working with social workers and mental health workers, psychometric and neuropsychological assessments, liaison with teachers, observation work within schools, risk assessment for self-harm, attendance at risk management and school meetings, liaison with schools and social services, observation of eye movement desensitization and reprocessing (EMDR) clinic
Teaching and Presentations: Presentation at a special interest group with psychologists from different specialties regarding neuropsychological profiles in children and adolescents
Consultation: Consultation to a mental health worker regarding adaptation of CBT for children
Learning Disabilities Placement - Year 2

Setting: Community Team for People with Learning Disabilities (outpatients, residential, client's homes, day centre), Assessment and Treatment Unit

Clients: Adults between the ages of 18 to 65 years

Theoretical Models: CBT, behavioural, systemic family therapy

Presenting Difficulties: PTSD, anxiety, depression, OCD, challenging behaviour, anger management, aggressive behaviour, sexually inappropriate behaviour, interpersonal difficulties, dementia related difficulties and supporting transition from residential homes

Clinical Experience: Assessment, formulation and intervention with clients, families and carers, indirect work with staff and carers, member of a systemic family therapy reflecting team, formal observations and functional analysis, formal risk and capacity assessment, psychometric and neuropsychological assessments

Teaching and Presentations: Presentation to ASD carer group regarding the role of clinical psychology within learning disability services

Consultation: Consultation to staff at a care home regarding challenging behavioural and consultation to multi-disciplinary team professionals at a strategy meeting surrounding client relocation

Older Adults Placement - Year 3

Setting: Older Adults Psychology Service, Neuro-Rehabilitation Ward, Day Hospital

Clients: Adults aged 60 years and over presenting with organic and mental health difficulties

Theoretical Models: CBT, rational emotive behavioural therapy, systemically informed work

Presenting Difficulties: Anxiety, depression, fear of falling, bereavement issues, memory difficulties, chronic health difficulties, interpersonal difficulties, dementia related difficulties and challenging behaviour.

Clinical Experience: Assessment, formulation and intervention with clients and carers, facilitation of relaxation and fear of falling groups, attendance at ward meetings, psychometric and neuropsychological assessments, formal risk assessments

Teaching and Presentations: Presentation and teaching regarding psychological management of fear of falling, presentation at a stroke survivors and carers meeting to obtain recommendations and thoughts surrounding a research grant
Advanced Competencies Placement - Year 3

Setting: Child and Adolescent Mental Health Service (outpatients, client's homes, schools), Family Therapy Service

Clients: Children and adolescents between the ages of 4 to 17 years

Theoretical Models: Systemic/narrative therapy, systemic family therapy, CBT

Presenting Difficulties: OCD, depression, anxiety, anger, ADHD, self-harm, school refusal, behavioural difficulties and chronic health difficulties

Clinical Experience: Assessment, formulation and intervention with children, parents and carers, lead therapist role and part the reflecting team within a family therapy service, joint working with senior mental health worker and consultant clinical psychologist, formal duty risk assessments, CAMHS triage assessments, liaison with schools and colleges and involvement with systemic family therapy interest group

Teaching and Presentations: Presentation at family justice council annual conference regarding managing contact issues with children and teaching at a multi-disciplinary team meeting surrounding the impact of domestic violence on children
SUMMARY OF CASE REPORT 1 - ADULT MENTAL HEALTH

Cognitive Behavioural Therapy with a Young Man Presenting with Obsessive Compulsive Disorder

April 2009
Referral: Nick is a man in his early twenties of Asian ethnicity, who was referred to the psychology service by the team psychiatrist for help with intrusive thoughts and anxiety.

Presenting Problem: Nick reported anxiety, intrusive thoughts and checking behaviours.

Assessment: An initial assessment with Nick was conducted jointly by my supervisor and I. Nick completed the Clinical Outcome in Routine Evaluation.

Formulation: An initial formulation was developed collaboratively. We conceptualised Nick's experiences as being consistent with obsessive-compulsive disorder and formulated using an integrated schematic model of OCD.

Action Plan: In line with NICE guidelines, Nick was offered twelve sessions of individual cognitive behavioural therapy.

Intervention: To date, Nick completed nine sessions of therapy. The areas collaboratively worked on during therapy were as follows: socialisation to the treatment, building motivation, exposure and cognitive restructuring. Future sessions aimed to focus on response prevention and relapse and recovery planning.

Reformulation: Throughout therapy, new information gained appeared to substantiate and develop the initial formulation. The emergence of a core belief and further understanding of how Nick interpreted his intrusive thoughts are discussed within the reformulation.

Outcome: Behavioural observations and feedback indicated that thus far, Nick had decreased the amount of covert rituals he was using and had subsequently experienced a reduction in anxiety and frequency of intrusive thoughts.

Critical evaluation of the therapy and issues relating to diversity are also explored.
SUMMARY OF CASE REPORT 2 - ADULT MENTAL HEALTH

Neuropsychological Assessment of a Man in his Thirties Referred for Concerns Regarding his Memory and Possible Asperger's Syndrome

August 2009
Summary of Case Report 2 – Adult Mental Health

Referral: Ben is a man in his early thirties of white British ethnicity, who was referred for a neuropsychological assessment to investigate concerns regarding memory and possible Asperger’s syndrome.

Presenting Problem: Ben reported having difficulty socialising and communicating with people; distress when his systematic routines were not adhered to by others; and problems remembering things that needed to be undertaken in the future.

Assessment: An initial screening assessment with Ben was conducted jointly by my clinical supervisor and I. Ben’s ex-wife was also present during this assessment.

Hypotheses: Ben’s cognitive profile would be consistent with that of Asperger’s syndrome and his memory difficulties would be more consistent with those of a functional rather than organic disorder.

Testing: A range of assessments were conducted, exploring pre-morbid and general intellectual functioning, memory, learning, executive functioning, theory of mind, anxiety and depression.

Results: The findings indicated that Ben did not produce a cognitive profile consistent with that of Asperger’s syndrome (rejecting the first hypothesis). Ben also showed no indication of any deficit in memory or executive functioning, but scored within the clinical range on a measure of anxiety.

Outcome: It was tentatively concluded, that Ben’s memory difficulties were suggestive of an anxiety disorder rather than organic changes. In light of the findings a number of recommendations were suggested.

Critical evaluation of the neuropsychological assessment and issues relating to diversity are also explored.
SUMMARY OF CASE REPORT 3 - CHILD AND ADOLESCENT MENTAL HEALTH

Working in an Integrative Way with a Fifteen Year Old Girl Presenting with Depression and Suicidal Ideation

April 2010
Referral: Grace is a fifteen year old girl of White British ethnicity, who was referred to the Child and Adolescent Mental Health Service psychology department, following a suicide attempt.

Presenting Problem: Grace reported experiencing suicidal ideation, low mood and anger.

Assessment: An initial assessment with Grace was conducted over two sessions. Grace's mother joined us for part of these sessions. Grace completed some pre-therapy outcome measures.

Formulation: Grace's difficulties were initially formulated using a cognitive behavioural model of depression, whilst also taking into consideration the family context.

Plan: In line with NICE guidelines, Grace was offered over three months of individual therapy using an integration of cognitive behavioural and narrative therapy principles.

Intervention: The areas collaboratively worked on during therapy were as follows: developing the therapeutic relationship, socialisation to treatment, family work, behavioural activation, thought challenging and cognitive restructuring.

Reformulation: Due to the re-emergence of suicidal ideation towards the end of the intervention, Grace's difficulties seemed to be better accounted for using a psychodynamic framework, namely object relations theory. As such, the final few sessions were spent focusing upon 'therapeutic endings'.

Outcome: Outcome measures and feedback indicated improvements in symptoms of depression, anger and low self-esteem. Moreover, Grace reported an improvement in communication with family members.

Critical evaluation of the therapy and issues relating to diversity are also explored.
SUMMARY OF CASE REPORT 4 – ORAL PRESENTATION

Development and Adaptation of CBT Intervention Skills with a Twenty Two Year Old Girl with a Mild Learning Disability, Presenting with PTSD

September 2010
**Referral:** Holly is a girl in her early twenties, who has a mild learning disability and a diagnosis of Post Traumatic Stress Disorder (PTSD) who was referred to the psychology department in a learning disabilities service due to an increase in symptoms of PTSD.

**Background:** A review of the literature surrounding PTSD and suitable adaptation of cognitive behavioural therapy (CBT) for people with learning disabilities are considered.

**Formulation:** Holly's difficulties were formulated using a cognitive model of PTSD, whilst taking into account her learning disability and family context.

**Intervention:** Holly was offered fourteen sessions of CBT. The intervention consisted of socialisation to the model, psychoeducation, building a hierarchy of traumatic events, reliving and cognitive restructuring. I modified my use of language, utilised different mediums of presentation and flexibly adapted the pace and content of the intervention to suit Holly's needs and aid her understanding. For example, increased time was spent on engaging Holly by building up a pictorial hierarchy of traumatic events.

**Outcome:** Although Holly showed improvement in symptoms of anxiety, it was felt that she would benefit from further sessions focusing upon consolidating some of the work carried out. Therefore, another psychologist in the team continued to see Holly following the end of my placement.

**Focus of the Oral Presentation:** I feel that this case illustrated a development in my CBT intervention skills, namely reliving and cognitive restructuring. I felt better able to identify 'hotspots' using Socratic questioning during reliving sessions and suitably apply cognitive restructuring techniques to identify and modify maladaptive appraisals.

Critical evaluation of this case, self reflexivity and issues relating to diversity are also explored.
SUMMARY OF CASE REPORT 5 - ADVANCED COMPETENCIES

*Working with 'Worry': Using a Narrative Approach with a Thirteen Year Old Boy*

April 2011
Referral: Tom is a thirteen year old boy of White British ethnicity, who was referred to the Child and Adolescent Mental Health Service psychology department, following concerns surrounding Obsessive Compulsive Disorder.

Presenting Problem: Tom reported experiencing constant "worry" that if he did not do certain things, something might happen to his or his mother's health.

Assessment: An initial assessment was conducted with Tom and his family, jointly by my supervisor and I.

Formulation: Tom's difficulties were formulated using a Narrative Therapy (NT) framework. Working within a NT approach, the description of the problem as "worry" was upheld.

Intervention: To date, Tom and his family engaged in seven sessions of NT. These sessions focused on externalising the 'worry', exploring the effects of 'worry', tracing the history of 'worry', discovering and expanding upon unique outcomes.

Outcome: Feedback was gathered from all perspectives at a formal review session. 'Worry' was reported to have become less troublesome; however Tom felt that he wanted to have a bit more control over 'worry' in the future. Future sessions aimed to develop and thicken the alternative story that had started to emerge of 'defiance and determination'.

Reformulation: Following the review, a therapeutic letter was sent to the family. This enabled a reformulation to be considered, taking into account the changes and new information that had become apparent through the intervention.

Critical evaluation of the therapy and issues relating to diversity are also explored.
RESEARCH LOG CHECKLIST

Summary of Research Skills and Experience
## Research Log Checklist

1. Formulating and testing hypotheses and research questions ✓
2. Carrying out a structured literature search using information technology and literature search tools ✓
3. Critically reviewing relevant literature and evaluating research methods ✓
4. Formulating specific research questions ✓
5. Writing brief research proposals ✓
6. Writing detailed research proposals/protocols ✓
7. Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly ✓
8. Obtaining approval from a research ethics committee ✓
9. Obtaining appropriate supervision for research ✓
10. Obtaining appropriate collaboration for research ✓
11. Collecting data from research participants ✓
12. Choosing appropriate design for research questions ✓
13. Writing patient information and consent forms ✓
14. Devising and administering questionnaires ✓
15. Negotiating access to study participants in applied NHS settings ✓
16. Setting up a data file ✓
17. Conducting statistical data analysis using SPSS ✓
18. Choosing appropriate statistical analyses ✓
19. Preparing qualitative data for analysis ✓
20. Choosing appropriate quantitative data analysis ✓
21. Summarising results in figures and tables ✓
22. Conducting semi-structured interviews ✓
23. Transcribing and analysing interview data using qualitative methods ✓
24. Choosing appropriate qualitative analyses ✓
25. Interpreting results from quantitative and qualitative data analysis ✓
26. Presenting research findings in a variety of contexts ✓
27. Producing a written report on a research project ✓
28. Defending own research decisions and analyses ✓
29. Submitting research reports for publication in peer-reviewed journals or edited books ✓
30. Applying research findings to clinical practice ✓
SERVICE RELATED RESEARCH PROJECT

Evaluation of a Dialectical Behaviour Therapy Service

July 2009
Acknowledgements

I would like to thank my placement supervisor for proposing the idea and for giving me further support and guidance with this project. I also am grateful to my supervisor on the clinical psychology training course team who offered me advice and assistance with the project. Finally I would like to thank the professionals who ran the DBT service for allowing me to audit their practice.
Abstract

Title: Evaluation of a Dialectical Behavioural Therapy Service

Objectives: To evaluate the effectiveness of a Dialectical Behavioural Therapy (DBT) service provided by two Primary Care Mental Health Teams (PCMHT).

Design: A repeated measures design was used to assess whether overall client distress and specific symptoms and behaviours decreased over the duration of the therapy. Single-case analysis was also employed to determine whether there was positive reliable change at the end of the therapy.

Participants: Five female service users with a diagnosis of BPD participated in the 6 month DBT service.

Outcome Measures: Overall symptom severity and specific symptoms were measured using the Symptom Checklist-90-R (SCL-90-R). Self-injurious behaviours were assessed using the Health of the Nation Outcome Scales (HoNOS). Service user evaluation questionnaires were also used to assess participants' views about the DBT service.

Results: Repeated measures ANOVA revealed that interpersonal sensitivity and phobic anxiety decreased over the course of the intervention. Paired t-tests revealed that global symptom severity and paranoid ideation were also significantly lower by the end of the therapy. Self-injurious behaviours were not found to significantly decrease during the therapy. Single-case analysis illustrated reliable change for clients on a number of symptom subscales and overall symptom severity of the SCL-90-R. In addition, service users generally reported satisfaction regarding the practicalities and overall experience of the program.

Conclusions: The results provide some justification for the future provision of the DBT service.
Introduction

Borderline Personality Disorder

Borderline Personality Disorder (BPD) is one of the most severe and complex mental health disorders (Kerr et al., 2009). The core feature of the disorder is thought to be emotional dysregulation characterised by frequent changes in mood, and fear of abandonment and rejection (Linehan, 1993). Individuals who are diagnosed with BPD can also present with a range of other behaviours including impulsive risk taking, suicide attempts and persistent self-injury (e.g. Sambrook et al., 2006). BPD is frequently associated with a number of co-morbid mental disorders including depression, anxiety, alcohol disorders and eating disorders (National Institute of Health and Clinical Excellence [NICE], 2009). BPD is also linked with significant personal, social and occupational impairments, which has been attributed to the difficulty individuals encounter in sustaining stable relationships (NICE, 2009).

Given the breadth and severity of symptoms, it is unsurprising that individuals with BPD are found to be high treatment utilisers (Surber et al., 1987). However, a number of interventions for BPD have been found to be largely ineffective. Moreover, staff administering therapy often experience emotional ‘burn-out’ (Kennedy & Thomas, 2007).

Dialectical Behavioural Therapy

Dialectical Behavioural Therapy (DBT) (Linehan, 1993) was devised with the aim of offering individuals diagnosed with BPD a comprehensive treatment approach designed to target areas of emotion dysregulation. DBT comprises group skills training, individual therapy, and telephone consultation administered by qualified staff members. DBT combines behavioural and acceptance strategies to enhance commitment, increase adaptive coping skills and reduce self-injurious and suicidal behaviours.

Initial studies have shown DBT to be one the few therapies effective in reducing the psychological distress and self-harming behaviours associated with BPD (Linehan et al., 1991; Linehan et al., 2006). As a result, the National Institute for Mental Health in England (NIHME) recommended DBT as one of the preferred therapies for BPD and proposed a drive towards training multidisciplinary team members to deliver this therapy (Department of Health, 2003). However, at present there is only limited evidence for the effectiveness of psychological interventions for BPD (NICE, 2009). NICE have therefore emphasised the
importance of further research "to develop a better understanding of their efficacy" (NICE, 2009, pp.33).

Objectives

The current study thus sought to assess the effectiveness of a DBT service provided jointly by two Primary Care Mental Health Teams (PCMHT). The service ran for six months and consisted of individual therapy and emotional skills groups administered across three core modules. The intervention aimed to reduce self-harming behaviours as well as reducing overall psychological distress (depression, anxiety, hostility and psychotic symptoms). Following completion of the three modules, client feedback was obtained in order to gain insight into how the therapy was regarded, and to facilitate future development of the DBT provision.

Given the range of symptoms and behaviours experienced by individuals with BPD, it appeared important to employ a multi-faceted evaluation of the service.

Hypotheses

1. Participants’ distress would significantly decrease over the course of the DBT program.
2. Self-injurious behaviours would decrease over the course of the DBT program.
3. For each individual client, reliable change would be seen following completion of the DBT program for overall distress and individual symptoms of BPD. It was considered unlikely that by the end of the program, participants’ scores would be more similar to the general population compared with the clinical population (clinically significant change) given the severe and enduring nature of BPD.

Method

Participants

Five female service users (mean age = 43.8 years) participated in the 6 month DBT service. All participants met the DSM-IV-TR (American Psychiatric Association, 2000) diagnosis for BPD.

Measures

Each participant completed the Symptom Checklist-90-R (SCL-90-R) (Derogatis, 1994). This is a self-report symptom inventory comprising 90 items. Each item is rated on a 5-point
The SCL-90-R was administered on four occasions; prior to starting DBT and after the completion of each module.

A multidisciplinary team member allocated to each participant completed the Health of the Nation Outcome Scales (HoNOS). This is a 12 item measure of behaviour, impairment, symptoms and social functioning (Wing et al., 1996). One of the items specifically concerns self-injury. Each item is rated on a 5-point Likert scale ranging from 'No Problem' to 'Severe to Very Severe Problem'. The 12 items are summed to form an overall score. The HoNOS was administered on four occasions; prior to starting DBT and at the end of each module.

Participants also completed a service user evaluation questionnaire (see Appendix 1) following completion of the DBT program. This assessed both the logistical aspects of the DBT service as well as the participants' experience of the program. Each item was rated on a 4-point Likert scale.

**Design**

The study employed a within-subjects design. The dependent variables were the SCL-90-R (nine primary symptom dimensions and the GSI) and the HoNOS (overall score and self-injury sub-scale). The independent variable was the time point (prior to starting DBT and at the end of each module). Given the limited number of participants in the current study and the importance of assessing within-participant variability over a treatment course (Long & Hollin, 1995), a single-case design was also employed.

**Procedure**

The DBT service was conducted within a Primary Care Mental Health Team. Five service users received this provision over a 6 month period. The emotional coping groups consisted of 24 sessions which were divided into three consecutive modules. The three modules each consisted of 8 sessions, and were labelled distress tolerance, emotional regulation and interpersonal effectiveness. Each module also contained core mindfulness. Each service user was allocated to one of the trained multidisciplinary team members involved in this service and received individual therapy from this professional throughout the duration of the service. This team member completed the HoNOS prior to the start of DBT and at the
end of each module. Service users were expected to fill out their diary cards on a daily or weekly basis and were given the SCL-90-R to complete at the beginning of therapy and at the end of each module. Service user evaluation forms were completed on the last group session.

Ethical Considerations

The present study is a service evaluation and therefore did not require ethical approval. However all data were anonymised in order to preserve participant confidentiality.

Results

For each of the SCL-90-R completed by the participants, ten measures were computed; the nine subscales and an overall GSI measure. The twelve items of the HoNOS, completed by each participant's care co-ordinator, were summed to form an overall measure for each person. Inspection of the distributions suggested that scores on each of the scales were normally distributed. No significance testing was performed on the service-user evaluation data, however participants' responses were summarised.

