Children and their Carers: Making Sense of the Impact of Interpersonal Violence.

By

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List of abbreviations

BPS	British Psychological Society
DV	Domestic Violence
WHO	World Health Organisation
DoH	Department of Health
DfE	Department for Education
ONS	Office for National Statistics
NSPCC	National Society for the Prevention of Cruelty to Children
ASSIA	Applied Social Science Index and Abstracts
CINAHL	Cumulative Index to Nursing and Allied Health Literature
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
UK	United Kingdom
USA	United States of America
IPA	Interpretative Phenomenological Analysis
LAC	Looked after Children
RSW	Residential Support Worker

Acknowledgements

I would like to take this opportunity to give thanks to those involved in this thesis. Firstly, I would like to thank all of the participants who took part in this research; your dedication and commitment to caring for the young people you work with is commendable and I have a great deal of respect and admiration for the work you do.

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Thank you to my cohort, it has been a real pleasure to train alongside you all and I know I have made some amazing friends for life. Good luck to all of you in your future ventures.

Finally, I would like to dedicate this thesis to my beautiful mum. Thank you for championing me throughout my life and always encouraging me to strive for the best I can be. You have shown me the remarkable strength, courage and determination needed to carry me through life's challenges and the unconditional love and care needed to make me the person I am today. I know you would have been so proud.

Declaration

I declare that this thesis is my own work and has not been submitted for any other degree at any other institution. The research was conducted under the supervision of Dr Tom Patterson (Academic Director, Coventry and Warwick Clinical Psychology Doctorate) and Dr Anthony Colombo (Senior Lecturer, Coventry and Warwick Clinical Psychology Doctorate). Both supervisors supported me to develop initial research ideas and provided feedback on research throughout the process. Dr Tom Patterson read and provided feedback on draft versions of the thesis. Colleagues were involved in validating coding for the empirical paper and quality assessment rating for the systematic literature review.

Summary

The present thesis reports on the experience of children and their carers who have been subject to interpersonal violence.

Chapter one is a systematic literature review of qualitative research studies investigating the experiences of children and adolescents who have witnessed domestic violence in their families. Empirical evidence was critically evaluated from 11 studies in order to identify what the various research findings tell us about children and adolescents experiences from their own perspectives. Reviewing this body of literature revealed three themes: impact of domestic violence, coping with domestic violence and life after domestic violence. A number of additional sub-themes were found. Findings are discussed and consideration is given to future research directions as well as the clinical implications of the review findings.

Chapter two is an empirical study exploring the lived experience of staff exposed to violence from Looked after Children (LAC) in residential care. This qualitative study used Interpretative Phenomenological Analysis methodology to analyse data from eight semi-structured interviews with residential staff. Three superordinate and eight subordinate themes emerged from the data analysis. Each theme is explored and consideration is given to the implications for future research and clinical practice.

Chapter three presents a reflective paper of the researcher's personal experiences while conducting this research. It explores the challenges faced during the research process as well as the way in which the researcher's personal and professional development has been shaped for the future. Additionally, the role of Clinical Psychology in LAC services is discussed.

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Chapter One:

Experiences of children and adolescents who witness domestic violence: a systematic review of qualitative literature

This paper has been prepared for submission to the following journal:

Journal of Family Violence

(See appendix M for author guidelines)

Word Count: 7998 (excluding footnotes, tables and references)

1.1 Abstract

Aim: This systematic review of qualitative literature investigates children's experiences of witnessing domestic violence from their own perspectives. The review aimed to critically evaluate the qualitative literature in this area in order to develop our understanding of the experience of witnessing domestic violence from the child's perspective. **Method:** A literature search was conducted using the following databases; PsychINFO, Applied Social Science Index and Abstracts (ASSIA), Cumulative Index of Nursing and Allied Health Literature (CINAHL), Scopus and Google Scholar. This resulted in 11 papers that met the inclusion criteria for the current review. **Results:** Findings highlighted three broad themes relating to children's experiences of witnessing domestic violence: impact of domestic violence, coping with domestic violence and life after domestic violence. Each theme contained a number of sub-themes, which together with the main themes are explored within the paper. **Conclusion:** Findings have implications for the development of services and support for children who witness domestic violence. In particular, interventions, staff training and social support for these children are discussed. Future research is suggested in light of current findings.

Key words: Children and Adolescents', Witnessing, Domestic Violence, Experiences, Systematic literature review, Qualitative research

1.2 Introduction

1.2.1 Domestic Violence context

Domestic violence (DV) is a serious and major public health concern. Global prevalence rates indicate that almost one third (30%) of women in relationships report having experienced some form of physical or sexual violence by their intimate partner (World Health Organisation (WHO), 2016). DV has been defined by the UK government as:

"Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and emotional." (Home Office, 2013)

Information is published each year recording the incidents of DV, however, those rates of incidents are likely to form the 'tip of the iceberg' in that many incidents of DV are likely to go unreported due to victims' fear of the consequences should they come forward to report DV (e.g. risk of further violence, financial consequences of partner leaving, risk to children, fear of social consequences). Therefore, statistics in this area should be viewed with caution as to the accuracy of reporting.