SCL-90-R

Group-Level Analyses

The overall mean scores on the nine subscales of the SCL-90-R at each of the four time points are described in Table 1 and represented in Figure 1. For each of the subscales there appears to be a decrease in score between module 1 and module 3. It is also worth noting for all the subscales except OC and IS, there appears to be a slight increase in the mean standardised scores at the end of module 2.
Table 1: Mean differences and effect sizes for each of the scales of the SCL-90-R. Effect sizes indicate Cohen's d values.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>Mean Difference</th>
<th>SD of Difference</th>
<th>P-value</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
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<td>SOM</td>
<td>58.2</td>
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<td>6.8</td>
<td>0.47</td>
<td>0.35*</td>
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<tr>
<td>OC</td>
<td>59.0</td>
<td>57.0</td>
<td>2.0</td>
<td>4.9</td>
<td>0.41</td>
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<td>8.2</td>
<td>5.2</td>
<td>0.02</td>
<td>1.59**</td>
</tr>
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<td>56.8</td>
<td>48.6</td>
<td>8.2</td>
<td>7.5</td>
<td>0.07</td>
<td>1.09**</td>
</tr>
<tr>
<td>ANX</td>
<td>59.8</td>
<td>53.6</td>
<td>6.2</td>
<td>5.7</td>
<td>0.07</td>
<td>1.09**</td>
</tr>
<tr>
<td>HOS</td>
<td>51.8</td>
<td>46.4</td>
<td>5.4</td>
<td>5.9</td>
<td>0.11</td>
<td>0.92**</td>
</tr>
<tr>
<td>PHOB</td>
<td>64.6</td>
<td>59.8</td>
<td>4.8</td>
<td>3.6</td>
<td>0.04</td>
<td>1.32**</td>
</tr>
<tr>
<td>PARA</td>
<td>56.0</td>
<td>52.2</td>
<td>3.8</td>
<td>3.0</td>
<td>0.05</td>
<td>1.25**</td>
</tr>
<tr>
<td>PSYCH</td>
<td>61.2</td>
<td>57.2</td>
<td>4.0</td>
<td>4.5</td>
<td>0.12</td>
<td>0.88**</td>
</tr>
<tr>
<td>GSI</td>
<td>61.4</td>
<td>55.2</td>
<td>6.2</td>
<td>4.7</td>
<td>0.04</td>
<td>1.32**</td>
</tr>
</tbody>
</table>

* Denotes a medium effect size
** Denotes a large effect size
a Denotes significant at $p < .05$

Figure 1: Mean standardised scores for each nine subscales of the SCL-90-R measured at four time points during the DBT service.
The nine subscales and the overall GSI measure of the SCL-90-R were analysed using ANOVA with time point (before therapy; end of module 1; end of module 2; end of module 3) as a within-subjects factor. There was a suggestion that GSI scores varied significantly between time points \( F(3,12) = 3.07; p = .069 \) and a paired t-test showed that GSI scores were significantly lower following completion of the DBT program than prior to therapy \( t(4) = 2.94; p < .05 \). IS scores varied significantly between time points \( F(3,12) = 7.30; p < .01 \) and a significant linear trend \( F(1,4) = 20.59; p < .05 \) indicated that scores decreased over the course of the intervention. The analysis of the PHOB subscale showed significant variation between time points \( F(3,12) = 3.94; p < .011 \) and a linear trend \( F(1,4) = 8.42; p < .05 \) indicated significant improvement over the course of the intervention.

The analysis of the remaining six subscales (SOM, DEP, ANX, HOS, PARA and PSYCH) did not reveal statistically significant main effects of time point (all effects \( p > .05 \)). However, paired sample t-tests found that PARA scores on completion of the program were significantly lower than scores prior to therapy \( t(4) = 2.80; p < .05 \). In addition, marginally significant paired t-tests suggested that DEP \( t(4) = 2.43; p = .072 \) and ANX \( t(4) = 2.44 ; p = .071 \) scores were lower following completion of the DBT program. Despite the slight increase seen in several of the subscales at the end of module-two, the sample size was too small to significantly detect a cubic-trend.

**Single-Case Analysis**

In order to evaluate within-participant variability over the DBT service, single-case analysis was conducted on each of the nine subscales and the overall GSI measure of the SCL-90-R. The within-case analysis, as outlined by Jacobson & Truax (1991), was assessed in two ways. First, the reliable change index (RCI) (Jacobson & Truax, 1991) was used to determine whether the degree of change observed for each client was unlikely to be due to chance. For the GSI and nine subscales, the reliability coefficient (\( \alpha \)) needed for this calculation was taken from the SCL-90-R manual (Derogatis, 1994) and a frequently cited study by Franke (1995). The relevant alpha values are presented in Table 2. A change of more than 1.96 from pre- to post-intervention was taken to signify that the change was reliable at a 5% significance level. Secondly, the clinically significant change (CSC) index (Jacobson & Truax, 1991) was used to establish whether individual scores remained within the clinical range, or were more typical of the non-clinical population. Group norms were taken from the SCL-90-R manual (Derogatis, 1994).
Table 2: Client Data and Reliable Change and Clinically Significant Change Indications for the nine subscales and global symptom index of the SCL-90-R.

<table>
<thead>
<tr>
<th>Client</th>
<th>GSI Pre</th>
<th>GSI Post</th>
<th>SOM Pre</th>
<th>SOM Post</th>
<th>OC Pre</th>
<th>OC Post</th>
<th>IS Pre</th>
<th>IS Post</th>
<th>DEP Pre</th>
<th>DEP Post</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a=.98</td>
<td></td>
<td>a=.88</td>
<td></td>
<td>a=.87</td>
<td></td>
<td>a=.84</td>
<td></td>
<td>a=.90</td>
<td></td>
</tr>
<tr>
<td>Client 1</td>
<td>69a</td>
<td>59a, c</td>
<td>57a</td>
<td>54a, c</td>
<td>63a</td>
<td>57a, c</td>
<td>73a</td>
<td>60a, c</td>
<td>68a</td>
<td>54a, c</td>
</tr>
<tr>
<td>Client 2</td>
<td>54a</td>
<td>56a</td>
<td>65a</td>
<td>58a, c</td>
<td>59a</td>
<td>55a, c</td>
<td>60a</td>
<td>46a, c</td>
<td>61a</td>
<td>50a, c</td>
</tr>
<tr>
<td>Client 3</td>
<td>69a</td>
<td>59a, c</td>
<td>62a</td>
<td>59a, c</td>
<td>67a</td>
<td>63a, c</td>
<td>62a</td>
<td>57a, c</td>
<td>51a</td>
<td>41a, c</td>
</tr>
<tr>
<td>Client 4</td>
<td>62a</td>
<td>54a, c</td>
<td>50a</td>
<td>59a</td>
<td>54a</td>
<td>60a</td>
<td>59a</td>
<td>57a</td>
<td>50a</td>
<td>55a</td>
</tr>
<tr>
<td>Client 5</td>
<td>56a</td>
<td>48a, c</td>
<td>57a</td>
<td>49a, c</td>
<td>55a</td>
<td>50a, c</td>
<td>63a</td>
<td>56a, c</td>
<td>54a</td>
<td>43a, c</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client</th>
<th>ANX Pre</th>
<th>HOS Pre</th>
<th>PHOB Pre</th>
<th>PARA Pre</th>
<th>PSYCH Pre</th>
<th>ANX Post</th>
<th>HOS Post</th>
<th>PHOB Post</th>
<th>PARA Post</th>
<th>PSYCH Post</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>a=.88</td>
<td>a=.85</td>
<td>a=.89</td>
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<td>a=.80</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Client 1</td>
<td>71a</td>
<td>55a, c</td>
<td>59a</td>
<td>52a, c</td>
<td>65a</td>
<td>64a, c</td>
<td>64a</td>
<td>56a, c</td>
<td>68a</td>
<td>60a, c</td>
</tr>
<tr>
<td>Client 2</td>
<td>60a</td>
<td>54a, c</td>
<td>50a</td>
<td>43b, c</td>
<td>64a</td>
<td>57a</td>
<td>47a</td>
<td>46a</td>
<td>59a</td>
<td>59a</td>
</tr>
<tr>
<td>Client 3</td>
<td>62a</td>
<td>59a, c</td>
<td>52a</td>
<td>39b, c</td>
<td>68a</td>
<td>58a</td>
<td>67a</td>
<td>61a, c</td>
<td>79a</td>
<td>70a, c</td>
</tr>
<tr>
<td>Client 4</td>
<td>55a</td>
<td>51a, c</td>
<td>45</td>
<td>48a</td>
<td>64a</td>
<td>61a</td>
<td>53a</td>
<td>51a</td>
<td>53a</td>
<td>54a</td>
</tr>
<tr>
<td>Client 5</td>
<td>51a</td>
<td>49a, c</td>
<td>53a</td>
<td>50a</td>
<td>62a</td>
<td>59a, c</td>
<td>49a</td>
<td>47a</td>
<td>47a</td>
<td>43a</td>
</tr>
</tbody>
</table>

a. Denotes within the 'clinical' range.
b. Denoted within the 'non-clinical' range.
c. Reliable (positive) change observed from pre-intervention observation (significant at p < .05)

The outcomes of the within-case analyses are presented in Table 2. Client 1 and client 3 showed a positive reliable change on all of the nine subscales and the GSI at post-intervention. Client 2 demonstrated a positive reliable change on all subscales except PARA and PSYCH but reliable change was not observed on the GSI at post-intervention. Client 4 showed a positive reliable change at post-intervention on only the GSI and the ANX and PHOB subscales. At post-intervention client 5 demonstrated a positive reliable change on the GSI and all of the subscales except HOS, PARA and PSYCH. For clients 1, 4 and 5, no clinically significant change was observed at post-intervention for any of the subscales or the GSI. For client 2 and 3, clinically significant change was only observed at post-intervention for the HOS subscale.
HoNOS
The overall score and the self-injurious subscale of the HoNOS were subjected to a repeated measures ANOVA, with time point as a within-subjects factor. No significant main effect of time point was observed. Similarly overall scores at completion (mean = 17.8; SD = 5.2) were found to be comparable with those prior to the intervention (mean = 18.2; SD = 2.8). These analyses suggest that the client risk, as perceived by the individual therapists, remained broadly constant across the service.

Service User Evaluation Forms
Each participant completed a service user evaluation form. Appendix 2 shows the responses in percentages to the evaluation questions regarding the DBT service. For questions surrounding the logistics and practicalities of the group, all participants agreed or strongly agreed that they were given enough information prior to starting the group and that the waiting time was acceptable. However, 2 of the 5 participant responses indicated that the group was held in an inconvenient location. Responses regarding participants’ experience of the group were varied. Four of participants found it ‘a little’ to ‘fairly’ easy to share their experiences with the DBT group, whereas, one participant found they could not share any of their experiences at all with the group. Four of the group felt that the DBT service had a fairly to very positive impact on their lives and that the individual DOT sessions strengthened their skill use. In terms of giving honest feedback to facilitators regarding the clients’ experiences of DBT, 4 of the 5 participants found they were ‘very’ to ‘fairly’ able to do this. Encouragingly, only one client reported that they were able to give honest feedback ‘a little’ of the time.

Discussion

Summary of Results
The first hypothesis that participants’ distress would decrease over the course of the DBT program was partially supported. Despite the small sample size, there was evidence that levels of interpersonal sensitivity and phobic anxiety decreased over the course of the intervention. There was also some suggestion that clients’ overall symptom severity and paranoid ideation had decreased by the end of the program and weaker evidence for a decrease in clients’ depression and anxiety. The second hypothesis that self-injurious behaviours would decrease over the course of the DBT program was not supported. A slight
A decrease in the self-injurious subscale of the HoNOS was observed, however this was not significant. It is possible with a larger sample and increased statistical power, a significant improvement may have been detected.

The third hypothesis that reliable change would be observed for overall symptom severity and specific individual symptoms was partially supported. Encouragingly, four of five clients showed reliable improvement for overall symptom severity, as well as somatisisation, obsessive compulsions, interpersonal sensitivity and depression. Moreover, all five clients showed reliable improvement for anxiety and phobic anxiety symptoms. However, only three clients showed reliable improvement for hostility, whereas only two demonstrated reliable improvement for paranoid ideation and psychoticism.

Review of the client feedback forms indicated that the service was acceptable in terms of information given, time it was held and waiting time. Every client reported that to some extent, the DBT service had a positive impact upon their lives and that the individual sessions were of some benefit to them. However, it appeared that some of the clients found it difficult to discuss their experiences within a group setting and two expressed concerns about the location of the service.

Strengths and Limitations

The standardised assessment measures used in the present study, enabled both group and single-case analyses to be carried out. In this instance, individual case analysis appeared to provide richer more meaningful data and a greater insight into improvements in particular symptom areas.

Regrettably, the small sample size meant that the group-level analyses had limited statistical power. Moreover, the sampling strategy, sample size and lack of a control group severely restrict the generalisability of the current findings, as they reflect the outcome of a single DBT service with no comparison group. Another potential limitation was that a comprehensive self-report measure of self-harming behaviours was not used to evaluate the service. Given that individuals with BPD often display frequent and severe self-injurious behaviours, a self-report measure of self-harm would have been a useful way of measuring the outcome of the DBT service.
Implications and Recommendations

The evidence that the DBT service had a positive impact upon clients' symptom severity supports future provision of DBT services. However, the lack of clear evidence that DBT improves self-injurious behaviours may motivate further evaluation. Future studies might evaluate several DBT services collectively. Such a design would eliminate any artefacts due to sampling bias, and ensure greater statistical power. In addition, it is recommended that a detailed self-report measure of self-harm be incorporated to more rigorously evaluate the impact that DBT has upon self-injurious behaviours. Indeed, a measure such as the Deliberate Self-Harm Inventory (DSHI), which has been found to have high internal validity and reliability (Gratz, 2001), could be utilised for this purpose.

The client feedback indicated that future delivery of the DBT service should try to facilitate the ease in which clients were able to speak about their experiences within the group. This could be achieved by spending more time engaging the clients in ice-breaker activities and emphasising core ground rules such as confidentiality.

In order to ensure that the insights gained from this evaluation were used to improve future DBT services, the findings and recommendations were relayed to the two PCMHT’s via a short presentation. Subsequently, it was decided that the next DBT group would be administered the DSHI at the beginning of therapy and at the end of each module.

Conclusion

The present study has proved useful in demonstrating the effectiveness of DBT as an intervention for BPD. In the majority of cases clients' overall distress decreased and an improvement was also seen on several symptoms. These findings not only justify future provision of DBT, but the limitations of the study may also inform future evaluations of DBT services.

5 Confirmation that these findings and recommendations were presented to the PCMHT was provided by the researcher's supervisor via email communication (Appendix 3).
References


### Appendix 1

#### Service User Evaluation Questionnaire

Below are some statements and questions about your experience of the DBT Group. Please read each statement or question and then circle to show how much you agree with that statement.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I was given enough information about the group beforehand</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>2.</td>
<td>I think the waiting time to for the group was reasonable</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>3.</td>
<td>The group was held in a convenient place for me</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td></td>
<td>Which places would have been more convenient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The group was held at a convenient time for me</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td></td>
<td>Which times would have been more convenient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The order of the DBT Group modules was: Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness. All modules began with Mindfulness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Were the modules were in the right order for you?</td>
<td>Yes</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>If no, what order would you have preferred?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>How easy did you find it sharing your practice commitments with the DBT Group?</td>
<td>Not at all</td>
<td>A little</td>
</tr>
<tr>
<td></td>
<td>Is there anything that would have made it easier for you</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Has your use of DBT skills had a positive impact on your life? E.g. in managing stressors or in your relationships?</td>
<td>Not at all</td>
<td>A little</td>
</tr>
<tr>
<td>8.</td>
<td>Individual DBT sessions are an opportunity to strengthen skills use. Did your individual sessions help to do this?</td>
<td>Not at all</td>
<td>A little</td>
</tr>
<tr>
<td>9.</td>
<td>Have you felt able to give the group facilitators honest feedback to about your experience of the group?</td>
<td>Not at all</td>
<td>A little</td>
</tr>
</tbody>
</table>
## Appendix 2

### Responses (%) to the Service User Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I was given enough information about the group beforehand.</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>2. I think the waiting time for the group was reasonable.</td>
<td>0%</td>
<td>0%</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>3. The group was held in a convenient place for me.</td>
<td>0%</td>
<td>40%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>4. The group was held at a convenient time for me.</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Question</td>
<td>Not at all</td>
<td>A little</td>
<td>Fairly</td>
<td>Very</td>
</tr>
<tr>
<td>5. How easy did you find it sharing your experiences with the DBT Group?</td>
<td>20%</td>
<td>40%</td>
<td>40%</td>
<td>0%</td>
</tr>
<tr>
<td>6. Has your use of DBT had a positive impact on your life? E.g. in managing your stressors or in your relationships?</td>
<td>0%</td>
<td>20%</td>
<td>60%</td>
<td>20%</td>
</tr>
<tr>
<td>7. Individual DBT sessions are an opportunity to strengthen skill use. Did you individual sessions help to do this?</td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>8. Have you felt able to give the group facilitators honest feedback about your experience of the group?</td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>40%</td>
</tr>
</tbody>
</table>
Appendix 3

Evidence that the Results of SRRP were Presented to the Service

Pratap Sarah (Sussex Partnership Trust) [Sarah.Pratap@sussexpartnership.nhs.uk]
Sent: 14 February 2011 08:57
To: Swanston Jennifer (SURREY PCT)

Dear Jennifer

This is an e-mail to confirm that while you were on your first year placement with me at Redhill, Reigate and Horley PCMHT, you carried out your SRRP looking into the outcome of our DBT skills training group.

Once this was completed you presented the results back to us in the DBT team consultation meeting, consisting of four professionals from a mix of different disciplines. This research was very useful and was used subsequently in the Trust to demonstrate the effectiveness of DBT.

Regards

Dr Sarah Pratap

Chartered Clinical Psychologist
A Qualitative Exploration of Parents' Experiences of Training as a Clinical Psychologist

May 2009
Abstract of Qualitative Research Project

Introduction: The impact that stress has on individuals has been well documented. Whilst the impact it has on postgraduate students and parents undertaking study has been investigated, limited research has been conducted into understanding the experiences of parents undertaking clinical psychology doctoral training. This is in spite of it being considered one of the more challenging postgraduate courses. The present study sought to explore the experiences of parents undertaking clinical psychology doctoral training.

Method: Adopting a qualitative approach, the present study explored four parents' experiences of clinical training using semi-structured interviews. Interpretive Phenomenological Analysis was used to analyse the data.

Results: Five master themes relating to parents' experiences of clinical training were identified. These were: Striking a Personal and Professional Balance, Self-Evaluation, Self and Family Adjustment, Coping Mechanisms and Looking to the Future.

Discussion: The present findings are discussed in relation to previous research. The use of IPA is discussed and the current research evaluated. Implications and future research directions are also considered.

Conclusion: The preliminary findings suggest that clinical doctorate training as a parent can be highly challenging and entails negotiation of professional and personal demands. Practical changes for clinical courses to consider in improving parents' experiences of clinical training are highlighted.
MAJOR RESEARCH PROJECT

Towards a Richer Understanding of School-Age Children's Experiences of Domestic Violence: The Perspectives of Children and their Mothers

July 2011
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ACKNOWLEDGEMENTS

I would like to thank Arlene Vetere, my research supervisor and key charity staff members for their support in undertaking this research. Kind thanks to all of the children and mothers who were willing to share their experiences with me, and without whom this research would not have been possible. Finally, I would like to give special thanks to Laura Bowyer, who has supported me in so many ways throughout this whole process - you are a truly amazing friend.
ABSTRACT

Introduction: Domestic violence is a longstanding phenomenon, affecting children every day. Previous studies have attempted to characterise the negative impact on children, however few have considered how children manage, negotiate, and make sense of their experiences. More pertinently, there is a lack of research that speaks directly with school-aged children living in the community, alongside their mothers, regarding exposure to domestic violence as a child. This study therefore sought to capture the dual-perspectives of school-aged children and their mothers, to develop a richer understanding of children's experiences of domestic violence, using a community-based sample.

Method: A qualitative research design was employed, with interpretative phenomenological analysis used to interpret the data. The study utilised a dual-perspective approach by speaking in parallel with school-aged children and their mothers. Five school-aged children and three of their mothers participated in the study.

Results: Two master themes are discussed from the analysis of the children's perspective: Domestic violence through the eyes of children; and learning from children's experiences. Two master themes are discussed from the analysis of the mothers' perspective: Reflecting on the child in the context of domestic violence; and learning from mothers - insights, support and services.

Conclusion: The crucial importance of the mother-child relationship in shaping children's experience of domestic violence was illustrated in both the perspectives; a finding which may have important implications for the development of interventions. It was also evident that children as young as eight were able to powerfully articulate their experiences of domestic violence.
1. INTRODUCTION

1.1 Orientation and Overview

Domestic violence is a longstanding and widespread phenomenon, spanning across ethnicity, culture, religion, social class and education (Alhabib et al., 2010). The difficulties encountered by children who live in this environment have only come to the fore within the last thirty years. Over this time there has been an abundance of empirical studies focusing on the negative impact for children, with less attention aimed at exploring how children manage, negotiate and make sense of the experience of domestic violence. Existing literature is also reliant on refuge samples, and under-represents the views of children who reside in the community. More pertinently, there is a lack of research that speaks with school-aged children alongside their mothers regarding exposure to domestic violence (Holt et al., 2008). This study therefore sought to capture the dual-perspectives of community-based school-aged children and their mothers, to develop a better understanding of children’s experiences of domestic violence.

To begin, domestic violence will be introduced and children’s exposure to this phenomenon explored. The quantitative literature surrounding the impact of domestic violence on children and factors influencing this will then be discussed and critiqued. Following this, the same will be done for existing qualitative research exploring children’s and mothers’ perceptions regarding exposure to domestic violence as a child. Finally, the rationale and aims of the current study will be presented.