Office for National Statistics (ONS, 2017) reported that almost two million people (including both male and female victims) in the UK experienced some form of DV in 2017. DV is a high risk crime with 100,000 people in the UK at imminent risk of death or serious injury as a result of DV (SafeLives, 2015, a report by an established charity for DV victims). From the perspective of the children involved, 'SafeLives' (2015) reported that 140,000 children were living in homes where the risk of DV was high.

1.2.2 Impact on children

A growing body of research, developed over a number of years, has highlighted the detrimental impact that DV has on children who have experienced or been witness to it during their childhood. Although the exact number of children exposed to DV is unknown, research suggests that the

prevalence of child witnesses is high (Holt, Buckley and Whelan, 2008). In particular, the National Society for the Prevention of Cruelty to Children (NSPCC) report that DV is a factor in over half of serious case reviews seen in children's services (Sidebotham et al, 2016). Holt, Buckley and Whelan (2008) found that children and adolescents living with DV are at higher risk of other forms of abuse including emotional, physical and sexual.

WHO (2016) state that children who grow up in families where violence is present may suffer from a range of behavioural and emotional difficulties (Holt, Buckley & Whelan, 2008; Harold & Howarth, 2004) which can be associated with either perpetrating or experiencing violence later in life (Wallace, 2002). Saunders (2003) review of the literature found experiences of childhood violence to be associated with problematic substance use, delinquent behaviour, a variety of mental health problems (including post-traumatic stress disorder, depression, anxiety disorder, sexual disorders and eating disorders), suicidality, risky sexual health behaviours, risk of future re-victimisation and general child development problems.

1.2.3 Hearing children's voices

DV research has been dominated by quantitative methodology and research which seeks to describe the impact of child exposure to domestic violence (Overlien, 2009). This research has been an invaluable contribution to developing our understanding of the effect DV has on children (Overlien, 2009; Rivett, Howarth & Harold, 2006). Additionally, the majority of research in the area has tended to use mothers as informants on behalf of their children rather than children having the opportunity to voice their experiences from their perspectives (Overlien, 2009). Mothers' reports tend to differ from children's (Overlien 2009) and research has highlighted that parents' tendency is to minimize the impact DV has had on their children (Apple & Holden, 1998; Rivett, Howarth & Harold, 2006), thus highlighting the importance of children being able to voice their own experiences and share their feelings about matters which affect them (James, Jenks & Prout, 1998). In particular, there has been increased emphasis on the importance of including children in research relating to DV (Baker, 2005; Macdonald, 2017).

Despite this growing awareness of children's capacity to articulate their own experiences (James, Jenks & Prout, 1998), there continues to be limited qualitative research aiming to develop an in-depth understanding of children's experiences from personal accounts of the children themselves.

1.2.4 Rationale for current review

Research into child exposure to DV has developed considerably since 1975 when the first study in this area published (Overlien, 2009). Since the early 1990s qualitative research has emerged which has aimed to understand the experiences of children and adolescents who have been exposed to DV, from their perspectives. However, reviews of the literature have largely focussed on quantitative empirical research with a specific focus on outcomes for child witnesses of DV (Edleson, 1999; Holt, Buckley & Whelan, 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003) rather than children's views of their experiences. To date, there have been no reviews of purely qualitative literature focussing on children's and adolescents' perspectives on their experience of DV. There is a need for such a review to draw together the findings from this body of qualitative research in order to further develop our understanding of the child's perspective. This would serve to inform interventions targeted to meet children's and adolescents' specific needs and ensure that their voices are heard and can influence practice.

1.2.5 Aim

The aim of the present review is to critically evaluate the existing qualitative literature that has explored the experiences of children and adolescents who have been exposed to DV. Specifically, the review will aim to answer the question:

- What does the existing body of qualitative empirical research literature tell us about children's and adolescents' experiences of witnessing DV within their home or immediate family from their own perspectives?

1.3. Methodology

1.3.1 Literature Search

A systematic search of the literature for qualitative studies that have investigated children's and adolescents' experience of witnessing DV was carried out between November 2017 and February 2018. The most relevant databases within Psychology, Social Care, Nursing and Allied Health included: PsychINFO, Applied Social Science Index and Abstracts (ASSIA), Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Scopus. Each database was searched using the search terms below. Searches for online literature were carried out using Google Scholar and reference lists of extracted articles were examined by hand in order to identify additional relevant articles.

Table 1.1 Overview of search terms

Main concepts	**Synonyms**	**Location**
Children/ adolescents	Youth, kids	Title & Abstract
Experience	Perception, lived experience	Title & Abstract
Domestic violence	Intimate Partner Violence, domestic abuse, family violence, marital conflict, family conflict	Title & Abstract

An overview of search terms relevant for this subject area are presented in Table 1.1. A 'Boolean' search strategy was adopted; each search was performed using the following search terms in title and abstract: (child* OR adolescen* OR kids OR youth) AND (experience* OR perception* OR "lived experience") AND ("domestic violence" OR "domestic abuse" OR "intimate partner violence" OR "family violence" OR "marital conflict"). The search was not limited to a specific time period as a review of qualitative literature in this area has not currently been published.

1.3.2 Inclusion and Exclusion criteria

Following the removal of duplicate articles, remaining article titles and abstracts were initially screened and retained if they were written in English, had been peer reviewed and were described as qualitative studies.

Table 1.2 Inclusion and exclusion criteria

Criteria	**Inclusion**	**Exclusion**
Participants	Children or adolescents who have experienced witnessing domestic violence within their home or their immediate family	Any other person who reported on the child or adolescent's experience of domestic violence
Age of sample	Ages 7-18 years old	Less than 7 years old or older than 18 years old
Study aims	Studies where a primary focus was on children's or adolescents' experiences of domestic violence	Studies which did not focus primarily on children's experience of domestic violence
Methodology	Studies employing qualitative methodology or mixed methods studies where the qualitative analysis of data is reported separately	Studies using quantitative methods, or mixed methods studies that do not report separate qualitative data analysis
	Studies which used formal qualitative methodology made explicit in the study write up	Studies which do not describe the use of a formal qualitative methodology
Language of study	Studies written in English	Studies not available in English language

Type of domestic violence	Any form of domestic violence as previously defined[1]	N/A
Gender	All genders	
Ethnicity	Any ethnicity	N/A
Location	UK and International articles	Articles which focus on culture-specific factors in relation to domestic violence
Articles	Qualitative empirical studies published in peer reviewed journals	Book chapters, opinion articles, case reports or any qualitative studies not published in peer reviewed journals

Following this initial screening process, full text articles were obtained and their eligibility was assessed in line with the specific inclusion and exclusion criteria outlined in Table 1.2. In order to meet the aims of the current systematic literature review studies were included when participants were children or adolescents between the ages of seven and eighteen years of age. In line with UK laws, any person under the age of eighteen constitutes a child (Office of the High Commissioner for Human Rights, 1989). However, research has suggested that children below the age of seven have difficulties in communicating their experiences (Ollendick and Hersen, 1993) and therefore it would not be appropriate to include them in this review.

Studies where a primary focus was on children and adolescents' experiences of DV were included. Due to the fact that the vast majority of existing studies

[1] *"Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and emotional."* (Home Office, 2013)

report another person's account of children's experiences, as well as a clear need to better understand children's own perspectives (Overlien, 2009), any studies which aimed to explore children's or adolescents' experiences based on another person's account were excluded.

Studies which explored all types of DV (as defined by Home Office, 2013) and its impact upon children were included in the review. No forms of DV were excluded from the review.

The nature of the current review is to synthesise qualitative findings on the experience of children and adolescents and therefore only studies using qualitative methodologies were included. Additionally, mixed methods studies where the qualitative data analysis is reported separately were included. Purely quantitative research was excluded from the review.

All genders and any ethnicity of participants were included within the review, UK and international studies were also included. Studies which focussed on culture-specific factors related to DV were excluded, for example studies where the primary focus was on DV which occurred in relation to specific cultural or religious practices (e.g. Female Genital Mutilation or ritualistic violence). This exclusion was made due to the distinct uniqueness of these experiences compared with other forms of DV. Additionally, violence can have different meanings for individuals due to cultural and religious beliefs (Douki et al. 2003; Fischbach and Herbert 1997) which requires further research specific to the area.

Peer review articles are considered to be of a high standard and quality and were included within the current review. Book chapters and opinion articles were excluded from the current review. Due to the limited transferability of findings, case reports were excluded within the current review. Additionally, retrospective accounts were excluded due to the focus of the present review on the children's experiences rather than the adult recall of childhood experience. Research has suggested that there is often false bias in retrospective accounts of adverse childhood experiences and therefore this is likely to influence the results of the review (Hardt & Rutter, 2004; Widom & Shepard, 1996).

1.3.3 Classification of Studies

The process of study selection was recorded on a ‘Preferred Reporting Item for Systematic Reviews and Meta-analyses’ (PRISMA) (Moher, Liberati, Tetzlaff, & Altman, 2009) flow diagram (see Figure 1). PRISMA sets out a protocol for systematic reviews which was designed in order to help authors improve reporting. PRISMA focusses on ways in which authors can ensure transparent and complete reporting when conducting this type of research (Moher, Liberati, Tetzlaff, & Altman, 2009).