1.2 Children and Domestic Violence

1.2.1 Domestic Violence: Definition and Prevalence

Domestic violence has been defined as a pattern of coercive behaviours carried out by a former or current intimate partner, intended to gain or sustain control in the relationship (British Medical Association, 2007). These behaviours, which include physical, verbal, sexual, emotional, psychological and/or financial abuse, can each occur alone or simultaneously. It is worth noting that the term ‘domestic violence’ is problematic because it highlights the physical component of domestic abuse, neglecting the other equally damaging forms of abuse that can occur (Stark & Flitcraft, 1996). However, ‘domestic violence’ is the most widely used term to denote intimate partner abuse within a domestic setting and therefore is used throughout this study.
Reports indicate that in the UK, at least one in four women experience domestic violence in their lifetime (Flatley et al., 2010). However, figures are often taken from crime statistics, which inevitably under represent true prevalence rates (Flatley et al., 2010). Indeed, crime statistics centre on physical violence, often neglecting other forms of abuse such as sexual or emotional. Moreover, victims of domestic violence are often overwhelmed by fear for their safety, apprehension that they will not be believed and feelings of shame and self-blame (McWilliams & McKiernan, 1993); all factors decreasing the likelihood of victims reporting domestic violence.

Domestic Violence is more commonly carried out by a male perpetrator against a female victim (Humphreys et al., 2008). Nevertheless, it is acknowledged that domestic violence is experienced in different ways, including “women’s violence towards their male partners, women’s abuse of children, the abuse of women by other female relatives or the man’s new partner, women’s violence in lesbian relationships, male violence in gay relationships, relationships in which both the woman and man are violent and abusive towards each other, [and] abuse by carers of disabled women” (Humphreys et al., 2008, p.15). The focus of the current study is on the most common type of domestic violence to which a child is exposed: the abuse of an adult woman by a previous or current male partner, who may or may not be living at the family home (Watson & Parsons, 2005).

1.2.2 Children’s Exposure to Domestic Violence

Historically children were thought to be ‘silent witnesses’ of the violence that occurred between their parents, peripheral to the experience (McIntosh, 2003). However, over the past 20 years there has been increasing evidence to suggest that children are in fact acutely aware of domestic violence occurring in their home. Although it is largely unknown exactly how many children are exposed, many studies suggest that the figure is high (Holt et al., 2008). In a report of domestic violence in Britain, McVeigh et al. (2005) highlighted that children were either present or within earshot of domestic violence in 90% of cases. Graphic descriptions and detailed recall of incidents of domestic violence can be given by children as young as three years old (Docherty & Sandelowski, 1999).

It is now widely acknowledged that the term ‘exposure’ encapsulates far more than the child witnessing or overhearing episodes of domestic violence (Edleson, 1999). For example, children often experience the aftermath of the violence as traumatic, such as seeing inflicted injuries or hearing recounts in later years (Ganley & Schechter, 1996). Thus,
for the purpose of this study, children's 'exposure' to domestic violence encapsulates far more than being within sight or sound of any incidents taking place within their home. Furthermore, many children exposed to domestic violence are likely to experience multiple adversities (Connolly et al., 2006). Children exposed to domestic violence are more likely to encounter child abuse, parental substance abuse, homelessness and social isolation (Golding, 1999). The co-occurrence of these adversities means that teasing out the impact of domestic violence on children is problematic (Connolly et al., 2006), yet something which the quantitative literature has endeavoured to explore.

1.3 Quantitative Literature

Not surprisingly, research has found that children exposed to domestic violence experience a range of behavioural, social, emotional, physical and long term detrimental consequences (English et al., 2005). The quantitative research has explored what factors may influence the relationship between exposure to domestic violence as a child and subsequent negative consequences; for example the quality of the mother-child relationship and the child's developmental stage. An outline of this quantitative literature will now be presented.

1.3.1 Impact of Domestic Violence

Children exposed to domestic violence are reported by parents and teachers to display higher levels of behavioural problems and physical aggression compared with their counterparts from families where domestic violence is absent (Sternberg et al., 2006). For example, studies using the Child Behaviour Checklist (Achenbach & Edelbrock, 1983) have found children exhibit significantly higher externalising behaviours (e.g. aggression, hostility and defiance), as well as internalising behaviours such as withdrawal and hyper-vigilance (Fantuzzo et al., 1991; Sternberg et al., 2006). Furthermore, children exposed to domestic violence have been found to experience higher levels of emotional problems compared with children not exposed (Kitzmann et al., 2003). For example, symptoms of depression, anxiety and post-traumatic stress disorder (PTSD) have been associated with exposure to domestic violence as a child (Sternberg et al., 2006; Zinzow et al., 2009). In addition, several studies suggest a physical health impact for children exposed to domestic violence; finding these children often experience feeding difficulties, stomach aches, headaches, enuresis, insomnia and asthma (see Carlson, 2000 for a review). For younger children, physical symptoms are hypothesised to be a manifestation of extreme fear due to a developmentally limited ability to verbalise strong emotions (Martin, 2002).
Turning to trauma theories, it is thought that behaviours such as withdrawal serve as protective in the context of ongoing violence (e.g. van der Kolk et al., 1996). However, in the long-term these behaviours limit the child accessing adult support which is known to buffer the development of further symptoms (Rossmann et al., 1997). Trauma theories further suggest that behaviours such as hyper-vigilance may protect the child in a threatening environment, but compromise the child’s ability to concentrate in other areas such as at school (Pollock & Kistler, 2002).

In relation to long-term implications of exposure to domestic violence as a child, research has indicated a higher likelihood of later involvement in anti-social behaviour, substance abuse, violent crime and adult criminality (e.g. Edleson, 1999; Osofsky, 1999). For example, Trocki and Caetano (2004) found higher rates of depression, drug and alcohol abuse in adults who had witnessed domestic violence as a child. Models of trauma have suggested that the use of alcohol or drugs in individuals exposed to threatening situations can be understood as strategies to manage symptoms associated with the trauma (Ehlers & Clark, 2000). There are however long-term consequences of this, such as the maintenance and exacerbation of symptoms of anxiety, depression and PTSD.

There is also evidence that adults from this context are more likely to act violently towards an intimate partner (Coohey, 2004). This provides support for the intergenerational transmission of violence theory, which postulates that exposure to domestic violence as a child is likely to lead to greater acceptance or use of violence as an adult (Smith et al., 2000). However, findings remain equivocal with some studies suggesting that children exposed to domestic violence have equivalent or better outcomes compared with children who are not (Kitzmann et al., 2003).

### 1.3.2 Factors Influencing Outcomes

It has been highlighted that research should seek to move past merely documenting the negative outcomes for children, towards understanding the factors influencing these outcomes (Kerig, 1998). A range of moderating\(^6\) and mediating\(^7\) factors have been explored in order to better understand the varying impact that exposure to domestic violence has on children. Research has investigated factors such as age of onset, gender, socioeconomic status, ethnicity, severity and type of abuse, coping styles, modelling, PTSD and disrupted

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\(^6\) Carlson (2000) explains “Moderators are factors that influence the strength or direction of the relationship between a predictor variable, such as exposure to partner violence, and outcome variables” (p.329).

\(^7\) Mediators are factors which explain the relationship between exposure to domestic violence as a child and consequent negative outcomes (Carlson, 2000).
parenting. The literature provides a mixed picture, with some studies providing support for these factors as either moderators or mediators (e.g. Kennedy et al., 2010) and others finding no such evidence (e.g. Zinzow et al., 2009). Nevertheless, two factors have received particular attention within the literature: the developmental stage of the child and the relationship between mother and child.

**Developmental Stage**

Research has explored how the impact of exposure to domestic violence presents differently according to developmental stage. Child development is often categorised using the following stages: pre-natal, infancy, toddlerhood, pre-school, school-age and adolescence (Cunningham & Baker, 2004). It has been suggested that the child's age will fundamentally influence the impact that domestic violence has upon them, given the role of developmental ability in relation to how distress is expressed and in understanding and processing of an experience (Holt et al., 2008). A review of empirical studies conducted by Carlson (2000) suggests that the impact of exposure to domestic violence varies according to the developmental stage of the child (see Table 1). However, many studies do not incorporate developmental stage into their design. This is unfortunate in light of considerable child development research, which argues that 'childhood' is far from homogeneous (e.g. Bowlby, 1988).

**Table 1: Effect of Exposure to Domestic Violence by Developmental Level - Taken from Carlson (2000).**

<table>
<thead>
<tr>
<th>Infants/Toddlers</th>
<th>Pre-schoolers</th>
<th>School-Aged</th>
<th>Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioural</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being fussy</td>
<td>Aggression, behaviour problems</td>
<td>Aggression, conduct problems, disobedience</td>
<td>Dating violence, delinquency, running away</td>
</tr>
<tr>
<td><strong>Emotional</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distress, problems sleeping, eating</td>
<td>Fear and anxiety, sadness, worry about mother, post-traumatic stress disorder, negative affect</td>
<td>Fear and anxiety, depression, low self-esteem, guilt, shame, post-traumatic stress disorder</td>
<td>Depression, suicidality, post-traumatic stress disorder</td>
</tr>
<tr>
<td><strong>Physical</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to understand</td>
<td>Limited understanding, self-blame</td>
<td>More understanding than young children, self-blame, academic problems, pro-violent attitudes</td>
<td>Pro-violent attitudes</td>
</tr>
<tr>
<td><strong>Cognitive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble interacting with peers and adults, ambivalent relationship with caregiver</td>
<td>Fewer and lower quality peer relationships</td>
<td>Violent dating relationships</td>
<td></td>
</tr>
</tbody>
</table>
Mother-Child Relationship

The mother-child relationship is considered an important factor in explaining the negative impact of exposure to domestic violence on children. Empirical research suggests that domestic violence affects the quality of the mother-child relationship (Holt et al., 2008). For example, it has been acknowledged that there are numerous ways the perpetrator can undermine the mother-child relationship, both directly (e.g. not allowing affection to be given to the child) and indirectly (e.g. decreasing the mother's emotional availability for the child through constant abuse) (Humphreys et al., 2011). Further, it is estimated that significant numbers of women encounter mental health difficulties both during and after leaving domestic violence, making it more difficult to parent (Levendosky & Graham-Bermann, 1998).

Attachment theory has long recognised the importance of consistency and responsiveness in relation to the development of a secure attachment relationship between a child and their primary care giver (Ainsworth & Bowlby, 1991). Research has also suggested that a secure attachment can buffer the effects of stressful life events (e.g. Crittenden, 1985). Therefore, it is not surprising that attachment theory has been drawn upon to explain how domestic violence affects the quality of the mother-child relationship (Mcintosh, 2002). For example, attachment theory may explain children's internalising and externalising behaviours as insecure attachment strategies (Holmes, 1993). Whilst insecure attachment strategies are thought to help children maintain vital attachments, they are costly as the child is denied the opportunity to process difficult emotions (Holmes, 1993).

1.4 Critique of Quantitative Research

1.4.1 Methodological Concerns

Whilst producing useful information on the impact of exposure to domestic violence, the majority of these studies collect data from mothers and professionals, with only a handful of studies collecting data from the children themselves. This is problematic due to the potential for these sources to either over or under report the impact upon the child (Appel & Holden, 1998). Further, research has clearly shown that the child's own view of the impact upon them is usually different to that of others, including mothers (e.g. McGee, 1997). It is deemed imperative that research within this field includes children directly in order to give them the opportunity to contribute their own unique experiences of exposure to domestic violence (Mullender et al., 2002).
The literature in this field has an overreliance on participants who are residing in refuges (Martin, 2002). Typically, mothers and children residing in refuges have been exposed to more severe forms of domestic violence and may represent lower socio-demographic groups (Kerig, 1998). Moreover, for refuge samples, it may be very difficult to separate the consequences of living in a refuge from the impact of the domestic violence (Fantuzzo et al., 1991). This means that results cannot be generalised to the much wider population of children who experience domestic violence, but who do not reside in this type of accommodation (Carlson, 2000).

Furthermore, the quantitative research typically relies on the use of questionnaires and checklists which ask about behaviours or symptoms. Conclusions are largely drawn by comparing group results with control samples (children not exposed to domestic violence) or by looking at correlations between certain presentations (e.g. aggression) and exposure to domestic violence. However, these generic measures are not designed to assess the complexity of the impact of exposure to domestic violence on children (Edleson, 1999).

1.4.2 Focus of Quantitative Research

Describing the impact of domestic violence on children using a uniform pattern of symptoms is impossible, as each child is an individual with their own unique circumstances (Morley & Mullender, 1994). This has led to the criticism that quantitative research in this field is focused too narrowly on the negative impact of domestic violence on children, with little attention aimed at exploring a broad range of factors related to exposure (Edleson et al., 2007). Mullender et al. (2002) cites “for children, living with domestic violence requires negotiating, making sense of, and managing a number of complex and overlapping issues” (p.91). However, the nature of empirical research (e.g. reporting group statistics) does little to enlighten the unique experiences of children exposed to domestic violence; including how they make sense of, negotiate and cope with their experience.

Most importantly, there is a lack of research which addresses in parallel the experiences of the child themselves, alongside other perspectives such as family members or professionals (Holt et al., 2008). Indeed, it is thought that the impact of domestic violence on children may be better understood if information is obtained from multiple sources (Sternberg et al., 2006). Thus, there is a need to privilege the voice of the child, alongside understanding how others (e.g. mothers) see that child’s experience.
1.5 Qualitative Literature

In recent years researchers have begun to address some of these concerns surrounding the quantitative literature by using the qualitative paradigm to explore children's exposure to domestic violence.

1.5.1 Children's Experiences of Domestic Violence

Talking with children has demonstrated that they experience domestic violence in many unique ways, each subjective experience shaped by the individual's complex reality (Goldblatt, 2003). In their discussions with 22 participants aged 8 to 18 years old, Buckley et al. (2007) found that children often experience considerable feelings of dread, anxiety and fear surrounding their safety. Children also report feelings of guilt, shame and self-blame surrounding domestic violence (McGee, 2000). Similar findings were reported from interviews with children conducted by Cunningham and Baker (2004). Here drawings provided a useful aid during the interviews with children. Drawings are thought to facilitate children's verbal reports, by helping the child feel more relaxed with the interviewer, organise their narratives and promote self-expression (Malchiodi, 2001).

Children who live with domestic violence report employing complex coping strategies to try and negotiate their environment and make sense of their experiences (Mullender et al., 2002). For example, Templeton et al. (2009) spoke with young people aged 12 to 18 and found some coped with their situation in confrontational ways (e.g. getting involved to protect a mother or sibling) and others by putting distance between themselves and the conflict (e.g. leaving the house). Many children report having to grow up very early, entering into a premature adulthood of insight and competency, something perceived either negatively or positively by children (Goldblatt, 2003).

Not surprisingly, children often report that the experience of domestic violence has a significant impact upon their relationships with parents, peers, teachers and professionals (Mullender et al., 2002). In terms of relationship with parents, some children report feeling torn, having to act as an intermediary between their mother and the perpetrator. Goldblatt (2003) found that some children were frightened and critical of the perpetrator, whilst at the same time feeling empathic towards him. Children often report keeping their friends at a distance due to fear of rejection and embarrassment regarding the situation at home (Buckley et al., 2007). Whilst some children perceived school as a place of safety away from home, others have described how their domestic situation impaired their ability to
complete homework or concentrate in class leading to conflict with teachers (Buckley et al., 2007).

1.5.2 Mothers’ Perceptions

Although there is an increasing literature that asks mothers about their own experiences of domestic violence, there is little qualitative research exploring mothers’ perceptions of their child’s exposure to domestic violence. Nevertheless, the few studies in this area have yielded useful insights. For example, mothers report how their children often needed increased amounts of attention, reassurance and support when living in the context of domestic violence (Mullender et al., 2002). Buckley et al. (2007) conducted focus groups with mothers who gave examples of how they believed teachers and professionals had shown a lack of understanding towards their child’s situation.

Integrating the unique perceptions of both children and their mothers has provided some useful insights surrounding the complexities of the mother-child relationship within this environment:

Women are acutely aware how, within the ideology of motherhood and the family, they have failed, but they believe that within the acutely constraining context of domestic violence they have protected their children both from extensive knowledge of the violence and from premature loss of their family and home. Simultaneously, children try and protect their mothers from awareness of how much they know and how unhappy they are. The consequent silence means that women are living with the illusion that they are staying for the sake of the children, whereas children live with the burden of secretly wishing that their parents would separate. (Mullender et al., 2002, p.176).

Mullender’s research explores the perspectives of mothers alongside the views of the child regarding their exposure to domestic violence. Although still in its infancy, this approach has proved useful in terms of illuminating understanding of this complex phenomenon from multiple perspectives.

1.6 Critique of Qualitative Research

1.6.1 Qualitative Approach

Qualitative designs provide participants with the opportunity to express their perception and understanding of their experiences in their own way, rather than fitting their
experiences to prescribed questions and terminology (Goldblatt, 2003). Qualitative methodology is also particularly advantageous when speaking with children due to their underrepresentation in domestic violence research, the sensitive nature of child research and in obtaining detailed accounts from mothers regarding their child's experiences (Mullender et al., 2002). However, this approach also encounters methodological criticisms, which generally centre on the quality, rigour and validity of qualitative designs (Smith et al., 2009).

Yardley (2000) argues that the validity of qualitative research can be assessed by the researcher's sensitivity to context, commitment, rigour and transparency in relation to data collection and analysis and, most importantly, the overall impact and importance of the research. The importance of researching children's experiences of domestic violence is undeniable, however many qualitative studies fail to provide information surrounding methods of data collection and analysis or evidence of credibility checks.

1.6.2 Gaps in the Qualitative Literature

School-Aged Children

Many of the qualitative studies speak with children from broad age ranges (e.g. Mullender et al., 2002), despite it being well documented that the impact of exposure to domestic violence is likely different for toddlers, pre-schoolers, school-aged children and adolescents (Carlson, 2000). Some qualitative studies have focused upon the adolescent group, however very few have solely based their sample on school-aged children (ages 8 to 12). At this age, children are learning to negotiate their school environment and develop relationships outside of the family context. Compared with pre-schoolers, school-aged children have a growing understanding of the feelings and perspectives of others, meaning that those exposed to domestic violence can show an appreciation of how their mothers might be affected (Cunningham & Baker, 2004). Furthermore, school-aged children show growing awareness and insight into themselves and others, something which means they may develop certain strategies to predict or manage domestic violence (Holt et al., 2008). Gaining the perspective of school-aged children regarding their experience of domestic violence would therefore represent a valuable contribution to the existing literature.

Community Based Sample

In common with the quantitative literature in this area, much of the qualitative research has recruited children and mothers residing in refuges. As described above, refuge populations are thought to be overly representative of lower socio-economic status and
research findings may say more about the unique experience of residing in a refuge, rather than the experience of exposure to domestic violence per se (Kerig, 1998). There is a lack of research which captures the experience of children exposed to domestic violence, who continue to live in the community. These children may well have distinct perceptions surrounding their experiences of domestic violence.

**Multi-Perspective Research**

There is a lack of research which captures children’s experience of domestic violence, as perceived by children themselves and by their mothers. Given the significance of the mother-child relationship (Bowlby, 1988), it seems crucial to explore and understand mothers’ perceptions of their child’s experience of domestic violence in parallel with the child’s own beliefs. Whilst speaking to children in their own right about their experiences remains a valid and meaningful approach, it is thought that the complexities relating to children’s exposure to domestic violence is better understood if information is obtained from multiple sources (Sternberg et al., 2006). Similarly, Mullender et al. (2002) proposes the need for further research into the experiences of children exposed to domestic violence, recommending the direct involvement of both children and their carers within this research.

To date, there has been no research which specifically speaks to both school-aged children residing in the community, and their mothers, about the child’s experience of domestic violence. Exploring both of these perspectives might give rise to some unique insights regarding this group of children.

**1.7 Why is this Important?**

Given the association between exposure to domestic violence and the array of difficulties experienced by children, it is unsurprising that there is a growing need for related services (e.g. housing, financial support and clinical intervention). However, reports suggest that services are consistently failing to provide adequate help for children affected by domestic violence (Hague et al., 2002; NSPCC, 2007). Further, it has been argued that previous research used to inform service provision has been based on refuge samples, consisting of too broad a range of child ages (Cunningham & Baker, 2004). Crucially, it seems that further research is needed to explore the experiences of children from specific age groups, residing in the community, so that domestic violence services can be tailored to meet each child’s individual needs.
As well as speaking with children, there is much to be gained from speaking to mothers about how they perceive their child’s experience of domestic violence (Mullender et al., 2002). Given the potential influence of the mother-child relationship in shaping any potential negative outcomes for children, gaining mothers’ views is an obvious and necessary focus. Indeed, Mullender et al. (2002) comments that it is vitally important that researchers speak directly with mothers to gain an insight into the processes mothers go through surrounding their child’s exposure to domestic violence.

Addressing these weaknesses in the existing literature will support the development of improved interventions. For example, recent research has highlighted the importance of the mother within child interventions, recommending that domestic violence services focus upon enhancing the mother-child relationship. If professionals and services are to better respond to children who have been affected by domestic violence, research is therefore required which speaks to both children and their mothers (McGee, 2000; Mullender et al., 2002).

1.8 Current Study and Research Questions

The current study aims to address the gaps in the literature by placing value in talking to both school-aged children (perspective one) and their mothers (perspective two), whilst recognising that each voice is valid and meaningful in its own right. The aim of doing this is to obtain a dual-perspective understanding of children’s experience of domestic violence. In order to address these aims, this study will focus on addressing the following research questions:

Perspective One
- How do school-aged children make sense of their experience of domestic violence?