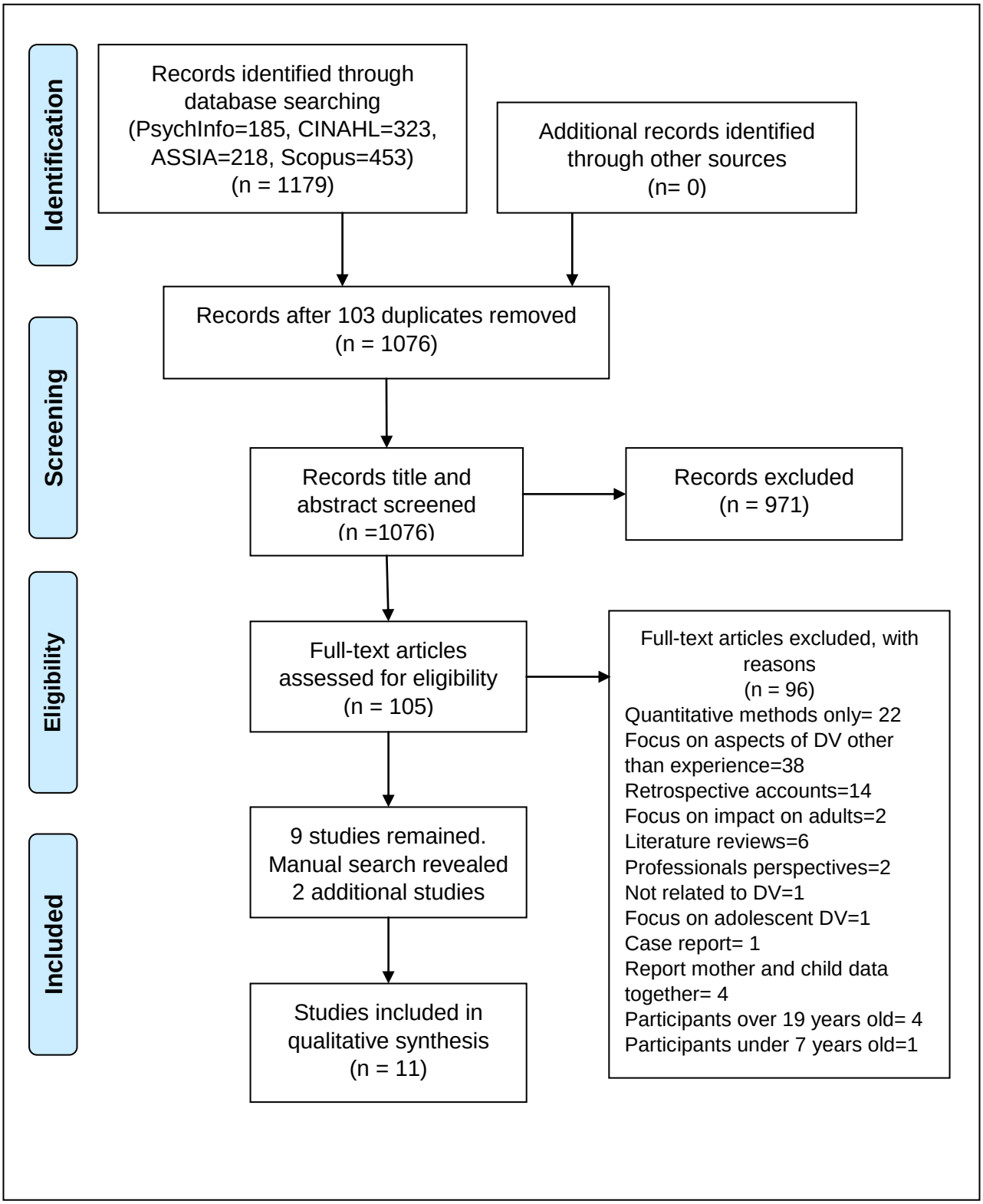

Figure 1. PRISMA flow chart for study selection (Moher, Liberati, Tetzlaff, & Altman, 2009)

In total 1179 articles were identified following initial database searches (PsychInfo=185, CINAHL=323, ASSIA=218, Scopus=453). Following the removal of 103 duplicates, 1076 articles remained to be screened in line with the inclusion and exclusion criteria (Table two). Following a manual review of title and abstracts a further 971 articles were excluded as they were not relevant to the current review. The full text for the remaining 105 were reviewed and a further 96 articles excluded with given reasons (see Figure 1). This resulted in nine relevant studies which met the inclusion criteria for the current review. An additional two studies were obtained from manually searching the reference lists of each of those nine articles. No additional papers were found from any additional sources. Following a systematic search of the literature, a total of 11 studies met the inclusion criteria and were retained for systematic review.