Perspective Two
- How do mothers perceive their school-aged child’s experience of domestic violence?
2. METHODOLOGY

2.1 Overview

The research design was qualitative, with Interpretative Phenomenological Analysis (IPA) used as the method of analysis. The study consisted of two perspectives. For perspective one, five school-aged children participated, using semi-structured interviews and drawings as the method of data collection. For perspective two, three mothers of these school-aged children participated, using semi-structured interviews as the method of data collection. Rationale for using this type of design, details relating to the participants, the procedure, ethical considerations, the process of data analysis and quality assurance will be described in detail below.

2.2 Rationale

2.2.1 Position of the Researcher

An underlying assumption of this study was that people have their own unique perception, interpretation and meaning surrounding a phenomenon or experience. Therefore, people can experience and perceive the 'same' phenomenon in many different ways, providing multiple, rich accounts. Moreover, a person's account of an experience is assumed to be accessed through social interaction; thus any interpretation of an individual's own, unique perception is ultimately influenced by the interpreter's own thoughts, assumptions and feelings.

2.2.2 Qualitative Approach

Qualitative designs provide participants with the opportunity to express their perception and understanding of their experiences in their own way, which allows the generation of new understanding of a phenomenon (Henwood & Pidgeon, 1992). The current research questions were concerned with the unique perceptions of participants, with the aim of obtaining a richer understanding of the experience of domestic violence as a child. The qualitative paradigm is therefore ideally suited to addressing both research questions. In addition, qualitative designs are thought to help minimise any potential distress caused to participants by facilitating more sensitive questioning (Eiser & Twamley, 1999). This is particularly beneficial given the sensitivity of domestic violence as a topic and speaking to children within any research context (McGee, 2000).
2.2.3 IPA

IPA was used as the qualitative methodology to explore the perspectives of both school-aged children and their mothers surrounding the experience of domestic violence as a child. Indeed, Smith et al. (2009) states “IPA is concerned with the detailed examination of human lived experience. And it aims to conduct this examination in a way, which as far as possible enables that experience to be expressed in its own terms, rather than according to predefined category systems” (p.32). Fundamentally, IPA is underpinned by phenomenology and hermeneutics; areas of philosophical thought briefly described below (Smith et al., 2009).

Phenomenology refers to how a person experiences, perceives, makes meaning of and gains knowledge about their world within a particular context (Willig, 2008). Phenomenology addresses experiences that are of particular significance or importance for the person (Smith et al., 2009). Emphasis is placed upon an individual's subjective experience rather than the objective nature of the world, as it posits that different individuals can experience the 'same' event in very different ways (Smith et al., 2009). Although experience is thought to be the product of interpretation, it is nonetheless 'real' to the person who is having the experience.

IPA is also influenced by hermeneutics which refers to the theory of interpretation and advocates that meaning is accessible through reflection. Smith and Osborn (2003) state that IPA involves a 'double hermeneutic', as it is not only the participant interpreting their understanding of an experience, but the researcher is also interpreting their meaning of the participant's account. Therefore, the researcher is inherently intertwined within the interpretative process as they will bring their own subjective reality to the mix. However, this is not seen as undesirable but rather a basic prerequisite of making sense of a person's experiences (Willig, 2008).

IPA was deemed an appropriate methodology for the current study as its philosophical underpinnings are consistent with the research question and positioning of the researcher. It is also worth noting that IPA is deemed appropriate to use with children, especially in conjunction with drawings to aid the interview process (Rollins, 2005). Nevertheless, it is important to note that other qualitative methodologies could also have addressed certain aspects of the research questions. These methodologies will be briefly presented below with a rationale for why IPA was deemed more appropriate.
2.2.4 Other Methodologies

Grounded Theory

Grounded theory, developed by Glaser and Strauss (1967), was originally designed to facilitate the development of theory by providing a systematic guide to qualitative analysis (Smith et al., 2009). Since the development of grounded theory, there have been many adaptations which place it as the main alternative to the use of IPA (Smith et al., 2009). One adapted version which shares similarities with IPA is constructivist grounded theory (e.g. Charmaz, 2006). Both methodologies have a largely inductivist approach and aim to generate a representation of a person or group's view of a particular phenomenon or social processes through systematic workings of transcripts to reduce and categorise the data (Willig, 2008). However, grounded theory is more likely to move towards an explanatory level based upon a larger sample with the focus being on theory generation; whereas IPA is likely to yield more detailed, richer analysis, exploring both similarities and differences between participants (Willig, 2008). Given that the research questions were centred on exploring participants' unique perceptions, with the focus on rich detail, IPA was deemed the more appropriate method of data analysis.

Narrative Analysis

Narrative analysis is interested in the ways individuals construct, cast and organise narratives of themselves and their lives (Willig, 2008). There is an emphasis on the process of 'storying', with different versions paying more or less attention to either the content or structure of people's stories (Emerson & Frosh, 2009). Although exploring narratives surrounding the experience of domestic violence as a child would be interesting, the focus would be on the creation and organisation of narratives rather than obtaining rich descriptions of the phenomenon. Thus, it was thought narrative analysis was less suitable for addressing the aims of the current research than IPA.

2.3 Participants

2.3.1 Sampling

For both perspectives, purposive sampling was employed to recruit a homogeneous group of participants for whom the research questions would be meaningful (Smith & Osborn, 2003). For perspective one, children aged between 8 and 12 years living in the community, who had previously been exposed to domestic violence, perpetrated by a male partner

*Inductivism refers to the reasoning by which one advances from particular observations to make general conclusions (Smith et al., 2009).*
against their mother, were eligible. For perspective two, mothers of the children who had participated in perspective one were eligible. Children and mothers were not considered for the study if they were unable to speak English fluently\(^9\) or if there was any indication that they would become unduly distressed by the interview.

2.3.2 Recruitment

Participants were recruited through a domestic violence charity, providing outreach support for women and children within the community. Children and mothers who were eligible to participate were identified by charity staff members, who provided them with information sheets. They were given the opportunity to meet with the researcher to discuss the project and determine the most appropriate place for the interview to be conducted. For perspective one, separate information sheets were provided for children (Appendix 1) and their mothers surrounding their child’s participation (Appendix 2). If these mothers were interested in participating in perspective two of the study, they were given a further information sheet (Appendix 3).

2.3.3 Situation of Sample

In order to strike a balance between preserving the participants’ right to anonymity, alongside ascertaining to which populations the current study will be most applicable, a brief description of the participants are detailed. For perspective one, five children participated, aged between 8 and 13 years old, two of whom were related. One child requested to participate in the study who was 12 when asked, but had turned 13 prior to the interview. It seemed unethical to exclude them from the study given that the overarching endeavour was to give precedence to children’s voices. Thus they were also included.

For perspective two, three mothers out of a possible four participated. None of the participants had current contact with the perpetrator\(^{10}\), apart from one child due to legal visitation rights. The demographic characteristics of the participants are presented in Table 2. The names used to identify the participants are fictitious.

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\(^9\) This decision was made as the study was not able to accommodate the related costs of translators and due to the acknowledgement that individuals from different cultures and ethnic groups may have distinct experiences that influence how a phenomenon is perceived (Willig, 2008).

\(^{10}\) It is acknowledged that the children’s and mothers’ relationship with the man who was alleged to be perpetrating domestic violence was varied (e.g. father/ mothers’ male partner), however for clarity, the term ‘perpetrator’ will be used throughout.
Table 2: Demographic Characteristics of the Participants.

<table>
<thead>
<tr>
<th>Perspective One</th>
<th>Name</th>
<th>Gender</th>
<th>Age Range</th>
<th>Ethnicity</th>
<th>Location</th>
<th>Perpetrator’s Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perpetrator’s</td>
<td>Claire</td>
<td>Female</td>
<td>8 - 13 years</td>
<td>White British</td>
<td>Community</td>
<td>Father</td>
</tr>
<tr>
<td>Relationship to</td>
<td>Aaron</td>
<td>Male</td>
<td>8 - 13 years</td>
<td>White British</td>
<td>Community</td>
<td>Father</td>
</tr>
<tr>
<td>Child</td>
<td>Kate</td>
<td>Female</td>
<td>8 - 13 years</td>
<td>White British</td>
<td>Community</td>
<td>Mother’s male partner</td>
</tr>
<tr>
<td></td>
<td>Tom</td>
<td>Male</td>
<td>8 - 13 years</td>
<td>White British</td>
<td>Community</td>
<td>Mother’s male partner</td>
</tr>
<tr>
<td></td>
<td>Nina</td>
<td>Female</td>
<td>8 - 13 years</td>
<td>White British</td>
<td>Community</td>
<td>Mother’s male partner</td>
</tr>
<tr>
<td>Perspective Two</td>
<td>Emma</td>
<td>Female</td>
<td>27 - 42 years</td>
<td>White British</td>
<td>Community</td>
<td>Husband</td>
</tr>
<tr>
<td></td>
<td>Gillian</td>
<td>Female</td>
<td>27 - 42 years</td>
<td>White British</td>
<td>Community</td>
<td>Husband</td>
</tr>
<tr>
<td></td>
<td>Rachel</td>
<td>Female</td>
<td>27 - 42 years</td>
<td>White British</td>
<td>Community</td>
<td>Male Partner</td>
</tr>
</tbody>
</table>

2.4 Procedure

2.4.1 Method of Data Collection

In order to explore, illuminate and expand understanding of the research questions but also remain flexible and sensitive to participants own experiences, agendas and needs, semi-structured interviews were employed for both perspectives. For children, the Kinetic Family Drawing (KFD) (Burns & Kaufman, 1972) was also employed at the beginning of the semi-structured interview to aid the children’s verbal reports. The KFD is thought to help children feel more relaxed with the interviewer, organise their narratives and promote expression (Malchiodi, 2001).

2.4.2 Development of Interview Schedules

A semi-structured interview schedule for perspective one (Appendix 4) and perspective two (Appendix 5) was developed in collaboration with the researcher’s supervisor, the domestic violence charity staff, mothers and children. Using Smith et al.’s (2009) recommendations, a process of funnelling was used, whereby initial questions were kept more general, leading into questions which were more focused on the areas of interest. Questions were open-ended in order to avoid participants being led by the researcher. Prompts were included in the schedule but only used if needed. Broad areas covered in the interviews and specifics to each perspective are detailed below.

Perspective One

The KFD formed the initial part of the semi-structured interview. Children were given the following instructions: ‘draw a picture of everyone in your family, including you, doing something. Try to draw whole people, not cartoons or stick people. Remember, make
everyone doing something, some kind of action' (Burns & Kaufman, 1972). The children were then asked to explain their drawing using open ended questions, which were then transcribed and analysed (Eiser & Twamley, 1999). Questions then went onto ask the child whether they had experienced seeing or hearing domestic violence and if so how they experienced and coped with this and whether they felt it had affected them in any way.

**Perspective Two**

While one question enquired about the context of domestic violence, mothers were primarily asked to consider their child's perspective and experiences of living and coping with domestic violence. Questions also centred on mothers' perceptions of their relationship with their child, whether there had been any changes in their child since leaving domestic violence, and if so, how they thought these had developed.

**2.4.3 Interviews**

**Perspective One**

Prior to the interview, informed consent was obtained from each child who participated (Appendix 6) and their mother (Appendix 7). Demographic data were collected from each child's mother (Appendix 8). All of the interviews were carried out individually with the child at their place of residence. After the interview, a separate de-brief sheet was given to both the child (Appendix 9) and their mother (Appendix 10). All interviews were audio taped and lasted between 40 to 65 minutes.

**Perspective Two**

Prior to the interview, informed consent was obtained from each mother who participated (Appendix 11). The interviews were all conducted within the mothers' place of residence. After the interview, mothers were given a de-brief sheet (Appendix 12). All interviews were audio taped and lasted between 45 to 120 minutes.

**2.5 Ethical Considerations**

**2.5.1 Ethical Approval**

Full ethical approval was obtained for the research study (Appendix 13) and for the subsequent inclusion of the 13 year old (Appendix 14) from the University of Surrey Ethics Committee.
2.5.2 Confidentiality and Anonymity

All of the participants were informed about the procedures in place to preserve anonymity and all data were held in accordance with the Data Protection Act 1998. Prior to the interview, participants were informed about the limits of confidentiality surrounding risk to self and others and the procedures in place if such issues were raised. It was proposed that if a risk or child protection issue was raised during an interview, the researcher would contact the relevant service who could then address the concern, following local authority procedures. No such issues were raised.

2.5.3 Minimisation of Distress

Participants were given the chance to have someone present during the interview and a 'safe word' was agreed so that they could terminate the interview at any time. The researcher used a visual measure to monitor distress with the children (Appendix 15) and mothers (Appendix 16), which was referred to at varying points during the interview. Time was allocated at the end of the interview for debriefing and ascertaining whether the participant needed any further support. No further support was requested nor deemed necessary for the participants.

2.6 Data Analysis

The audio tapes of participant interviews were transcribed verbatim. In order to preserve the participant's anonymity, any identifying features were omitted or changed. IPA was conducted independently and separately for both perspectives. This process of analysis followed guidelines provided by Smith et al. (2009) and began with reading and re-reading one transcript in conjunction with listening to the corresponding audio recording to enable the researcher to stay closely connected with the original data. Broad descriptive, linguistic and conceptual content were explored, with no attempt made at this stage to focus or categorise the data (Smith et al., 2009).

The next stage involved developing emergent themes by analysing, summarising and mapping connections between the exploratory notes. Following this, the emergent themes were organised according to their perceived meaning and connections into clusters, which formed superordinate themes. This procedure was undertaken for each transcript in turn. Having completed this step, the researcher looked for patterns and connections across all cases. This was an iterative process and prompted the repeated re-examination of the
transcripts, and the reconfiguring of superordinate themes to produce a separate list of master themes for both the perspectives.

2.7 Quality Assurance

Yardley (2000) argues that the quality of qualitative research can be evaluated by the commitment and rigour in relation to data collection and analysis, and the researcher's overall transparency regarding the research. In order to ensure the quality of the current study and the process of data collection and analysis in relation to these criteria, a number of steps were taken.

2.7.1 Position of the Researcher

As discussed, IPA involves a ‘double hermeneutic’, whereby the interpretation of the meaning of a participant's account involves an interplay between participant and researcher (Smith & Osborn, 2003). Because the researcher is inherently intertwined within the interpretive process of IPA, it is therefore crucial for the researcher to reflect upon their own thoughts, assumptions and beliefs surrounding the study. I will now reflect upon my position in making sense of the participant's experiences.

I am a twenty five year old White British heterosexual female, with no children, who has had no direct experience of living with domestic violence as a child. However, within my personal life I have seen firsthand the impact that parental conflict can have upon children and how children can feel powerless and unheard within that context. During my professional career, including my role as a trainee clinical psychologist, I have worked with young people and their families who have fled domestic violence. I have seen these young people struggle with their experiences, often feeling alone and unheard. This led me to feel passionate about listening to and respecting the voices of children. Further, it contributed towards my choice of clinical psychology as a career, with a specific interest in working with children and their families.

I have worked in close connection with mothers who have experienced domestic violence and seen how they often feel let down and blamed by services, leading them to feel just as powerless as their children. These experiences have been particularly relevant to my professional development and have motivated me to think about the benefit of multi-perspective research. Hearing the struggles of mothers who have left domestic violence and how the blame is often shifted away from men's violence onto women, has motivated

11 In order to own my perspective in this reflective process, this section is written in first person.
me to ensure mothers' voices are also privileged. However, I can also empathise with the
many professionals who feel children may be put at risk by living in that environment, and
who become frustrated with mothers who deny that ongoing domestic violence is affecting
their child. I wondered whether mothers feel unable to talk openly with professionals about
their children's exposure to domestic violence for fear of being blamed. Indeed, I tried to
remain curious regarding mothers' perceptions of their child's exposure and the challenges
they faced both within the context of domestic violence and after leaving.

In relation to the perpetrator of the domestic violence, as a woman who is in a committed
non-violent relationship and has not experienced domestic violence, it was hard for me to
comprehend how anyone could abuse a partner, especially in front of children. However,
experience of working clinically with men and women perpetrators of different forms of
abuse, has made me aware how many perpetrators are also victims themselves. Although
this does not detract from the seriousness of what these women and their children have
been exposed to, my experiences made me mindful that there is a wider context behind
every account.

Further, it is worth acknowledging the differences and similarities between myself and
some of the participants in terms of age, gender, culture, ethnicity and professional and
personal background. I initially thought that my gender might aid both the mothers and the
children to feel comfortable in speaking about their experiences, given that the perpetrator
of the violence was male in all cases. However, I was also aware that as a result of being a
young female with no children, the mothers' responses may be inhibited by beliefs that I
might not understand or appreciate their position as a mother.

With regard to my professional background, I was mindful that I was approaching the
current study as a researcher and not a clinician. I held the assumption that this may be a
personal and distressing subject to discuss with someone to whom I was not offering any
intervention. Prior to conducting the interviews, I was concerned that mothers and children
might find it difficult to speak with me about their experiences. However, I found that once
I explained the aims of the study, both the children and their mothers were able to give
richer, more detailed descriptions of their experiences than I had expected. Offering the
children and their mothers an opportunity to openly share their experiences seemed to
supersede differences in age and background.
2.7.2 **Supervision and Peer Review**

In order to help 'bracket off' some of the assumptions and beliefs held by the researcher, regular supervision and peer review was sought throughout the research process. Supervision was undertaken with an experienced qualitative researcher and clinician specialising in the area of domestic violence. Peer review took place in the form of a qualitative research group and regular meetings with colleagues researching similar topic areas. This enabled the researcher to ensure their interpretation of the data at each stage remained grounded in participant's experiences.

2.7.3 **Drawings**

The initial function of the KFD was to facilitate and promote the children's verbal accounts in perspective one. It was not the researcher's original intention to use the drawings as part of the analysis. However, it became clear once the interviews began that there were some interesting and salient features within and across the children's drawings, including the positioning and size of the child in relation to their family members. For example, many of the children drew themselves either larger or of equal size compared with their mother. Given this, it is clear that the drawings would have inevitably influenced the process of analysis in perspective one. Tentatively exploring drawings to further enlighten, validate and elaborate analysis of verbal accounts is deemed appropriate within child-focused qualitative research (Burkitt, 2004; Malchiodi, 1998). Therefore, a few salient features across drawings have been tentatively drawn upon within the results section in order to further validate the findings in perspective one. The children's drawings are presented in Appendix 17 to 21.

2.7.4 **Independent Audit**

As Smith *et al.* (2009) comment "independent audit is a really powerful way of thinking about validity in qualitative research" (p.183). The transcripts were therefore checked by an independent auditor to assess whether the interpretations were representative of the original data. Following an iterative process, the suggestions and comments made by the auditor were fed back to the researcher, resulting in minor changes to the super-ordinate and master themes. Verification of these changes was then sought from the auditor.

It is recommended that the process by which any interpretations are reached should be clear to the reader, so that they can check the validity of the findings for themselves.
(Sherrard, 1997). To this end, a sample of an annotated transcript for perspective one (Appendix 22) and perspective two (Appendix 23) are included to help inform the reader.
3. RESULTS

3.1 Overview of Results and Discussion

Following analysis using IPA, three master themes emerged for perspective one regarding the school-aged children's experiences of domestic violence; and three master themes emerged for perspective two regarding the mothers' perception of their children's experience of domestic violence. The results for perspective one will be presented first, followed by discussion of how these results correspond with existing literature and theory. Thereafter, the same will be done for perspective two. Throughout the presentation of the results, interpretations are supported with direct quotes from participants' transcripts. Following presentation of the results and limited discussions specific to both perspectives, an overarching discussion will explore how the different perspectives of school-aged children and their mothers may illuminate our understanding of children's experience of domestic violence. This overview will also contain consideration of the clinical implications of these two perspectives; a reflection on the limitations of this study; and ideas for future research.

3.1.1 A Note on the Presentation of the Results

Presentation of results in an IPA study is flexible and dependent upon the purpose and breadth of the study in hand (Dallos & Vetere, 2005). Due to the breadth of this study and limitations of word count, it was decided that not all master themes would be discussed here. This was to ensure that the depth of analysis could be illustrated to the reader. Therefore, only those most pertinent to expanding understanding of the research questions are presented in the results.

A decision to prioritise some of the themes over others was made in collaboration with the researcher's supervisor and an independent auditor. However, it is worth acknowledging the prejudice inherent in the prioritisation of the themes, which is not atheoretical. Since much is already known about the impact of domestic violence on children from both mothers and children (e.g. Holt et al., 2008), it was decided that the themes relating to the impact of domestic violence on children would not be discussed within the results section. Instead, a decision was made that the themes relating to children's and mothers' explanations of the context of domestic violence for children and the insights gained from these two perspectives would better contribute to illuminating the research questions.

Within these quotations, information omitted will be indicated by the following ellipsis points (...) and square brackets are used to clarify information e.g. [ ].
While not discussed fully, it was considered important to briefly mention the content of the two omitted master themes.