1.3.4 Quality Assessment

In order to assess the quality of the final 11 articles included in the current review, the assessment framework developed by Caldwell, Henshaw and Taylor (2005) was adopted (see Appendix B). This framework was identified as suitable for the current review as it has been increasingly used in health related research, particularly clinical psychology. Additionally, the framework can be adopted for assessing both quantitative and qualitative research methodologies. The use of quality assessment within systematic literature reviews has been said to be useful in terms of ensuring a sound evidence base for use in the review (Kmet, Lee & Cook, 2004), however, Barbour (2001) recommend that over prescriptive or rigid use of such checklists can impede the overall understanding and contribution that qualitative research can offer.

For the purposes of the present review, the qualitative strand of the framework was utilised in line with the aim of the review. Included studies were scored against eighteen criterion (individual questions about the research study being assessed). For each criterion, studies were assigned a score of 0 if the criterion was not met, 1 if the criterion was partially met and 2 if the criterion was fully met. The final score was calculated by adding the

scores from all eighteen criterion, therefore, each article received a score between 0 and 36. When using this framework a mid-point of 18 was assigned and any papers which scored below 18 were excluded from the review as they would not reflect satisfactory level of rigor with regards to the quality assessment framework. Articles which scored 18 and above were included in the review.

In order to enhance reliability of the quality assessment 6 of the 11 articles were randomly selected and independently rated by another researcher using the same quality assessment checklist and scoring criterion. Inter-rater reliability analysis using Kappa statistic was performed showing an overall kappa coefficient (k=0.882), according to Altman (1999) this indicates a strong overall level of agreement. A more detailed breakdown of the papers indicated that three papers showed perfect agreement across ratings (K=1.00), one paper showed strong agreement (K=0.83) and two papers showed moderate strength agreement (K=0.77; K=0.64).

All 11 papers resulted in an above average score on the quality assessment framework. Scores ranged from 28 to 35 out of a possible 36 scores. Consequently, no papers were excluded for this proposal. Please see Appendix C for an overview of quality assessment scores for the 11 studies.

1.3.5 Characteristics of Studies

Table 1.3 Characteristics of studies

Title, Author, year of publication, country of origin and quality assessment score	**Study aims and research questions**	**Sample size, participant details: gender, age, ethnicity, inclusion criteria**	**Recruitment strategy**	**Data collection method and analysis**	**Key findings**
Title: Adolescent males' coping responses to domestic violence: A qualitative study Author(s): Aymer Year of publication: 2008 Country of origin: United States Quality assessment score: 29	Aim: To explore the coping strategies of 10 adolescent males who were exposed to domestic violence perpetrated by a male parent; to examine how the participants were affected by poverty, poor parenting, social injustice, maltreatment and parental pathology. Research question(s): What behavioural difficulties are evident in males exposed to domestic violence? What risk do environmental and familial factors play in developing coping capacities? What environment and	Sample size: N=10 Participant details Age: 14-17 years Gender: Male Ethnicity: 2 Peurto Rican/ Dominican 1 Peurto Rican/ Dominican/ Cuban 1 Peurto Rican and Hispanic 1 Black and Hispanic 1 Hispanic 1 African/ American 3 participants unspecified Inclusion criteria: Eligibility criteria: urban male adolescents	A non-probability purposive sampling procedure was employed. All participants were clients at the same social services agency in New York City.	Data collection: Interviews were conducted with participants. Each participant was interviewed once for 2 ½ hours. Interview guide was used to address the following; emotional, physical and economic abuse, environmental factors and coping. Data analysis: Content analysis was used to code manifest and latent content. Interviews were coded and themed. Themes and patterns of coping specific to; seeking social support from family and/or	Five key areas emerged: • *The violent familiar context:* related to the participants witnessing of violence. • *Double jeopardy: domestic violence and substance use/abuse:* related to the participants' experience of one or both parents regularly drinking alcohol, using or selling drugs. • *The neighbourhood context: socio-demographic environmental issues:* refers to the participants experience of living in their neighbourhood witnessing violence, moving home frequently

	familial circumstances impact coping behaviours? What conditions promote resilience?	between the ages of 14 and 17 who has been exposed to domestic violence.		professionals, acting out behaviours, playing sports, engaging in aggressive behaviours such as fights and arguments and seeing specific forms of violence perpetrated by their fathers were all analysed	and their father's abuse disrupting ties to friends, schools and other family members • *On growing up young, Latino/African-American, and male* • *Parental attachment:* refers to participants close relationship with their mothers • *Coping:* refers to the participants emotional response to their experience
Title: Beyond "witnessing": Children's experiences of coercive control in domestic violence and abuse Author(s): Callaghan, Alexander, Sixsmith & Fellin Year of publication: 2015 Country of origin: UK Quality assessment	Aim: To explore how children experience domestic violence and abuse, specifically focusing on their experiences of coercive control in the family, it's impact and their capacity for agency and resistant action in these situations Research Question(s): None specified	Sample size: Draws upon a sub-sample of a larger scale project. This article explores 20 interviews with 21 participants Participant details Age: 8-18 years Gender: 12 girls and 9 boys Ethnicity: Not specified	Sampling method: Not specified Recruitment context: participants recruited through specialist domestic violence services, particularly domestic abuse refuges and support organisations	Data collection: Semi-structured interviews with children which lasted between 24 and 83 minutes. Interviews audio-recorded and transcribed. Spatial emotional mapping of children's houses and family drawing used to support and facilitate children's accounts of their lived experiences. Data analysis:	Main themes/ areas: • *Children's experiences of coercive control:* describes children's awareness of coercive control and the physical/ psychological impact it has on their family • *Constraint- a coherent response to coercive control:* Discusses the impact that domestic violence and coercive control has on the