3.1.2 Omitted Master Themes

The two master themes not discussed in the results centred on the impact of domestic violence on children from the perspectives of the school-aged children and their mothers. The children talked about unresolved, overwhelming and relentless emotions and feelings, both within themselves and directed at the perpetrator. Moreover, children spoke about feeling continued fear for their safety and experiencing intrusions from the past. It seemed these impacted upon their arousal system, sleep and functioning in daily life. The mothers believed that domestic violence resulted in behavioural, emotional and physical changes in their child, something they considered to be pervasive and long lasting.

These two master themes can be found in full within Appendix 24 for perspective one and Appendix 25 for perspective two.
3.2 Results - Perspective One

For perspective one of the study, three master themes emerged: (1) Domestic violence through the eyes of children; (2) The impact of domestic violence for children; and (3) Learning from children’s experiences. The themes are presented in Table 3, and themes one and three discussed in more detail below.

Table 3: Summary of Master and Sub-Themes for Perspective One.

<table>
<thead>
<tr>
<th>Theme One: Domestic Violence Through the Eyes of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Children as aware</td>
</tr>
<tr>
<td>ii. Pervasive sense of threat and fear - Trying to predict the unpredictable</td>
</tr>
<tr>
<td>iii. Loss of a normal childhood</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme Two: The Impact of Domestic Violence for Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Unresolved feelings towards the perpetrator - Punishment and accountability</td>
</tr>
<tr>
<td>ii. Overwhelming emotions and sense of self</td>
</tr>
<tr>
<td>iii. Hyper-arousal, sleep disturbance and impaired functioning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme Three: Learning from Children's Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Diminished trust in adults - The reliance on the self</td>
</tr>
<tr>
<td>ii. Coping and healing following domestic violence</td>
</tr>
<tr>
<td>iii. Services and support - Experience and suggestions</td>
</tr>
</tbody>
</table>

3.2.1 Theme One: Domestic Violence Through the Eyes of Children

The first master theme centred on the experience of being a child living in a family where domestic violence was taking place. This encompassed three sub-themes: (i) Children as aware; (ii) Pervasive sense of threat and fear - Trying to predict the unpredictable; and (iii) Loss of a normal childhood. These sub-themes offer an insight into the children’s experiences of living in the context of domestic violence. There was an indication that the children were not only acutely aware that domestic violence was taking place, but actively assumed the role of trying to predict and manage a seemingly unpredictable situation. Moreover, it appeared that living in this context meant that they had missed out upon a ‘normal’ childhood.

i. Children as Aware

All the children spoke about their awareness (overhearing and witnessing) of many different forms of domestic violence taking place within their home, seeing their mother as the victim and their father or their mother’s partner as the perpetrator:
He [perpetrator] like used to swear a lot and that's stuff that I caught onto and he used to hit and like physically abuse... and verbally and mentally. I saw him threaten with a knife, hit mum. (Claire)

A few of the children recited the story of domestic violence entering their lives and how it developed, with a sense of it becoming more frequent, pervasive and severe as time went on:

Mum and him [perpetrator] and us lot got a house together and after about two weeks he started hitting her. He hit her first because her dinner wasn’t like, her dinner wasn’t warm... then he started doing it more and more often. Eventually he tried to stab her. (Kate)

Children often spoke about times when serious physical harm had been caused to their mother. For these instances, often the children spoke about secretly watching what was going on:

He [perpetrator] locked my mum outside in the middle of the night and then... my mum was she just got back in the house and me and [sister] were on the stairs and we peeked over and just saw my dad punch my mum from front door to the back door and then we saw our dad stab our mum. (Aaron)

For many of the children, they reported witnessing their mother’s distress following instances of domestic violence. Moreover, some of the children reported trying to keep their mother safe, indicating a sense of protectiveness towards her:

One night he [perpetrator] hurt mum and then he like, mum came crying up to my room. (Tom)

My mum’s come up screaming, like proper screaming so I’ve locked my bedroom door to keep her in there so he don’t hurt her. (Kate)

Although all of the children talked about the fear associated with overhearing and witnessing instances of actual violence, there was an overarching sense that it was not just at these times when children experienced threat and fear as discussed below.

ii. Pervasive Sense of Threat and Fear - Trying to Predict the Unpredictable

When all of the children spoke about their experience of living with domestic violence, there was a suggestion that their environment was one of pervasive fear concerning
possible threat to either themselves and/or others (e.g. mother and siblings) by the perpetrator. Indeed, children indicated that they felt constantly unsafe, on edge and fearful, whilst living in an environment where they were exposed to domestic violence:

Unsafe, scared all the time. I didn’t sleep, I used to sleep at school... Quite distressing actually cos I like knew that if we stayed in that environment we would all die. (Kate)

I was always worried about my mum. I thought she was going to get hurt. (Nina)

A number of the children appeared to be constantly thinking about what might happen to them or others in their family and what the perpetrator might do next, trying to work out his hidden intentions. Many of the children cited actually monitoring the perpetrator's behaviour. It seemed that by engaging in these constant thinking and monitoring processes, the children were attempting to predict what might happen next in this fearful, threatening environment:

You had to act like weary and stuff... Cos you didn’t know like when he [perpetrator] was going to be drunk and stuff... It would depend how drunk he was really, because when he was really drunk he was horrible because he started getting abusive and angry but... like when he wasn’t like really drunk, it was still bad but not as bad... It made me always think about that, I could never think about anything else... I was always thinking about what had happened, what was going to happen next. (Claire)

Monitoring the perpetrators behaviour appeared to provide the children with an increased sense of control in preventing anything from happening. Indeed, a few children reported changing their own behaviour or actively intervening as a result of this monitoring process:

And he [perpetrator] tried to torch our house once... I was in my room at the time and I heard something like gas or something, I went downstairs and he had a lit match and I managed to put it out. (Kate)

Nevertheless, it seemed that although the children spoke about attempting to predict the perpetrators behaviour, these attempts were essentially futile as the behaviour of the perpetrator was described as constantly changing and unpredictable. Often the children described episodes of domestic violence coming completely out of the blue, without
warning, catching them off guard. It seemed therefore, children were essentially trying to predict something that was unpredictable:

> It was stressful and like you didn’t know what mood he was going to be in... me and mum were watching TV, we were watching Pirates of the Caribbean and dad came up and threatened us... It was scary because I didn’t know what he was gonna do or if he was being serious. (Claire)

**iii. Loss of a Normal Childhood**

Although many of the children believed their environment was normal at the time, reflection on their experiences after leaving domestic violence seemed to allow the children to notice many discrepancies between their own and others’ childhoods. This realisation appeared to reveal a sense of loss or deprivation of what they now considered to be a ‘normal’ childhood:

> He [perpetrator] wasn’t like nice to us, he never used to do, we couldn’t ever do anything unless it involved beer and a pub and we didn’t really do anything fun... It felt normal then because that’s what we were used to... Half of my life has been really bad because we haven’t done, wasted if you like, because we haven’t done anything... Like other kids in the playground [said] “my weekend I went on holiday” and that, and I like could never say that I went on holiday. (Claire)

> My mum and dad never hugged and all that... Like it feels really annoying cos you just like want to be like a normal family with a nice dad, a nice mum and all that. (Aaron)

The children often spoke about the loss of opportunity to have a normal childhood as a result of taking on the role of protecting or being responsible for their mother or siblings. Indeed, children seemed to be taking on heightened responsibilities beyond what might be expected for their age (Department of Health, 2004):

> One night he [perpetrator] hurt mum and then he like, mum came crying up to my room and he was like pretending he was like innocent for hurting her and then I just shut the door on him. (Tom)

> I wasn’t being looked after properly and cos I didn’t know what to do, I used to have to look after [younger brother] when he was a week old cos my mum was always unconscious on booze... I wouldn’t let anyone hurt him. Like before, like
when we have been walking in [town] down an alleyway where he goes frequently, I used to pick [younger brother] up and have a stone ready in my hand to literally fling at him [perpetrator] cos I wouldn’t let anything hurt [younger brother] cos he’s my bubby. (Kate)

All but one of the children cited an environment of either neglect or abuse when living in the context of domestic violence. For most children living in that environment, their basic needs appeared to be unmet (e.g. being fed properly). A number of the children also spoke about how they experienced direct physical or emotional abuse at the hands of the perpetrator:

[Perpetrator] punched me the night before my birthday, kicked me out the house in the middle of the night, stole my mum’s car. (Aaron)

He [perpetrator] wouldn’t like feed us and stuff... He said to us, said to me that no one loves me and kept putting me down and stuff. (Claire)

Thus, the children were not only deprived of a childhood without domestic violence, but may have also experienced further losses due to not being nurtured, fed and cared for.

3.2.2 Theme Three: Learning from Children’s Experiences

This theme surrounded what can be learnt from the children’s experiences of domestic violence. This theme consisted of three sub-themes: (i) Diminished trust in adults - The reliance on the self; (ii) Coping and healing following domestic violence; and (iii) Services and support - Experience and suggestions.

i. Diminished Trust in Adults - The Reliance on the Self

Many of the children spoke about a diminished confidence and trust in the ability of adults to support and protect them. Some cited times when they had felt let down by adults not helping them when they were living with domestic violence, whilst others spoke of being betrayed by adults after leaving that environment:

When he [perpetrator] first started coming round I was about, I duno, I was in year four... And then like, started hitting her and I told the school and they didn’t do anything. (Kate)

For some of the children, their diminished confidence in relying specifically on adults was expressed through feelings of being let down and unprotected by their mother when they
lived with domestic violence. The perception of their mother as unable to protect either herself or the child seemed to be considered as something permanent for the children. However, there was a sense that children found it difficult to express any negative feeling towards their mother due to guilt about how vulnerable their mother was at the time:

[How witnessing domestic violence makes her feel] Well quite disgusted really because like feel a bit annoyed with my mum at times because like she still would like she still put us through that. But then I start feeling guilty because I know it wasn’t her fault... I feel annoyed at her [mother] because like she has gone without a boyfriend for two years, yet she will let someone that’s broken her heart once back into her life again and it just annoys me so much because I never get a decent night’s sleep cos I’m always up here scared rigid... I sit up in bed at night ear to the floor sometimes to make sure he’s [mother’s new boyfriend] not hitting her or shouting at her. (Kate)

Further, it was noted how some children simply placed less emphasis on their mother’s ability to help and protect them in general, mentioning her far less in this role compared to other adults:

Just thought there’s no point [in telling her mother she was being bullied] cos it will just make things worse. (Claire)

It seemed that due to this diminished sense of trust and reliance on adults, children had learnt to rely on themselves. Indeed, all of the children spoke of their reliance on themselves for comfort, some seeking specific toys when feeling unsafe or upset:

[When feeling sad] My teddy, this helps me... I whisper in his ear and then I pretend he’s whispering in my ear and then I say ok then it cuddles me and then it makes me feel a bit better... It’s the only thing that helps me. (Nina)

[When feeling angry, depressed and frustrated] I’ve got my teddy when I’m asleep and then I think, I just cuddle it and then I go to sleep... Cos I always say once I cuddle him, I go “take away all my bad memories and all my bad dreams I’ve ever had and fly them so far away that I will never ever see them”. (Tom)

Within the children’s Kinetic Family Drawings (KFD) many of the children drew themselves as either larger or of equal size compared with their mother. This could be interpreted as these children taking on an increased sense of responsibility and protective role in relation
to their mothers. This may be explained by the above accounts that many children felt unable to rely upon their mother and consequently relied upon themselves for protection and comfort. Thus, the KFD appeared to validate children's verbal accounts of their experiences.

ii. Coping and Healing Following Domestic Violence

All of the children spoke about how they had been coping with, and trying to heal from the perceived impact of being exposed to domestic violence. After leaving domestic violence, many of the children reported a brighter outlook for their future. This seemed to be due to an increased sense of safety for them and their family, something which was helping them cope. For some, this process of feeling safer was aided simply by the knowledge that the perpetrator was no longer in their lives:

They're [current circumstances] better because I know that when I go to school and stuff everything is going to be ok and at home mums alright, my brothers alright and I feel safer... That I know that my dad's not here now and I've got nothing to worry about anymore. (Claire)

For a few of the children, talking about their experiences played a key part in how they were coping with difficult feelings, something which appeared to be helping them heal from the impact of domestic violence.

I feel it's [talking] helpful that it helps really, because... it's not at the back of my mind all the time. I like talking things out instead of keeping it all in. (Claire)

I'm starting to deal with it [domestic violence] a bit better cos I can actually talk about it. (Kate)

However, as emphasised in the previous sub-theme, many of the children seemed to find it difficult to trust adults and therefore were more reliant upon themselves. Instead of talking, some of the children favoured forgetting or distracting themselves from thinking about their experience of domestic violence by engaging in certain activities:

I only started cooking about two years ago and now I really like cooking and it just takes my mind off stuff and all that... Either playing on my Xbox, punching a wall, playing football or eating or cooking calms me down. (Aaron)
Within the children’s KFDs, a few of the children drew themselves at a physical distance in relation to other family members. This could be interpreted as the children seeing themselves as isolated and possibly perceiving physical and emotional support from others at a distance to them. This seems to support the above illustration that a number of the children took on independent forms of coping.

This illustrates the range of strategies used by children in their coping and healing process, including distraction, talking and self-soothing. Although there were similarities across the children’s coping strategies, there was also uniqueness and nuances within each, highlighting the importance of gaining feedback directly from the child.

iii. Services and Support - Experience and Suggestions

Many of the children spoke about receiving input from services either during the time when they lived with domestic violence or after leaving. The children spoke about a wide range of services, ranging from specific domestic violence charities to more generic services such as school or the police. For many of the children, there were times when services were experienced as unhelpful indicating that little was done to keep them or their family safe during this time. Some of the children felt that they were not listened to or that their position was not taken into account by services, even though they were being directly affected by domestic violence:

"We actually called the police, I kept a record, about 350 times and that’s just in about six months and they didn’t, like my mum used to not press charges so they couldn’t do that much... [Feels] Quite annoyed and not really reliant on the police cos they’re really big pains in the bottoms... [What the police could have done differently] Probably actually installed us with a panic button or actually let me press charges when I wanted to when I was the one also getting hit. But they wouldn’t let me press charges because I was under age apparently... [Feels] Quite annoyed really cos I feel that everyone has the right to press charges if they need to, not just adults. (Kate)"

As is evident from the above quote, there is a sense that many of the children perceived their age as rendering them powerless, resulting in a loss of entitlement in comparison to adults. In contrast, the support received following leaving domestic violence seemed to be viewed by many children as positive:
My head of house knows what I've been through and one of my teachers and all my friends know so like if I've got a problem, I can just go straight to them... It helps cos I know I got people at school that I can go to. (Aaron)

Here the school is perceived as helpful in contrast to an earlier quote where one of the children viewed school as not responding to their needs. This highlights that the same service can be experienced as either helpful or unhelpful depending upon the child's unique experience. Furthermore, a few children spoke about how services could be more supportive to others who experience domestic violence in the future:

[What could help children who experience domestic violence] Getting installed with a panic button and being able to contact other children that have been through this and getting like help off of them... More support from social services and the police... Like kids being able to press charges and seeing that they can talk to the police and social services. Maybe being more assemblies on domestic abuse because there are many children not knowing what's going on because like there is hardly any assemblies from the police for it. (Kate)

Within all of the suggestions there was an indication of the necessity of actually hearing and acting upon the voice of the child. It seemed that an overarching message given to services by all of the children was that they have a voice, if only people would listen:

Give [children who experience domestic violence] them more opportunities, some opportunities to speak out and be heard... What had happened and what makes them happy and stuff. (Aaron)
3.3 Discussion – Perspective One

Each of the master themes from the children’s accounts will now be discussed in relation to existing research and theory.

3.3.1 Theme One: Domestic Violence Through the Eyes of Children

An overarching theme within perspective one of the study was how school-aged children experienced living in a context where domestic violence was taking place. Children expressed not only being acutely aware that domestic violence was happening but also actively involved in trying to predict and manage what they experienced as an environment of pervasive threat and fear. Their perspectives appear to accord with findings from a number of studies that show that children of a variety of ages also experience the environment where domestic violence occurs as fearful and threatening (Goldblatt, 2003). Further, the children described the complex ways they attempted to manage and cope with their environment, trying to be constantly alert and predict the perpetrator’s behaviour in order to prevent undesirable consequences (e.g. harm to their family or themselves).

Models of trauma can provide a useful framework to explain the children’s behaviour within the context of domestic violence. Being exposed to a series of traumatic events (e.g. domestic violence) can leave an individual feeling helpless, vulnerable and believing that their environment is uncontrollable and unsafe (James, 1989). It is believed that children develop coping methods to try to provide some control of their environment in order to decrease any negative emotions associated with the traumatic events (Silvern & Kaersvang, 1989). This may explain why these children seemed to go to great lengths to predict what might happen next.

While using these strategies seemed to give the children some fleeting sense of control over their situation, many of the children cited how this was futile as the perpetrator’s behaviour was essentially unpredictable. This experience is interesting given that predictability and continuity within a child’s environment are thought to be essential ingredients for normal child development (Streeck-Fischer & van der Kolk, 2000); something which these children believed they did not have. Indeed, children spoke about a number of losses due to their experience of domestic violence, all amounting to the loss of a ‘normal’ childhood. One could see that alongside the more tangible losses children reported, they had also lost out on being cared for and nurtured due to neglect and abuse. Their experience is in line with research suggesting that exposure to domestic violence is
not a linear experience and is associated with multiple forms of abuse (e.g. emotional, physical and neglect) whether intentional or not (Edleson, 2001).

There was an overall recognition from these children that the environment of domestic violence was not conducive to their development. It is important to therefore consider the impact of this unpredictable and lost childhood. The findings of the current study seem to link with research which suggests that repeated exposure to domestic violence as a child results in a constant state of hyper-arousal, which in turn puts them at a higher risk for anxiety disorders (Saltzman et al., 2005). In addition, research suggests that being in a constant state of hyper-arousal due to continuous exposure to traumatic events (e.g. domestic violence) in childhood, has considerable negative neurobiological and physiological implications (Adams, 2006).

In summary, these school-aged children indicated that they were acutely aware of domestic violence and active in their efforts to manage and predict this. These findings echo Mullender et al. (2002) in the sense that these children were not ‘silent witnesses’ of domestic violence; rather, they were active in negotiating and managing this threatening, fearful environment. However, although these strategies helped children to control their environment, there is a sense this contributed to children’s lost childhood.

3.3.2 Theme Three: Learning from Children’s Experiences

Within this overarching theme the children spoke about how they felt unable to trust adults, due to feeling betrayed or let down by them in the context of domestic violence. As a consequence, children believed adults were unable to support and protect them indefinitely. For example, some cited experiences of feeling unprotected by their mother, consequently leading them to question her ability to protect or support them after leaving domestic violence. This is in part consistent with Mullender et al. (2002), who found children exposed to domestic violence often took on the role of protecting their mother. However compared to other research, the school-aged children in this study seemed to have far less faith in adults’ capacity as caregivers and providers. Moreover, these children seemed to have developed coping strategies which were largely self-reliant (e.g. cuddling a teddy or distracting themselves).

Attachment theory may also be a useful framework within which to consider these findings (Ainsworth & Bowlby, 1991). Attachment theory posits that responsive, consistent caregiving is crucial for child development and a secure attachment with their caregiver.
However, children who do not receive this type of care giving are forced to adapt and develop different strategies (e.g. avoidance and adherence) to maintain attachment (Bowlby, 1988). This can result in either insecure avoidant or insecure ambivalent attachment strategies. An avoidant attachment strategy is where the child minimises their own needs, becoming overly self-reliant to reduce the chances of rejection. Within an ambivalent attachment, a role-reversal can be seen whereby the caregiver (e.g. mother) is cared for by the child (Holmes, 1993). These role-reversal and self-reliant strategies are frequently cited by the children in the current study, indicating that an insecure attachment strategy may be an issue for these children. Children rely on their primary care giver as their main attachment figure, whereas adolescents move to forming increasing attachment relationships with their peers (Layard & Dunn, 2009). Given this, the importance of considering the mother-child attachment relationship for school-aged children exposed to domestic violence is highlighted.

Whilst self-reliant coping strategies can be used to maintain vital attachments, they are strategies which are costly (Holmes, 1993). Indeed, from a cognitive perspective (Brewin et al., 1996) it is noted that repeated rehearsal of memories following traumatic events is likely to reduce intrusive memories and future negative affect. It is claimed that social support has a crucial role to play in this emotional processing of memories. If these children do not trust adults to support them and instead use self-reliant coping strategies, it may be these children are missing out on the opportunity to adequately process their experiences of domestic violence and reduce any negative emotions associated with it.

Following a move away from domestic violence, the children employed a range of coping strategies to manage their feelings, including self-soothing and distraction. For some children, talking about their experiences played a key part in how they coped with difficult feelings. Safety and availability of appropriate others seemed to be the key factor influencing this, as being able to speak about their experiences only seemed to take place once they felt safe and settled. This is in line with existing literature which posits that safety needs to be established prior to processing of any traumatic experience (Osofsky, 2004). Once children are given appropriate support and a safe environment, they may therefore experience talking as extremely cathartic (Mullender et al., 2002).

Children also spoke about coming into contact with services either during the time when they lived with domestic violence or after leaving. Some services were praised for their responsiveness, understanding and support. Being listened to and having their opinion
taken into account by services was paramount for these children, however this was something which many of the children believed had not happened. This is consistent with existing reports that children often feel unheard by services such as social services and the police (Stanley et al., 2010). Being heard by services seems especially important when we consider the age of these children and that they have less opportunities to independently seek help and support (Golden, 2007). These findings advocate the stance taken in the National Service Framework (NSF) for Children, which recommends services listen to and respect the voices of children (Department of Health, 2004).

The results from perspective two of the study will now be presented and discussed.
3.4 Results – Perspective Two

For perspective two of the study three master themes emerged: (1) Reflecting on their child in the context of domestic violence; (2) Perceived impact of domestic violence on their child; and (3) Learning from mothers - Insights, support and services. The themes are summarised in Table 4. Themes one and three will be discussed below, whilst theme two is presented in Appendix 25.

Table 4: Summary of Master and Sub-Themes for Perspective Two

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3.4.1 Theme One: Reflecting on their Child in the Context of Domestic Violence

The first theme concerned mothers’ reflections on their child in the context of domestic violence. This encompassed two sub-themes which offered an insight into mothers developing realisation of their child’s awareness of domestic violence and mothers’ perceptions of their child within the context of domestic violence. These were: (i) Developing awareness of children as miniature radar devices; and (ii) Absence of a normal childhood.

i. Developing Awareness of Children as Miniature Radar Devices

Most of the mothers spoke about a developing sense of awareness over time that their child had in fact witnessed much more domestic violence than they had previously thought. Most of the mothers indicated that within the context of domestic violence, they had tried many ways to protect their child from exposure, leading them to believe at the time, that their child had seen or heard far less than they actually had:
I'd try and get them upstairs to bed and put them to bed about half four or five o'clock in the afternoon so that they wouldn't hear. In my eyes the way as a mother, I thought it was protecting them, I thought they wouldn't hear nothing...

At the time I didn't, I knew they'd [children] seen some of it, I wasn't aware, in my own little world at the time of my trying to protect them, I didn't think they heard or saw anything. (Gillian)

There was a sense that prior to the move, acknowledging that the child existed in the same world of threat and fear as them would have been unbearable. It seemed that leaving that environment acted as a particular transition that enabled the mothers’ awareness to develop. Some mothers even went as far as to suggest that they now believed with hindsight that their child had actually picked up on everything, suggesting children as something akin to a miniature radar device:

I honestly thought as much as the arguments and stuff you know, she [daughter] never really you know, you always try and kid yourself that you think yeah I'm protecting them and then you know that they don’t really hear the arguments cos I’d go out the room or whatever. And you forget your children are like miniature radar devices, you know. Like to earwig absolutely everything to then draw their own conclusion. (Rachel)

Although all three mothers indicated that children noticed more of the domestic violence then they had previously thought, there was still a continued sense of uncertainty around how much their child had witnessed or overheard. The role of age played an important part in mothers’ interpretations of how much of the domestic violence their child was likely to process:

I think when they [children] get to school age and realise that their daddy, or whoever is drinking and things like that isn’t the norm things where they see other children’s dads doing things with them and their daddy cant... [Son] I am not too sure about it [whether he witnessed domestic violence] cos his dad went when he was about five and so he’s been in a better place type of thing. So I don’t think he quite understands fully. Or he might though but he is not saying it, does that make sense? (Emma)
ii. **Absence of a Normal Childhood**

All three of the mothers reflected that in retrospect they could now perceive that their children grew up in a world very different to that of other children. The three mothers believed that their children behaved in ways that were not ‘normal’ for children of their age, presenting as constantly fearful and uncertain:

> Well with obviously growing up with domestic violence they [children] haven't really well the norm... a normal house when you have two loving families, parents and everything else, it's not been like that... So they've grown up with that environment of quite being, not very nice actually... [Children were] On edge all the time, like myself, not knowing what was going to happen or what mood or whatever. (Emma)

There was a clear sense that the environment their child was exposed to was something unpleasant and less than ideal for a child. Further, they indicated their child’s experiences resulted in an absence of a childhood:

> They [children] weren't running up like “oh daddy’s home” you know what I mean like normal... They were very quiet, very I duno obedient sort of thing you know what I mean. Toys used to be put away, they never used to have any toys downstairs... They were very quiet children when he [perpetrator] was around. Very quiet... weren’t children. (Gillian)

### 3.4.2 Theme Three: Learning from Mothers - Insights, Support and Services

This theme surrounds what we can learn from mothers’ insights into their child and their parenting of that child. The mothers reflected upon the services they received and what might be helpful in terms of provision of future support for children. Four sub-themes emerged which were: (i) Child contact with the perpetrator - Continued neglect and re-traumatisation; (ii) Mothers' emotional fragility - Reduced capacity to support the child; (iii) To express or not express emotions - The importance of others in healing the child; and (iv) Services - 'The good the bad and the ugly'.

i. **Child Contact with the Perpetrator - Continued Neglect and Re-traumatisation**

All of the mothers spoke of how their child either suffered neglect or abuse at the hands of the perpetrator when they lived within the context of domestic violence. Regardless of whether the children had contact with the perpetrator or if this was a future possibility, all
three of the mothers expressed their concern that at the very least their child would be neglected during contact:

_She [daughter] doesn't want to go back, put back in that environment because she doesn't feel safe to be in that environment... When they go to his care he doesn't look after them properly... I think the only time they [children] get worried if they know about their dad, if they've got to go to their dads. I think that's the only trigger point that they don't want to go and see him or have contact with them cos of what he's done to them._ (Emma)

Mothers, who initially agreed for the child to have contact with the perpetrator, spoke about how this seemed to distress and essentially re-traumatise the child; a belief that led some to cease this contact:

_I still agreed to him [perpetrator] to try and keep him calm, that he could see them [children], but you know within I duno a few weeks, I had [son] making himself physically sick in the bathroom cos he didn't want to go and see him, [daughter] was clinging to me and that._ (Gilliam)

_When [older daughter] came out, cos [older daughter] went from a daddy's girl to, “I don't want to see my dad no more” getting really, really upset. You know the level of distress was actually causing me a quite, a bit of concern and basically I then stopped his access which didn't go down too well._ (Rachel)

_ii. Mothers Emotional Fragility - Reduced Capacity to Support the Child_

All three of the mothers spoke about their own emotional fragility both during the time when they were living with domestic violence and also after leaving the situation. For one mother this was spoken about in terms of their emotional and mental state being at 'breaking point':

_I knew I was crying a lot before I left... But when it gets to the stage where you know you're at breaking point, you can't physically or mentally deal with anymore._ (Rachel)

With reference to Rachel's quote above and her use of 'breaking point', we may consider that if something is broken, it is not working and can no longer function for its intended purpose. Given this, it could be implied this mother believed she was no longer able to adequately fulfil her role as a mother. Indeed, many of the mothers believed that their
‘broken’ emotional state made them less able to emotionally support their child whilst in the context of domestic violence and also after leaving:

*I'm not quite sure how they [children] coped really, I was obviously not in the right place myself. I was not emotionally and physically in the right frame of mind... I can’t support them.* (Emma)

Mothers recognised the role of the perpetrator in undermining their ability to care for and support their child when living in the context of domestic violence:

*Anything for [son] he’d try and ruin it. I wasn’t allowed to love [son] really cos he never wanted [son] so [son] was just a pain in the arse to him really.* (Gillian)

There is a suggestion that most of the mothers thought that the children were quite aware of their emotional fragility. A few mothers even spoke about their child actively supporting them during times when they were especially vulnerable:

*And then when I asked them [children] “do you like being here?” and it’s, it’s so bizarre because [daughter] was like... “Yeah because you don’t cry anymore mum”... And when your nine year old comes up to you with tissues like it’s an everyday occurrence, that makes you cry even more.* (Rachel)

There was also a suggestion from the mothers that their child’s awareness of their emotional state meant that the child felt unable to talk to them for fear of making her feel worse:

*They talk, think they sort of talk more to some other people then they do to me because they get a bit, I think they don’t like bringing it cos they know it upsets me I think to start making me talk about it so.* (Emma)

It appeared from the mothers’ accounts, that their emotional fragility meant the children were left in a dilemma about whether or not to express their emotions.

**iii. To Express or Not to Express Emotions - The Importance of Others in Healing the Child**

When speaking about their child coping with the impact of domestic violence, many of the mothers seemed to be giving mixed messages as to whether the child should or should not express their emotions. All three mothers suggested that it was important that their children be able to express their emotions regarding their experience of domestic violence.
One mother spoke of how she believed a lack of emotional expression in her child had led to health related problems:

[Daughter] obviously with her classic irritable bowel now, that's obviously she couldn't let all her anger and everything out then maybe she wouldn't be so stressed and she'd be able to talk about things. (Emma)

However, what seemed to emerge was that while most of the mothers were keen for their child to express their emotions, often they felt ill equipped to help with this process or unable to cope with hearing what their child had to say:

I can't support them in the respect that I'm not qualified enough to have the right answers to help them and I think sometimes it needs an organisation or other people to sit down and talk to them and help them. (Emma)

I was so upset, it distressed me. Cos I wanted to kill myself. I just feel, I feel awful as a mother... The worst part is hearing what the kids have been through and them telling me what they heard and them telling me what they saw. (Gillian)

Indeed, all three mothers stated the importance of having others (e.g. family and friends, services) to help promote emotional expression in their child:

I like them [children] to have quite a good network so they can talk about things. He's [son] had counselling at school and she's [daughter] had counselling... I had such support from [domestic violence charity worker]... she's keeping an eye on the kids for me, monitoring what their emotions are, you know making sure everything's coming and that we're dealing with it. (Gillian)

There was a sense that having left domestic violence and subsequently received support for their own emotional wellbeing as well as their child's, the mothers felt more able to support their child's emotional needs:

I want them [children]... not necessarily forget it [domestic violence], but be at peace with it because you can't forget it, be at peace with it and know that it has made them a better and stronger person than anything else is what I want them to have the outcome of this. You know, my job as a parent is to turn every negative into a positive and I damn well will if it kills me. (Rachel)
All of the mothers spoke about their encounters with certain services, citing some good, bad and particularly difficult and traumatic experiences. All three mothers spoke about how they had received extremely positive support for their child following leaving domestic violence, from charities specifically orientated to this field. There was a sense that the support was immediate, flexible and provided a much needed service for their children:

All I done was make a phone call to [domestic violence charity] and they were there like a shot. You know the support was put into place for the kids straight away by [domestic violence charity worker], you know she’s tremendous, they go to this youth group, you know they do a lot of work with them, you know in many forms, not that the kids are aware of what’s going on they get things out of them in certain ways. You know but for the future it would be nice to know that they’re still there for the kids, later on in like when they’re older sort of thing. (Gillian)

In the above quote, we can also see how mothers believed they would have been lost without this support and expressed concern about the future provision of these services due to funding difficulties. However, two of the mothers provided examples of other child services, which had not provided the support that they felt their child needed:

We’ve been, we’ve tried before to the doctor tried to refer [daughter] and [son] to CAMHS [Child and Adolescent Mental Health Service] and they wouldn’t accept them because they didn’t fit the criteria... [Feels] Oh very upset, very upset because I was at my wits end and they [children] help, needed help... At the time they needed, they needed someone to talk to but it wasn’t there. They needed help and support. (Emma)

In addition, a few of the mothers cited times when they felt that professionals had acted inappropriately and outside the bounds of their role. In these instances there was a sense that the child was forced to talk about their experiences by someone who was not qualified to do so and who had not gained consent from either the mother or their child:

I then had an incident where the teachers, one teacher in particular, decided to try and interfere with my child... with her emotional wellbeing. Sitting there asking her questions “oh what did your dad do? Well I know you had a counsellor from the [children’s charity], can you bring your council work, counselling paperwork in and let me have a look at it?“... Well, it’s an invasion of my daughter privacy. It’s
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"got nothing to do with her... I just went on one [said to the headmistress] "she's [daughter] wetting the bed now, she's not sleeping, she's crying, you're making her miss her dad... You know, stop, leave it". (Rachel)

This instance seems to highlight what many of the mothers were echoing, that although appropriate services were considered essential and necessary to support the children, the people supporting their child needed to be appropriately qualified and should intervene in collaboration with both the child and their mother.

On a final note, one mother gave a particularly powerful message, that had she not received the appropriate help from services, the consequences for both her and her child would have been dire:

[If domestic violence charity wasn’t there] I think I would have gone back to him [perpetrator]... I think I’d be leaving the house in a coffin and that’s my view on it. I’ve always said that, if it weren’t for them, I you know, I wouldn’t have killed the kids but I’d probably, I don’t think I’d be here. Cos I think it was getting to the point where I just couldn’t take it anymore. Either he would’ve put me in the coffin or I would have put myself in there. Or he might have been in the coffin as well... If [domestic violence charity] weren’t there I think it would have been a whole different ball game. The kids would have probably had a really bad life and you know God knows what would have happened to the kids. (Gillian)
3.5 Discussion – Perspective Two

Each of the master themes relating to mothers’ perceptions of their child’s experience of exposure to domestic violence is discussed below in relation to relevant research and theory.

3.5.1 Theme One: Reflecting on their Child in the Context of Domestic Violence

This theme highlighted mothers’ unique perceptions of their child’s experience of domestic violence. It centred on a developing awareness, by mothers, of the child’s exposure to a less than ideal environment. It is useful to consider that mothers experiencing domestic violence are often understandably unable to think or reflect upon the impact it is having upon their child at the time (McIntosh, 2002). Trauma theorists posit that an individual’s cognitive capacity is diminished in a threat based environment due to preoccupation with safety and arousal levels (e.g. van der Kolk et al., 1996). This might explain the mothers’ lack of awareness of their child’s exposure to domestic violence at the time it was taking place. However, from a psychodynamic perspective one could also see the lack of awareness of their child’s exposure at the time, as representing some level of denial. Under this approach, the mothers’ denial could be viewed as a defence mechanism, serving to protect them from the reality of the harmful consequences exposure to such a difficult environment might be having on their child (Lemma, 2003). Indeed, as will be discussed in the final theme, mothers often reported feeling suicidal when realising the impact that exposure to domestic violence had upon their child. Further, consistent with other findings (Mullender et al., 2002) the mothers all spoke of how in the context of domestic violence, they denied the extent of their child’s exposure, thinking they had succeeded in their efforts to protect the child.

However, leaving the abusive environment seemed to act as a transition point for the mothers, enabling a developing awareness that their child was acutely aware of the situation; like a ‘miniature radar device’, picking up on everything. Moreover, following the move, there was a clear realisation from mothers that the environment to which their child had been exposed had resulted in their child having to behave in ways not typical of children of their age. Indeed, there was a developing awareness that their child experienced an absence of a ‘normal’ childhood. This is consistent with the assertion that having left the relationship, mothers are better able to reflect on their children’s experience of domestic violence, often attributing negative changes in the child to this experience (Mullender et al., 2002). It is thought that a mother’s ability to reflect and attune to their
child's experience of domestic violence and the resulting impact, is essential to a child's recovery (McIntosh, 2002). However, this group of mothers were only able to achieve this once they had left the context of domestic violence. Therefore, the importance of supporting traumatised mothers, in the context of safety, to enable them to listen to their children is highlighted.

3.5.2 Theme Three: Learning from Mothers - Insights, Support and Services

This theme surrounded the mothers' insights regarding their children, including how their child experienced contact with the perpetrator. Mothers spoke about how their own emotional fragility impacted upon their ability to support their child's expression of emotions and how others were crucial in helping facilitate this. Moreover, mothers gave their perceptions of the services provided for their child.

In terms of contact with the perpetrator, the mothers seemed to think that this would lead to further neglect and re-traumatisation for the child. Existing research has illustrated that mothers have vast concerns over their children having contact with the perpetrator (Buckley et al., 2007). The current study provides new insights into these concerns, as mothers cite what appear to be more specific and severe instances of trauma as a result of contact. Recent research in this area has emphasised the importance of carrying out a comprehensive assessment of the risk posed by the perpetrator (Humphreys, 2007). The present study highlights the importance of putting children's safety first and the necessity of gaining multiple perspectives surrounding future contact with the perpetrator, to ensure a comprehensive assessment of risk is carried out. Morrison (2009) spoke about how safety was paramount in determining how contact was experienced by children, something that is echoed by the mothers in this study.

Speaking with mothers about their perception of their child's experience of domestic violence highlighted specific issues regarding the difficulty of mothering, both before and after they had left the abusive environment. Mothers spoke about their own emotional fragility and for some, the development of mental health problems throughout this time. This led them to believe they were less able to care for and support their child. This finding accords with existing research which documents how women who experience domestic violence often develop mental health difficulties, making it difficult for them to care for and support their child (Lapierre, 2007; Radford & Hester, 2006).
However, it is worth noting that the mothers also suggested that the perpetrator undermined their ability to parent by ensuring their emotional and physical unavailability for their children. Indeed, it seems important to acknowledge the harm that the perpetrator’s behaviour can have on the mother-child relationship, given the propensity in society for seeing these mothers as inadequate (Lapierre, 2008). This study supports the claim that mothers go to great lengths to protect and care for their children (theme one), but that the extremely difficult context of domestic violence undermines their own emotional wellbeing, making it extremely difficult to fulfil their mothering potential (Lapierre, 2007).

Mothers described how their children seemed aware of their emotional fragility in the context of domestic violence and believed that their children chose not talk to them about their experiences for fear of upsetting them. After leaving the abusive context, mothers spoke of regaining a sense of emotional stability. However, they still felt unable to speak with their child, suggesting that they did not feel suitably qualified or able to cope with hearing what the child had to say. This is consistent with previous research studies which indicate that very few mothers and children speak about the domestic violence after leaving the situation (Mullender et al., 2002). Attachment theory highlights the significance of the mother’s ability to attune to the emotions of her child (Stern, 1985). A mother’s ability to attune to her child’s emotional needs following domestic violence is thought crucial to a child’s recovery (McIntosh, 2002). However, although better attuned to their children’s emotional distress since leaving domestic violence, the mothers still felt ill equipped to deal with the level and intensity of the child’s distress. Several mothers spoke about feeling able to ‘parent’ their child, but less able to manage their child’s emotional and behavioural problems, believing that this required the support of services. Mothers spoke about the valuable role of others (e.g. family members and professionals) in both supporting them and facilitating their child’s emotional expression. Many positive outcomes were cited as a result of this support, including how they themselves felt more empowered to support the child. Thus, the current study raises interesting questions about working towards facilitating the mother-child relationship rather than separating out mother and child services (Humphreys et al., 2011).

Finally, mothers spoke about their perception of how their child had experienced services, citing good, bad and particularly difficult examples. The mothers seemed to express confusion about why some more generic child services (e.g. Child and Adolescent Mental
Health Services) had not offered support for their child. Although there was a suggestion that the child had not met the criteria for these services, mothers clearly thought that they needed some support for their child after leaving domestic violence. The mothers deemed that appropriate services were essential to support their child, but that the people providing this support needed to be suitably qualified and should intervene collaboratively with both the child and the mother. Community domestic violence charities were frequently cited by mothers as providing invaluable support. This echoes Mullender et al. (2002) who found that community domestic violence projects were hugely important for children and especially attuned to their needs.
4. **OVERALL DISCUSSION**

4.1 Overview

The results of perspective one and two have been discussed separately in relation to existing research and theory. The aim of the current study was to better understand the experience of domestic violence as a child by gaining the perspectives of school-aged children and their mothers. To help illuminate and expand our understanding of this phenomenon, the perspectives of children and their mothers will now be brought together, reflected upon and common links explored (Dallos & Vetere, 2005; Smith et al., 2009). The clinical implications of the findings will also be discussed, followed by a consideration of the limitations of the current study and suggestions for future research.

4.2 Bringing the Two Perspectives Together

It is interesting that both the mothers and children saw living with domestic violence as a loss or absence of childhood. There was a sense for both that this realisation only came once they had left the context of domestic violence. For children, they were aware of the threatening, neglectful context in which they were living but thought it was normal. Whereas mothers seemed to deny that their child was growing up in a less than ideal environment, thinking they had succeeded in their efforts to protect the child. Reflection seemed a crucial process for this increased awareness for both children and mothers after leaving domestic violence. For mothers, reflection aided their appreciation of the extent of their child's exposure to domestic violence and the consequences of this. For children, reflection led them to consider their environment as not 'normal'. During the process of reflection, their views became more aligned, both coming to see the experience of domestic violence as causing a loss or absence of childhood. This seems to support theory suggesting that following traumatic events such as domestic violence, reflection can help individuals make sense of experiences, which can promote post traumatic growth (Calhoun & Tedeschi, 2006). However, Fonagy (1991) cautions that premature engagement in full reflection on painful memories can be overwhelming for individuals. What seems important is that mothers' and children are given adequate support to help them to reflect upon these difficult experiences within a safe context.