score: 34/36 K=1.00				Interpretive interactionalism used to analyse transcripts. Transcripts coded independently and then discussed by research team to facilitate refinement.	children and how the abuse imposes a sense of constraint on their lives • *Children as agents:* explains children's active strategies in dealing with the impact of coercive control
Title: Children's embodied experience of living with domestic violence: "I'd go into my panic, and shake, really bad" Author(s): Callaghan, Alexander & Fellin Year of publication: 2016 Country of origin: UK Quality assessment score: 32/36 K=1.00	Aim: To explore children's accounts of their experience of emotional and physical pain, in situations of domestic violence. Research Question(s): None specified	Sample size: 28 participants Participant details Age: 8-17 years Gender: 17 girls and 11 boys Ethnicity: Not specified	Sampling method: Not specified Recruitment context: Participants recruited through specialist domestic violence services.	Data collection: Interviews which incorporated family drawings, photographs and spatial maps and explored with children their experiences of living with and coping with domestic violence. Data analysis: Interpretive interactionalism used to analyse transcripts. Transcripts coded by two members of the research team and then discussed by wider research team to facilitate refinement.	Main themes/ areas Subjectivity ,Use of space And The wounded body The experience of domestic violence and pain related to such violence was found to be expressed through the process of embodiment. Within children's accounts of embodied experience there is an element of resistance to violent control. The wounded body refers to the way in which children describe their body or wounds in relation to violence. Children also described space within the home in terms of how to manage the violence they

					experienced.
Title: Children and domestic violence: emotional competencies in embodied and relational contexts Author: Callaghan, Fellin, Alexander & Papathanasiou Year of publication: 2017 Country of origin: UK Quality assessment score: 35/36	Aim: To explore the embodied, relational and contextual emotional experience and competence of children growing up with domestic violence. Research Question(s): None specified	Sample size: 107 participants Participant details Age: 8-18 years Gender: 44 boys, 63 girls Ethnicity: Not specified	Sampling method: Convenience sampling Recruitment context: Participants recruited mainly via domestic violence organisations across four European countries- Greece, Italy, Spain and the United Kingdom	Data collection: semi-structured interviews were used to explore children's experience of domestic violence with particular focus on their understanding of how they coped with it. Drawings were used to support verbal articulation of their experiences. Interviews ranged between 24-83 minutes Data analysis: Interviews transcribed and coded independently by two researchers using Interpretive interactionism	Main themes/ areas: • *Constrained articulation- expressing emotions:* explores how children find complex symbolic ways to express their experiences and embodied emotionality • *Emotion, Embodiment and Relationality:* considers how children's emotionality is not experienced in social isolation but in their relationships with others • *Catharsis, Comfort and Self-Soothing:* explores children's expressed strategies for coping with difficult emotions
Title: Children's meaning-conciliation of their fathers' violence related to fathers and	Aim: To contribute to theoretical development by identifying	Sample size: 10 participants Participant details	Sampling method: purposive criterion sampling	Data collection: Semi-structured interviews conducted- an interview guide consisted of	Main themes/ areas • Conceptualising the violent father as one of several 'kinds' of father

violence in general Author(s): Cater Year of publication: 2007 Country of origin: Sweden Quality assessment score: 34/36	patterns in how children can relate general conceptions of fathers to general conceptions of violence to create conciliated meaning about their own father's violence against their mother Research Question(s): None specified	Age: 8-12 years old Gender: 3 girls, 7 boys Ethnicity: Not specified	Recruitment context: children had been exposed to their fathers' violence towards their mothers. Children recruited from women's shelters in Sweden	introduction and invitation to talk about three main themes "please tell me about your father", "please tell me about fathers" and "please tell me about violence". Interviews took place at the shelter, the child's home or at the university. Interviews were 20-57 minutes long. Data analysis: Analysis of abstractions and generalisations of concepts were developed to form meaning conciliations	• Conceptualising father's violence as minor part of his overall personality • Conceptualising violence as distant from father's relative goodness
Title: Children exposed to Intimate Partner Violence describe their experiences: A typology-based qualitative analysis Author(s): Cater &	Aim: To develop understanding of children's experiences of Intimate Partner Violence by exploring how children describe the nature of the violence they have been exposed to and	Sample size: N=10 Participant details Age: 8-12 years Gender: 3 girls, 7 boys Ethnicity: Not specified	Children recruited from four women's shelters and selected by purposive criterion sampling. Criteria were that: • The child had witnessed violence by their father	Data collection: Data obtained by qualitative interviews which aimed to identify children's conceptualisation and descriptions of their experiences of violence. Semi-	Findings indicated three types of experiences of violence amongst the children in the study: • *Obedience-demanding violence*- related to complying with their father's demands to be obeyed, fathers