Although this study did not focus specifically upon the mother-child relationship in the context of domestic violence, it seems that both the children and their mothers highlight this as central to the child's experience of domestic violence. Looking at the accounts from mothers and their children alongside each other however, allows us to better understand
how the mother-child relationship is seen to be affected from both perspectives. Children spoke about becoming less reliant upon their mother due to a lack of trust that their mother could support them, whereas mothers felt their child chose not to burden them for fear of increasing their emotional fragility. This supports the 'conspiracy of silence' notion, whereby children protect their mothers from their knowledge of the domestic violence, while mothers assume that not talking about the past will protect their child and help them move on (Humphreys et al., 2006). This study adds to the 'conspiracy of silence' by highlighting that children avoid talking to their mother not only to protect her, but also to protect themselves due to the fear that others cannot be trusted to protect them. This raises interesting questions if we consider the emotional security hypothesis, which posits that if a child perceives their parents relationship as insecure, they adjust their behaviour and emotions in order to protect themselves from feelings of insecurity (Davies & Cummings, 1994). It seems that for these children, domestic violence has led them to feel insecure about the relationship between their mother and the perpetrator, which could have led them to hide their emotions as a way of protecting themselves.

Moreover, children and mothers both spoke about the importance of children being able to express their emotions surrounding their experience of domestic violence. However as mentioned above, there were clearly barriers to the children and mothers talking to each other. Mothers believed they needed help from appropriate others in order to support their children's emotional expression. This study supports the view that the needs of mothers and their children are essentially interconnected and advocates against the strict separation of mother and child services (Humphreys et al., 2011). However, it is worth noting that this group of mothers and children may have been more settled compared with those residing in refuges and thus may be more able to work on strengthening their relationship. This is in line with recent research indicating that being settled, both emotionally and in the environment, is crucial when nurturing the mother-child relationship in the aftermath of domestic violence (Humphreys et al., 2011). Thus this study raises interesting questions for the timing of interventions focusing on the mother-child relationship.

In summary, it seems that by looking at the accounts of school-aged children and their mothers alongside each other, has provided useful insights into children's experience of domestic violence. Moreover, this dual-perspective research not only privileges the voice of the child but also helps us expand on their experiences by looking at the wider context of
what is happening in that child’s environment by speaking with the child’s mother. Given
the lack of existing research which speaks to school-age children living in the community,
this study has provided useful insights into how this group of children experience domestic
violence.

4.3 Clinical Implications

Looking at the perspectives of children and their mothers alongside each other appeared to
give rise to two potentially pertinent clinical implications.

Firstly, while there were some commonalities between the children’s coping strategies,
each was also characterised by unique nuances. For some children, speaking about their
experiences allowed them to process the difficulties and traumas they had experienced.
However, other children seemed to require further intervention to help them express and
process their emotions. This has implications for how professionals direct service provision,
suggesting a ‘needs led’ approach guided by the child and their particular presentation. The
current study supports the view that different children are suited to different interventions,
depending on the child’s particular presentation (Itzin et al., 2010). What seems important
is that children are given the opportunity to speak about and express their emotions,
needs, wishes and experiences. Emotional and physical containment is crucial in facilitating
the children’s expression of difficult emotions (Bion, 1962). Given the possible attachment
difficulties these children experience, the need for input from suitably trained professionals
seems crucial; a view echoed by the mothers. Services need to collaborate with each other
to decide which professionals and what services they are making available to these children
and their families, ensuring that this is a collaborative process at every step.

Secondly, this dual-perspective research highlights the benefit of seeking to strengthen the
mother-child relationship in the aftermath of domestic violence. This supports a growing
body of research which argues that integrating mother and child intervention services;
supporting communication between mothers and children; and ending the ‘conspiracy of
silence’ should be the focus of interventions (Humphreys et al., 2011). Theraplay is an
intervention which seeks to promote a secure attachment relationship between children
and their caregiver, by encouraging the caregiver to empathically attune to the child’s
needs (Booth & Jernberg, 2010). Another intervention which focuses upon enhancing the
attachment relationship between child and caregiver is SPIN (see Pease et al., 2004). SPIN
helps parents to build healthy attachment relationships with their children by identifying
their strengths as parents and building upon these using play, feedback and reflection. Both
theraplay and SPIN could be considered as possible interventions to help children express difficult emotions and become less self-reliant, by promoting a secure attachment relationship with their mother in the aftermath of domestic violence. Indeed, appropriate interventions are seen as crucial in helping facilitate the children's emotional expression by giving the child a space to express their emotions alongside helping mothers gain confidence in supporting their child to do this. This is an important consideration given that school-aged children have less ability to seek help independently and often rely on their mothers as their primary care giver (Layard & Dunn, 2009).

These recommendations mirror the stance taken in the NSF for children, which advocates the voice of the child, support for parents in caring for their children and the provision of high quality family centred services for children (Department of Health, 2004). Overall, the message from both children and their mothers was clear: Without the help of community domestic violence services the children’s outlook would have been bleak. This is a powerful message to the commissioners of services in the time of vast cuts to these types of projects (Butler, 2011).

4.4 Limitations and Future Research

IPA research aims to obtain an in-depth analysis of the accounts of a small number of participants to produce a rich and detailed account of a phenomenon from a particular perspective. Although there is no concrete rule in relation to sample size in IPA, Smith et al. (2009) advocates between three to six participants. The benefits of such numbers are thought to include “the development of meaningful points of similarity and difference between participants, but not so many that one is in danger of being overwhelmed by the amount of data generated” (Smith et al., 2009, p.51). However, it is worth noting that some researchers advocate much larger samples (12+), considering this as a move towards overcoming criticisms surrounding validity and rigour within qualitative research (see Guest et al., 2006). Nevertheless, Dallos and Vetere (2005) argue that large sample sizes are inconsistent with the purpose of qualitative research which aims to capture uniqueness, as well as commonalities relating to a phenomenon. Indeed, it was felt that a small number of cases would be more in line with the aims of the current research, which was to obtain a rich, detailed, in-depth account of school-aged children's experience of domestic violence.

IPA does not aim to achieve a representative sample of a wider population (Touroni & Coyle, 2002). Nevertheless, Smith and Osborn (2003) comment that themes from one sample might be pertinent to individuals from comparable populations. It should be noted
that all the participants from the current study are from White, British backgrounds. Literature suggests that cultural context can play a part in how an individual experiences domestic violence (Goldblatt, 2003). Therefore, it is likely that the perceptions of the children and mothers in this study are different to children and mothers from other cultural and ethnic backgrounds who have experienced domestic violence. As such, the findings and clinical implications from the current study may only be pertinent to children from similar ethnic and cultural backgrounds as the children in this study.

One aim of this study was to gain different perspectives of children's experiences of domestic violence. However, what the project gained in breadth, meant sacrifices in terms of depth. Indeed, the scope of the project unfortunately meant that two master themes were omitted from the results. Although, careful consideration was given to which themes would be presented, the potential of the two omitted themes to highlight some useful nuances in terms of the impact of domestic violence on the children were lost from this report (see Appendix 24 and Appendix 25). Nevertheless, the present study has produced some useful insights, and highlights the potential benefits of applying multi-perspective approaches to other complex clinical phenomenon.

The suggestion from mothers that their children have been re-traumatised by having contact with the perpetrator is an area that needs further examination. It is worth noting that the perpetrator's relationship with the child varied; in some cases they were biologically related and in others not. This may have implications for how the child feels about the perpetrator and contact arrangements following leaving domestic violence. However, given the seriousness of the mothers' concerns surrounding their child's contact with the perpetrator, it seems that this is something which future research should seek to investigate. In line with the ethos of multi-perspective research, it may be that future studies need to explore the perspectives of the perpetrator and professionals working with the families, alongside those of the mother and child.

4.5 Final Reflections

This study has sought to capture the perspectives of school-aged children and their mothers in order to help illuminate and expand our understanding of how children make sense of domestic violence. The benefits of using a dual-perspective method and how one perspective can help illuminate another has been demonstrated, whilst recognising each perspective as equally valid and meaningful in their own right. Specific consideration has been given to exploring the perspectives of school-age children from a community setting.
and their mothers, yielding some novel insights for this group of children. Indeed, the important role of the mother-child relationship in managing the experience of domestic violence as a child is highlighted. Perhaps more importantly, is the illustration that children as young as eight were able to powerfully articulate their experiences and needs; now it is time for us to listen.
5. REFERENCES


Templeton, L., Velleman, R., Hardy, E. & Boon, S. (2009). Young people living with parental alcohol misuse and parental violence: 'No-one has ever asked me how I feel in any of this'. *Journal of Substance Use, 14*(3), 139-150.


6. APPENDICES

6.1 Appendix 1 - Information Sheet for Children (Perspective One)

UNIVERSITY OF SURREY

INFORMATION SHEET

Towards a Richer Understanding of School-Age Children’s Experiences of Domestic Violence: The Perspectives of Children and their Mothers

My name is Jen and I am a trainee clinical psychologist studying at the University of Surrey. As part of my 3 year training I am asked do a piece of research.

Why am I doing this research?

I would like to learn from you and other children about how you felt living in a home where someone experienced domestic violence.
**Why do I want to ask you about these things?**

I want to make sure that children are listened to so that their stories can help others understand what it is like living with domestic violence. Hopefully this will also help other children in the future to feel supported.

**What will happen to me if I want to take part?**

If you and your mum agree it is ok for you to take part, you will be asked to come and have a talk with me and do some drawings. You can bring someone with you if you want to and you can stop the talk at any time using a special word that we agree together.

**Do I have to take part?**

You do not have to take part. It is up to you and your mum to decide if you want to. You can ask me any questions before you make a decision. If you decide you want to take part and then either you or your mum changes your mind that is fine. If you want to take part, I will ask you to sign a consent form.

**Will what we talk about be kept confidential?**

What you talk about will be recorded and written up by me. I may write some things you and other children have said down and other people may read this so they can understand what it is like living with domestic violence. But no-one will be able to tell that it is you that has talked to me. This means, unless you...
choose to have your mum present at the interview, she will not be able to know what you have said to me. But you can tell anyone whatever you want to about our talk. The tape recordings will be permanently deleted once I have written up what you have said. I will store written material in a locked cabinet. If I am worried about you or someone else I will have to tell a member of staff at the domestic violence charity so they can make sure you are ok.

**What happens after?**

After we talk, you may feel upset, sad or angry or you may not. If you feel like this or have any questions you should talk to me or your mum or someone at the domestic violence charity.

**Contact Information**

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THANK YOU FOR THINKING ABOUT TAKING PART IN THIS RESEARCH
My name is Jen and I am a trainee clinical psychologist studying at the University of Surrey. As part of my 3 year training I have been asked to carry out a piece of research. Your child is being invited to take part in this piece of research. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to ask if you would like any more information. Take time to decide whether or not you wish your child to take part.

**What is the purpose of the study?**
I would like to learn from your child about how they felt living in a home where there was domestic violence taking place.

**Why am I researching this?**
I am passionate about speaking to mothers and children about their experiences of domestic violence so that their stories can help others to better understand what it is like. Children's views are under-researched and not widely understood. Therefore, I hope that by doing this research it will lead to services making improvements so that you, your child and others like you will feel more supported.
**Does your child have to take part?**
It is up to you and your child to decide whether or not they take part in this research. If you both agree for your child to take part, I will ask you and your child to sign a consent form. You and your child are still free to withdraw from the study, without giving a reason, even after signing a consent form.

**What will happen to your child if they take part?**
Your child will be asked to come and have a talk with me and do some drawings. They can bring someone with them if they want to and can stop the talk at any time. Usually, these talks last around an hour and your child can choose whether or not to answer the questions I ask.

**Will this talk be confidential?**
What your child talks about will be recorded and written up by me. However, no-one will be able to tell it is your child that has talked to me. Any information about your child will have their name removed so that they cannot be recognised from it. This means, unless your child chooses to have you present, you will not be able to know what they have said to me. I will store written material in a locked cabinet. This will be destroyed by shredding after 10 years. If I am worried about your child or someone else I will have to tell a member of staff at the domestic violence charity so they can make sure your child is ok.

Therefore, apart from me, your child’s identity will remain anonymous.

**What happens after?**
After the interview your child may feel upset. It is important that they talk to one of the staff at the domestic violence charity or yourself if they do.
Staff will be aware your child has been for an interview and will be on hand to offer support. If you or your child has any questions following the interview, please leave a message for a member of staff to contact me and I will arrange to visit again.

Eventually I hope to write up the research and publish it as part of my clinical doctorate course. I may in the future also present my results at meetings. Your child will not be identifiable in any of these results or presentations.

**What if I have a complaint?**

If you have a complaint about the research or the research staff, you should initially raise this with me. If you are still not happy, please contact my research supervisor.

**Contact for further information**

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THANK YOU FOR TAKING THE TIME TO READ THIS
6.3 Appendix 3 - Information Sheet for Mothers (Perspective Two)

UNIVERSITY OF
SURREY

INFORMATION SHEET

Towards a Richer Understanding of School-Age Children's Experiences of Domestic Violence: The Perspectives of Children and their Mothers

My name is Jen and I am a trainee clinical psychologist studying at the University of Surrey. As part of my 3 year training I have been asked to carry out a piece of research. You are being invited to take part in this research. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to ask if you would like any more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
I would like to learn from you about what you think it was like for your child living in a home where there was domestic violence taking place.

Why am I researching this?
I am passionate about speaking to mothers and children about their experiences of domestic violence so that their stories can help others to better understand what it is like. Mothers' views are under-researched and not widely understood. Therefore, I hope that by doing this research it will lead to services making improvements so that you and others like yourself will feel more supported.
Do I have to take part?
It is up to you to decide whether or not to take part. You will have the chance to ask any questions you may have before you agree to take part. When you are sure you want to take part, I will ask you to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?
If you agree to take part, you will be asked to talk to me about both yours and your child's experiences of domestic violence. Usually the talk will last up to an hour. Even if you agree to take part, you can choose not to answer anything I ask you. You can bring someone with you to the interview if you wish, or you may choose to talk alone.

Will this talk be confidential?
What you talk about will be recorded and written up by me. However, no-one will be able to tell it is you that has talked to me. Any information will have your name removed so that you cannot be recognised from it. Therefore, apart from me, your identity will remain anonymous. The tape recordings will be permanently deleted once I have written up what you have said. I will store written material in a locked cabinet. This will be destroyed by shredding after 10 years.

If I am worried about you or someone else after our talk, I will have to tell a member of staff at the domestic violence charity so they can make sure that you are ok.
What happens after?

After the interview you may feel upset. It is important that you talk to someone if you feel like this. Staff at the domestic violence charity will be aware you have been for the interview and will be on hand to offer support. If you have any questions following the talk, please leave a message for a member of staff to contact me and I will arrange to visit you again.

Eventually I hope to write up the research and publish it as part of my clinical doctorate course. I may in the future also present the results at meetings. You will not be identifiable in any of these results or presentations.

What if I have a complaint?

If you have a complaint about the research or the research staff, you should initially raise this with me. If you feel this has not been resolved please contact my research supervisor.

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THANK YOU FOR CONSIDERING TO TAKE PART IN THIS RESEARCH
6.4 Appendix 4 - Semi-Structured Interview Schedule (Perspective One)

Interview Schedule - Perspective One

Prior to the Interview

- Explain study to child, making it clear there are no right or wrong answers.
- Explain confidentiality.
- Check child’s mood at beginning, end and at various intervals of the study using visual distress monitor.

Note: Bullet points denote possible prompts

1. Can you tell me a little bit about yourself?
   - What do you like/dislike doing?
   - Do you have any hobbies?
   - Do you go to school?
   - What is your favourite subject?
   - Do you have any brothers or sisters?

2. Kinetic Family Drawing (KFD) -- Burns & Kaufman (1972)
   Please could you draw a picture of everyone in your family doing something? Try to draw whole people, not cartoons or stick people.
   Remember, make everyone doing something, some kind of action.
   - Tell me about each person in the picture
   - What are they like?
   - What is your relationship like with them?
   - What are they doing?
   - Is there anyone missing from the picture?
   - If yes – why are they missing?
   - What would they be doing if they were here?

3. What has it been like for you living here?
   - When did you come to live here?
   - What has been good/bad about living here?
   - Is anything different since you came to live here?

4. Can you tell me a bit about what things were like for you at home before?
   - Who did you live with?
   - What was it like?
   - What was good/bad about it?
   - If siblings: How do you think they found living at home?

5. Can you think of any times when you have seen or heard people being treated badly at home?
   If yes –
   - What sort of things happened?
   - What did you see?
   - What did you hear?
   - How often did this happen?
Major Research Project

- What did you do?
- Did anything else happen? (e.g. shouting, name calling, hitting, punching or scary behaviour)
- If siblings: What did they see/hear/think happened?
  - If no –
    - Some children see their mother being treated badly – have you ever seen your mother being hurt, shouted at or treated badly?
    - Some children know of other people/mothers who have been hurt, shouted at and treated badly at home – have you?

6. How did it affect you when you saw/heard your mother being treated badly?
   - How did it make you feel?
   - What did you think?
   - What did you do afterwards?
   - How does it affect you now? (behaviour, emotions)
   - Some children feel sad/angry/hurt/guilty when they see their mother being hurt – did you feel any of these things?
   - After seeing their mother being hurt, some children start behaving differently – did you notice that you behaved any differently afterwards?
   - If siblings: How do you think it affected your siblings?

7. What do you do if you feel scared or upset?
   - Do you have a safe place you can go?
   - Is there a safe person you can talk to?
   - What do you do to comfort yourself?

8. What do you think would help children who live with domestic violence?
   - What would have helped you/other children?
   - What made things better/worse?
   - How do you think people could help more?
   - Do you feel you can ask for help?
   - If yes – why?
   - If no – what stops you?

9. Those are all of my questions. Is there anything that I didn’t ask you that you want to talk about?
   - Did you understand my questions?
   - What would have helped you understand them more?
   - Do you think I could have done/asked anything differently?
6.5 Appendix 5 - Semi-Structured Interview Schedule (Perspective Two)

**Interview Schedule – Perspective Two**

**Prior to the Interview**
- Explain study to mother.
- Explain confidentiality.
- Check mother’s mood at beginning, end and at various intervals of the study using visual distress monitor.

Note: Bullet points denote possible prompts

1. **Can you tell me a bit about yourself?**
   - Do you have any hobbies or interests?
   - What do you do during your spare time?

2. **It would be helpful if you could tell me a bit about your child/children?**
   - Do they have any hobbies or interests?
   - What are they like? (temperament, character, personality)
   - Do they have any brothers or sisters?
   - How do they behave on a day to day basis?
   - How do they get on with other children/adolescents?

3. **What is your relationship like with your child?**
   - How much time do you spend together?
   - What do you do together?
   - How would you describe yourself as a mum?
   - Can you tell what (child) is feeling or thinking?
   - How are you able to do this?
   - What signs are there that (child) is feeling fine/happy/sad/scared/angry?

4. **I’d be interested in hearing about what brought you to live here – can you tell me a bit about that?**
   - Would you be able to say a little bit about the domestic abuse you experienced? (physical, verbal, emotional, sexual)
   - How long did it (abuse) go on for? (chronology)
   - At what point did you decide to leave the abusive relationship?
   - What were the triggers/reasons for this?

5. **I was wondering what you think your child’s understanding is of the domestic violence you experienced?**
   - Did they witness any domestic violence?
   - Did they hear any of the domestic violence?
   - If so – did you talk about it?
   - If not – what makes you think your child didn’t see anything?

6. **What do you think your child’s understanding (if any) is of leaving domestic violence?**
   - How do you think they made sense of the move at the time?
   - How did they cope with the move?
   - How do you think they make sense of the move now?

7. **Have you noticed any changes in your child?**
   - During/after the domestic violence (emotional/behavioural/physical/social)
8. What do you think your child does if they need comfort or safety?
   - What do you think makes your child feel comforted or safe?
   - Who do they turn to if they feel scared or upset?
   - What do they do if they feel scared or upset?

9. That is the last of my questions - is there anything that you feel I haven't asked you?
   - How have you found answering these questions?
   - Could I have asked anything differently?
6.6 Appendix 6 - Consent Form for Children (Perspective One)

CONSENT FORM

Towards a Richer Understanding of School-Age Children's Experiences of Domestic Violence: The Perspectives of Children and their Mothers

Name of researcher: Jen Swanston

- Jen would like to talk to me about what happened when I was at home.
- Jen gave me some information to read with my mum. I understand what it said.
- I was able to ask Jen any questions I had.
- Jen will record what we talked about and write it up.
- I can tell anyone I want to about what we talk about.
- Jen will not use my real name so that other people do not know that she is writing about me.
- I can say 'no' to this.
- Jen will not mind if I say no.
- This will not affect any help I get.
- If I say yes I can change my mind without having to say why.
My decision:

I agree to take part in Jen's research

OR

I do not want to take part in Jen's research

My name:

My signature:

Today's date:

Researcher          Date          Signature
Jennifer Swanson
University of Surrey
Guildford
GU2 7XH
j.swanston@surrey.ac.uk

Professor Arlene Vetere
University of Surrey
Guildford
GU2 7XH
a.vetere@surrey.ac.uk
01483 652911
6.7 Appendix 7 - Consent Form for Mothers (Perspective One)

CONSENT FORM

Towards a Richer Understanding of School-Age Children's Experiences of Domestic Violence: The Perspectives of Children and their Mothers

Name of Parent: ____________________________

Name of Child: ____________________________

Please initial box

a) I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. □

b) I understand that my child's participation is voluntary and that I am free to withdraw this at any time, without giving any reason. □

c) I agree for my child to take part in the above study. □

Name of Parent ____________________________ Date ____________ Signature ____________________________

Researcher ____________________________ Date ____________ Signature ____________________________

Jennifer Swanson
University of Surrey
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01483 602911
6.8 Appendix 8 - Demographic Information Form

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<th>Demographic Information</th>
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**Child**
- Age
- Gender
- School year
- Ethnicity
- No. of siblings and ages (please say if step/half brother or sisters)

**Mother**
- Age
- Ethnicity
- Occupation
- Current living arrangements
- Previous living arrangements
  - e.g. rented house/flat, owner occupier, with relatives or friends
- Who is living at current home?
- Who was living at previous home?
- Current relationship status
  - e.g. single, married, cohabiting, in a relationship but not cohabiting

**About your previous partner(s)**
- How many relationships have you had since your child was born?
- How many relationships have you been in that have been abusive?
- Length of time in previous abusive relationship(s)
  - Month  Years
- Is he the biological father of (child taking part in the study) YES/NO
- How much of (child's) life was he living with you for?
6.9 Appendix 9 - De-Brief Sheet for Children (Perspective One)

DEBRIEF SHEET

Thank you very much for coming to talk with me today. By talking to me you have helped me understand what it has been like living with domestic violence. By telling me your story I hope that other children like yourself can be helped better in the future.