Sjogren Year of publication: 2016 Country of origin: Sweden Quality assessment score: 33/36 K=0.77	identify patterns in their experience Research question: None specified		against their mother • Children were 8-12 years old • Children were not displaying emotional symptoms that might be exacerbated by participation • Children spoke Swedish well enough to be interviewed.	structured guide which included three themes introduced by the phrases "Please tell me about your father", "Please tell me about fathers" and "please tell me about violence". Interviews lasted 20-57 minutes. Data analysis: Directed thematic analysis used to analyse interview material. Three themes identified: • The function and consequences of the violence • The father's characteristics • The father's role in the family	described as passively present in the family. • *Chronic and mean violence*- violence as a result of their fathers malicious personality making it impossible for them to avoid. • *Parenthood embedded violence*- related to the relationship with the father overshadowing the violence experienced, seek to understand the function of violence for their fathers
Title: Children's perceptions of Intimate Partner Violence: Causes, consequences, and coping Author(s): DeBoard-	Aim: Investigate children's perceptions of violent interactions between their caregivers from a phenomenological perspective	Sample size: N=34 Participant details Age: 7-12 years (Mean age= 10.2 years)	Participants were recruited from community agencies providing shelter and outpatient services to victims of domestic violence.	Data collection: Children participated in a semi-structured interview that lasted 30-45 minutes. Mothers completed a questionnaire. Children	Five main areas identified using the coding scheme: • *Children's exposure to Intimate Partner Violence:* relates to the types of physical violence witnessed

Lucas & Grych Year of publication:2011 Country of origin: United States of America Quality assessment score: 28/36	Research question: None specified	Gender:18 girls, 16 boys Ethnicity: African American (41.2%), Latina (41.2%), Cuacasian (14.7%), Biracial (2.9%)		were interviewed with mothers in the same room. Data analysis: Children's responses coded using a coding scheme and checked by a second coder for inter-rater reliability. Coding scheme was: *Thoughts about violent interactions:* categorised into three classes: threat that violence cause, who to blame and thoughts about intervening. *Emotions during violent interaction:* found that children felt fear/worry, anger, sadness or distress most commonly. *Behavioural responses during violent interactions:* included the child directly intervening, indirectly	(pushing, shoving, kicking, biting, punching, throwing and use of weapons) • *Children's reports of their thoughts:* children's fears about what would happen during or after the fight, fear that both parents may be hurt, uncertainty around what would happen or understanding about why the violence continued and who was responsible, thoughts about intervening. • *Children's reports of their emotions:* sadness and anger most frequently experienced; feeling scared also reported • *Children's reports of their behavioural responses:* some children frequently left the room, others stayed and watched, while others left but continued

				intervening (e.g. calling police), withdrawing, seeking comfort, expressing emotion (e.g. crying) or observing or distraction.	to watch. One third of children described intervening • *Perceived causes of Intimate Partner Violence:* perpetrator losing control of their anger, victim provoked the perpetrator in some way, characteristics of the perpetrator
Title: Naming the unmentionable: How children exposed to Intimate Partner Violence articulate their experiences Author(s): Georgsson, Almqvist & Broberg Year of publication: 2011 Country of origin: Sweden Quality assessment score: 31/36	Aim: To describe how children talk about and relate to their experiences of family violence Research question: None specified	Sample size: 14 participants Participant details Age: 8-12 years old Gender: 8 boys, 6 girls Ethnicity: Not specified, however, all children spoke Swedish, four had mothers who were born in Sweden. Others originated from other nations within or outside of Europe	Sampling method: Not specified Recruitment context: children who were interviewed participated in a treatment programme for children who have witnessed violence against their mothers.	Data collection: Face to face, semi-structured interviews prior to or at the beginning of treatment. Length of interviews ranged from 20-60 minutes. Data analysis: Analysis employed NVivo-7 to aid sorting and coding of data. Thematic analysis used to identify, analyse and report patterns related to children's experiences of IPV	Three main themes identified: • How children were able to talk about the abuse of their mother • How children described their own actions/ situation when violence occurred • How children related to or handled experiences of conflict and violence