It may have upset you talking to me today. It is important that you tell your mum, a member of staff, me or my supervisor if you feel upset so that they can help you. You can ask one of the staff to leave me a message and I will call you back as soon as I can. You may also like to ring Childline by phoning free on 0800 1111 or visiting their website: www.childline.org.uk to talk about anything on your mind.

Next year, I will be feeding back the results of this research. I will invite you and your mum to hear this. If you cannot come I will write a letter to you to let you know what I found out by talking to you and other children.
My details:
Jennifer Swanston
University of Surrey
Guildford
GU2 7XH
j.swanston@surrey.ac.uk

My supervisor's details:
Professor Arlene Vetere
University of Surrey
Guildford
GU2 7XH
a.vetere@surrey.ac.uk
01483 682911

It was nice to meet you and thank you again for talking to me.
Thank you very much for agreeing that your child could come and talk with me today. By talking to me your child has helped me understand what it has been like living with domestic violence. By telling me their story I hope that other people will understand more about what it is like living with domestic violence as a child.

It may have upset your child talking to me today. It is important that they can talk to you, a member of staff, me or my supervisor if they feel upset so that they can be supported. If you or your child has any questions, you/they can ask one of the staff to leave me a message and I will call you back as soon as I can. They may also like to ring Childline by phoning free on 0800 1111 or visiting their website: www.childline.org.uk to talk about anything on their mind.

I will be discussing the findings of this research with staff and other professionals in around 18 months time. You will be invited back to hear about what this research told us. If you are unable to make it, I will send you a summary of what this research found if you would like me to.
My details:
Jennifer Swanston
University of Surrey
Guildford
GU2 7XH
j.swanston@surrey.ac.uk

My supervisor’s details:
Professor Arlene Vetere
University of Surrey
Guildford
GU2 7XH
a.vetere@surrey.ac.uk
01483 682911

It was nice to meet your child today and thank you again for agreeing to let them take part.
CONSENT FORM

Towards a Richer Understanding of School-Age Children’s Experiences of Domestic Violence: The Perspectives of Children and their Mothers

Name of Participant: ________________________________

Please initial box

a) I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

b) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

c) I agree to take part in the above study.

Name of Participant Date Signature

Researcher Date Signature

Jennifer Swanson
University of Surrey
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j.swanston@surrey.ac.uk

Professor Arlene Vetere
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GU2 7XH
a.vetere@surrey.ac.uk
01483 682911
Debrief Sheet

Thank you very much for taking part and talking with me today. By talking to me, you have helped me understand what it has been like for you and your child living with domestic violence. I hope that our talk will help other people understand more about what it is like for children living with domestic violence.

It may have upset you talking to me today. It is important that you talk to a member of staff, me or my supervisor if you feel like this. If you have any questions, you can ask one of the staff to leave me a message and I will call you back as soon as I can. You may also like to ring The Samaritans by phoning free on 08457 909090 or visiting their website: www.samaritans.org to talk about anything on your mind.

I will be discussing the findings of this research with staff and other professionals in around 18 months time. You will be invited back to hear about what this research told us. If you are unable to make it, I will send you a summary of what this research found if you would like me to.
My details:
Jennifer Swanston
University of Surrey
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My supervisor's details:
Professor Arlene Vetere
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a.vetere@surrey.ac.uk
01483 682911

It was nice to meet you today and thank you again for agreeing to take part.
6.13 Appendix 13 - Ethical Approval for the Research Study

Faculty of Arts and Human Sciences
Ethics Committee

Chair's Action

Ref: 410-PSY-10
Name of Student: JENNIFER SWANSTON
Title of Project: Working title: Working towards a greater understanding of the effects of domestic violence on children; the views of mothers and children
Supervisor: Professor Arlene Vetere
Date of submission: 25th January 2010

The above Project has been submitted to the FAHS Ethics Committee.

Favourable ethical approval has now been granted.

Signed: Adrian Coit
Chair

Dated: 18th Feb 2010
 Amendment to your proposal
Earl JE Mrs (FAHS Faculty Admin)
Sent: 15 October 2010 14:10
To: Swanston J Miss (PGR - Psychology)

Dear Jennifer,

After speaking to Dr Adrian Coyle again concerning your request to raise the upper age limit for the children participating in your study to 13 I can confirm that this is absolutely fine and you can proceed with the study.

Kind regards,

Julio
Secretary and Administrator FAHS Ethics Committee
Administrative Assistant
Faculty of Arts and Human Sciences
University of Surrey
Tel: 01483 689175
Room 36 AD 04
Mondays, Tuesdays, Thursdays & Fridays
6.15 Appendix 15 - Distress Monitor for Children

Distress Monitor

How are you feeling at the moment?
6.16 Appendix 16 - Distress Monitor for Mothers

Please indicate below how are you feeling at the moment?

0 = very distressed
5 = ok/unaffected
10 = very happy
6.17 Appendix 17 - Aaron's Drawing
Appendix 18 - Claire's Drawing
6.19 Appendix 19 - Kate's Drawing
6.20 Appendix 20 - Nina’s Drawing
6.21 Appendix 21 - Tom’s Drawing
6.22 Appendix 22 - Sample Annotated Transcript (Perspective One)
Major Research Project

Questioning reality of threat

Perpetrator's absence seen as respite

Dreaded perpetrator's return

| 531 | I: What was that like? |
| 532 |  |
| 533 | C: It was scary because I didn't know what he was gonna do or if he was being serious. |
| 534 |  |
| 535 | I: And what did you think? |
| 536 | C: Didn't think that it was happening. |
| 537 | I: And what did you do after that? |
| 538 | C: Can't remember. That's all I remember. |
| 539 |  |
| 540 | I: Ok, was there anything good about living here before? |
| 541 | C: It was good when dad was down the pub. Well in a way really, because when he was down the pub he wasn't here but when he was down he pub I knew he was coming back and he, and when he was coming back he was gonna be drunk. |
| 542 | I: And what did that feel like? |
| 543 | C: Just, weird knowing that he's gonna come back drunk. |
| 544 | I: And was there anything else good about living here before? |
| 545 | C: No. |
| 546 | I: What was bad about living here before? |
| 547 | C: Dad was living here. It was more, it |

Scary - Not knowing whether threat was serious - fearing whether threat was real. Helplessness/fear

Denial event was happening - Denial of DV. Was it easier to forget/deny what was happening

Dad's absence seen as respite - Absence of dad

Good - False sense of security

Anticipation of dad's return - Preparation - Knowing he was away but dreading his return. - Constant state of alert

State of high alert - False sense of security
<table>
<thead>
<tr>
<th>Lack of Safety</th>
<th>572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612</th>
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<tr>
<td>was less relaxed, didn't feel safe, more hungry.</td>
<td>Less relaxed and unsafe - high state of alert and fear of being deprived of food for safety.</td>
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<tr>
<td>I: Can you tell me a little bit about that?</td>
<td>Dad wouldn't feed children - being forgotten - taking the back seat in the family - being deprived of right to eat.</td>
</tr>
<tr>
<td>C: Well he wouldn't like feed us and stuff.</td>
<td>Feeling ill - health repercussions for food deprivation - did this affect any other areas of her life?</td>
</tr>
<tr>
<td>I: And what did that feel like?</td>
<td>Feeling hungry seen as normal. It's thought knowing that this wasn't normal and that you should eat more - knowing nothing else.</td>
</tr>
<tr>
<td>C: Made me feel ill because I was hungry.</td>
<td>Knowing it wasn't right (dad's behavior) - feeling right and realizing this behavior was wrong.</td>
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<tr>
<td>I: And what did you think about that?</td>
<td>Anger about the past - feeling unfairly treated.</td>
</tr>
<tr>
<td>C: Just felt, thought it was normal and you just ate at dinner.</td>
<td>Younger siblings lack of understanding - feeling of being alone maybe? Older before her age.</td>
</tr>
<tr>
<td>I: And what do you think about that now? Now, now that you are out of that situation?</td>
<td>Younger siblings catching on. Thinking circumstances was normal. Normality = DV.</td>
</tr>
<tr>
<td>Warped view of reality</td>
<td>Reality was normal. Normality = DV.</td>
</tr>
<tr>
<td>Warped Realisation of Situation</td>
<td></td>
</tr>
<tr>
<td>Unfairness of treatment</td>
<td></td>
</tr>
<tr>
<td>Warped sense of normality</td>
<td></td>
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</tbody>
</table>
I'll just wondering when you decided to leave...

E: Well he, when he got arrested...

I: When he got arrested...

E: I didn't know it anymore, you just can't take it anymore, you just can't take it, you can't go back to what I'm doing, what I'm thinking. I just can't do it. And I was thinking of the children, cos I kept saying to them, while he was here, it won't be like this. I will get, I will get you out of this one way or another, I will try my hardest. Like any person would try and do and obviously the end shot was that their dad got arrested.

I: Thank you for telling me about that...

E: Going back a little bit, I know you spoke about the children, and I'm just wondering, you said about problems they were having... How do they behave on a daily day to day basis?

E: Depends, it depends on different days. A lot of it I think depends on if they are due to go and see their dad, cos their dad has them every other weekend because I need to work and that's the only time he wants to see them is every other weekend, which...

So I think if its building up if they are going to go there that they get a bit upset and they get very angry and
everything else. (Daughter')s health has deteriorated, she's got been to the hospital recently because she keeps pooling blood and having bad episodes of stomach problems. So she's been, had an endoscopy and a colonoscopy and they've found out that she's got chronic IBS now, which they say can be brought on by stress. So she's been having this for the last two years, so I think as she's got older now, cos obviously her dad's gone and everything else that has come on... Schooling, ok but she doesn't like being bullied and she's scared to talk about things to people because she's, quite ashamed, it's not like I said before, it's something you don't want to talk about because you feel ashamed that you've been in this situation.

I: And talking about the health issues, what do you think about that? What do you think has kind of had an impact on that?

E: I think it has had an impact on them. (Son) is getting to the stage, I think cos he was younger, from five I think they don't sort of remember anything but they do, when they do go, they know he doesn't they don't... they don't have much interaction with their dad. They don't, he doesn't play a part in them. They go to them but they are left to their own devices, so he doesn't particularly want to go there anymore and see their dad. And as you say (daughter')s health has deteriorated what with all this she gets very anxious and very angry, emotional, stressed

Daughter health deterioration - impact of stress + health of DV. Physical exercise of IBS.

Many physically related probabth IBS.

Shims as causing physical problem - Shims + DV.

Continuing impact of DV.

Doesn't like being bullied + scared to talk about DV

Bullying surrounding DV? Shame about circumstances inhibiting talking.

Scared about the implication of talking

DV as having impact on kids

Thinking kids wouldn't remember but they are thinking kids would forget.

In this case, DV - how being neglected - overcomes

Son not wanting to see dad due to being "good" impact of DV on daughter.

Define and explain anxiety, health, anger, emotional breadth of symptoms
| 283 | and everything else just because of this, which I think is terrible. I'm glad we got them out that situation really. |
| 284 | |
| 285 | I: And have things kind of got better or got worse since, since leaving the relationship? |
| 286 | |
| 287 | E: You can say good and bad. Now I've got a new partner, it's come on tremendously. They, he's supporting us and he does listen to them and does understand, still not fully what we are going through, it's hard on him. But... how can you really explain it, the children are learning to trust him. They are very wary between adults, they are very wary about anyone drinking alcohol, smoking and things like that, they do get quite concerned thinking that something might happen to them. |
| 288 | |
| 289 | I: Why do you think that is? |
| 290 | |
| 291 | E: Because of what they've been through with the drinking and everything else they associate drinking as bad and the police. (Son) thinks the police are bad cos they took their daddy away. So because they, they've got to get the trust back with trying to get my friend, she's a police officer, to come round and sort of say that we're not all, police aren't all bad, and you don't have to associate police as bad people cos they take dads away. |
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Theme Two: The Impact of Domestic Violence for Children

The second master theme concerned the children's perception of how living with domestic violence had impacted upon them since leaving that environment. Three sub-themes emerged which were: (i) Unresolved feelings towards the perpetrator - Punishment and accountability; (ii) Overwhelming emotions and sense of self; and (iii) Hyper-arousal, sleep disturbance and impaired functioning.

i. Unresolved Feelings Towards the Perpetrator - Punishment and Accountability

Many of the children spoke about the emergence of difficult negative feelings towards the perpetrator, wanting him to be held accountable and punished for what had happened in their past:

I want to kill him [perpetrator]. He killed my rabbit, give it anti-depressants...

Basically I want to get compensation, I want to kill him. Torture him very slowly.

(Kate)

There was a sense that the children had not been able to 'do' anything with these negative feelings toward the perpetrator, thus leaving them 'left over' or unresolved in the child:

I wished we never lived with him [perpetrator]. I wish he was dead cos he kept beating up mum. Then I wish that I was a grown up and then I could punch him so hard that he gets knocked out and then his teeth will fall out. (Tom)

ii. Overwhelming Emotions and Sense of Self

The experience of domestic violence was viewed by children to impact upon how they experience emotions and upon their view of themselves. For example, many children spoke about how their emotions were overwhelming to them. For a few children, their experiences of emotions were now quite different from their peers:

In history I just felt really weird, sort of get really weird stomach... It's like what's going and am I dying or something? And then mates said "it's about, it's how, it's that you've got a girlfriend now and that you're gona start feeling weird and that"... It felt like things are going to jump out of me or like do that through me [gestures something coming out through the stomach area]. Like felt like I was
dying and all that... I asked my mates and they said it was a good feeling but it felt a bit like a bad feeling. (Aaron)

For other children, it seemed that the experience of domestic violence was so overwhelming that they started to experience a diminished sense of self, represented in their desire to end their own life:

I was really withdrawn, I was like dirty looking, I felt sick all the time. I tried to kill myself on many occasions cos there was a motorway by our like house just going up the road a bit and there was like a bridge and I thought about jumping off of that like loads of times. (Kate)

Moreover, a diminished sense of self was experienced by other children as illustrated by low self-esteem and feelings of worthlessness due to the experience of domestic violence:

I had a low self esteem, still have really... I thought that I was the only one, felt worthless, not loved, other than by my mum... He [perpetrator] said to us, said to me that no one loves me and kept putting me down and stuff... I've still got a low self-esteem. Don't think much of myself. (Claire)

iii. Hyper-arousal, Sleep Disturbance and Impaired Functioning

As well as unresolved and overwhelming emotions, the children also seemed to experience increased arousal as a result of exposure to domestic violence. This seemed to be expressed in terms of hyper-vigilance to particular sights and sounds that acted as reminders of the domestic violence:

Well I don't like men now, I won't, I don't like it scares me shouting. I don't like men, I get scared if someone shouts, I can't be in the room if people argue. I don't like anyone hugging or anything my mum, like another bloke. And I don't like people calling me pet names... I don't like teachers shouting, I don't like male teachers at all. It scares me a bit if I have to go into the classroom with one of them. (Kate)

Many of the children spoke about experiencing intrusive memories and nightmares surrounding the domestic violence after they had left:

When I try getting to sleep, I think when I'm asleep and then dreamed about nightmares... I have a nightmare about he's [perpetrator] coming through our
door and he was gona chop me in half and [older sister] in half and then he’s gona
go into the front room and slice mum’s head off. (Nina)

This hyper-arousal and intrusions experienced by many children, was reported to influence
their functioning including their ability to sleep and manage daily life (e.g. during school
lessons):

I think it [domestic violence] affected my behaviour really badly because I was, cos
I have never done well in school and I started falling asleep. I’m still not doing well
in school and I’m struggling to learn... I keep having memories of my dad like
walking into the class room and like dragging me out by the collar so my hand
writing gets really messy... in lessons sometime I can’t get his [perpetrator] image
out of my head and then I just end up going mental... It feels like all I want to
learn about is history, I wana do is PE and I don’t wana think about you
anymore... Like pictures, sometimes I keep on thinking that he’s the devil and all
that. (Aaron)

Thus, it seemed that witnessing domestic violence had far reaching consequences for these
children, in sense that it appeared to permeate their thoughts making it extremely difficult
to adequately function in daily life.
6.25 **Appendix 25 - Master Theme Two (Perspective Two)**

**Theme Two: Perceived Impact of Domestic Violence on their Child**

The second master theme centres on what mothers think the impact that being exposed to domestic violence has had upon their child. Two sub-themes emerged which were: (i) Behavioural, emotional and physical changes in the child; and (ii) Long term implications.

### i. Behavioural, Emotional and Physical Changes in the Child

All of the mothers cited many changes in their child after leaving domestic violence. For some mothers, these changes in their child involved an escalation in the child's difficult behaviour:

> They [children] become a little bit more gobbier than normal, a little bit more disruptive. You know they wouldn't, [older daughter] would back chat more. She would be more defiant... [Younger daughter] as well more naughty. Doing more disruptive things. Like things that they hadn't done since they were like two, screaming, shouting. (Rachel)

Other mothers cited how their child was displaying unusual behaviours that were causing them concern:

> [Son] went through a stage when we first left, he wouldn't talk to no one. He used to freak out quite a lot, he used to curl up in a little ball on the floor and have his coat round him so no one would come near him. He was into ninja's... He used to take all the scissors, he used to take all the knives and I used to find them all under his bed and stuff you know. I used to have to go hunting for everything but when we lived in the temporary accommodation... He used to rip, tear things up and shred things up. He swallowed a pad lock. (Gillian)

Some of the mothers also reported a range of emotional changes in their child as a consequence of being exposed to domestic violence:

> I think it [domestic violence] has had an impact on them [children]... She [daughter] gets very anxious and very angry, emotional, stressed and everything else just because of this, which I think is terrible... They [children] have low self esteem, angry because obviously of what they've been through (Emma)
Further, there was an indication that the emotional impact of being exposed to the domestic violence was being expressed through physical health related difficulties:

*I think it [domestic violence] has had an impact on them [children]... [daughter]'s health has deteriorated what with all this she gets very anxious and very angry, emotional, stressed and everything else just because of this, which I think is terrible... They've [medical professionals] found out that she's got chronic IBS now, which they say can be brought on by stress. (Emma)*

**ii. Long Term Implications**

There was an indication that all three of the mothers thought the difficulties encountered by their children as a result of being exposed to domestic violence were not going to abate for some time. Indeed, mothers perceived a level of stability and consistency of their child's problems:

*Her self esteem I think she doesn’t like, never had a positive attitude, she always negative, she always says she can’t do these things... Cos she’s always been told by her dad that she’d never be good at this and never be good at that and thinking psychologically is does get embedded into you. (Emma)*

Moreover, the mothers all cited their concerns about the continuation and development of these difficulties, suggesting that there would be long term implications for their child as a result of being exposed to domestic violence:

*Everyone says “oh they’re kids, they’re are resilient, they’ll adapt, they’ll get over it”. But yeah they get over it but it causes effects in the long term, so then as a teenager, if it’s not dealt with in the teenage years its gona progress to adulthood. (Rachel)*

For a few mothers, there was a distinct concern regarding whether their children would fall into a pattern of domestic violence; being either the perpetrator or victim. Within these concerns there seemed to be a clear sense that gender would play a role in whether their child might become a victim or perpetrator of domestic violence:

*Well and I worry that [daughter]'s gona end up with the same sort of bloke that I ended up with. Just the way she is with, she’s very, she’s just, because she wants to please men, she cuddles them... You know I hope [son] doesn’t escalate with his, his anger... The way he talks like he wants to kick him [perpetrator] in and*
stab him and punch him and do this to him and he's gona punch him like he punched him and he's gona kill him and that. You know I hope to Christ he doesn't go and kill him you know cos it would ruin his life... I just hope [son] doesn't end up like [perpetrator]... Yeah, does worry me, cos sometimes he does things and like it reminds me a little bit... Like sulking you know. (Gillian)