Title: How children with experiences of intimate partner violence towards the mother understand and relate to their father Author(s): Georgsson Staf & Almqvist Year of publication: 2015 Country of origin: Sweden Quality assessment score: 34/36 K=0.64	Aim: To describe how, in the aftermath of intimate partner violence against the mother, children understand and relate to their father Research question: How do children with experiences of IPV against the mother understand and relate to their father?	Sample size: 8 participants Participant details Age: 8-12 years old Gender: 4 boys, 4 girls Ethnicity: Not specified, however, two of the participating children had mothers who were born in Sweden whilst mothers of the remaining were from other countries	Sampling method: Not specified Recruitment context: children who were interviewed participated in a treatment programme for children who have witnessed violence against their mothers.	Data collection: face to face semi-structured interviews at the start of treatment and one year after termination Data analysis: Interpretative Phenomenological Analysis (IPA) was employed. Analysis carried out by first author and then discussed with second author	Two main themes identified: • The disjunctive image of the father: alluded to the children's understanding of the father. Two subthemes of 'relating to different versions' and 'living with shifting feelings' were identified • Being entangled in a conflict: captured how children related to and behaved in relation to the father in light of their understanding of him and of their own situation. Two subthemes of 'what you want or need is not safe to express' and 'responsible for handling the father's influence' were identified
Title: Strategies of coping among adolescents experiencing interparental violence	Aim: To understand the essence of the experience of being an adolescent in a violent family environment based on the subjective	Sample size: 21 participants Participant details Age: 13-18 years old	Sampling method: purposeful criterion sampling Recruitment context: sampled from a	Data collection: in-depth semi-structured interviews which lasted approximately 2 hours that were tape recorded and transcribed	Main findings: • Youths' involvement in their parents' quarrels. Subthemes of 'being in disputes in real time', 'living with the short

Author(s): Goldblatt Year of publication: 2003 Country of origin: Israel Quality assessment score: 31/36 K=0.83	meaning that adolescents attribute to events Research question(s): None specified	Gender: 10 males, 11 females Ethnicity: Israeli born, Jewish	population of adolescents experiencing inter-parental violence that were known to social services in Haifa and northern region of Israel	Data analysis: Phenomenological method adopted. Thematic content analysis was performed, using cross-case analysis, identifying themes across cases. Coding was compared against colleagues	term outcomes of disputes from close distance' and 'living with the long term outcomes of disputes from a distance' • Coping as a mode of survival action in a violent ecology • Coping as a positive outcome of life in spite of negative influences
Title: Towards a richer understanding of school-age children's experiences of domestic violence: the voices of children and their mothers Author(s): Swanston, Bowyer & Vetere Year of publication: 2014 Country of origin: UK Quality assessment score: 35/36	Aim: To capture the dual perspectives of school aged children and their mothers, to develop a richer understanding of children's experiences of domestic violence Research question(s): How do school-aged children make sense of their experience of domestic violence? How do mothers perceive their school-aged child's experience of domestic violence?	Sample size: 5 child participants, 3 mothers Participant details Age: 8-13 years old Gender: 3 females, 2 males Ethnicity: White British	Sampling method: purposive sampling employed to recruit a homogenous sample Recruitment context: participants recruited through a domestic violence charity providing outreach support for women and children	Data collection: semi-structured interviews were used with additional tools to facilitate children's accounts (Kinetic Family Drawing) Data analysis: Interpretative phenomenological analysis used to explore the perspectives of participants	Two master themes emerged: • *'Domestic violence through the eyes of the children'* - Children as aware - Pervasive sense of threat and fear: trying to predict the unpredictable - Loss of normal childhood • *'Learning from children's experiences'* - Diminished trust in adults: the reliance on the self - Coping and healing following domestic

K=1.00					violence - Services and support: experience and suggestions

1.3.5.1 Location

Of the eleven studies identified for review, four were carried out in the United Kingdom (UK). Four of the studies were conducted in Sweden. Two of the studies were conducted in the United States of America (US) and one study was conducted in Israel.

1.3.5.2 Aims of studies

In line with the inclusion criteria, all studies focussed on an aspect of children's or adolescents' experience of witnessing DV. However, within this overall aim, some studies focussed on broader experience of DV (Cater & Sjogren, 2016; DeBoard Lucas & Grych, 2011; Georgsson, Almqvist & Broberg, 2011; Goldblatt, 2003; Swanston, Bowyer & Vetere, 2014) whilst other studies were more specific in their focus. One study focussed specifically on coping strategies in response to DV (Aymer, 2008). Another looked specifically at children's experience of coercive control (Callaghan, Alexander, Sixsmith & Fellin, 2015). Two additional papers focussed on children's embodied experience of DV (Callaghan, Alexander & Fellin, 2016; Callaghan, Fellin, Alexander & Papathanasiou, 2017). Finally, two papers explored how children who have experienced DV relate to their father (Cater, 2007; Georgsson Staf & Almqvist, 2015). It is important to recognise that studies with a narrow or specific focus on just one aspect of experience could lead to other aspects of the child's overall experience of DV being overlooked or unreported.

1.3.5.3 Sample size and participants

Sample sizes varied across the eleven studies reviewed. Five studies had a sample size of 10 participants or less. One large-scale study was conducted by Callaghan, Fellin, Alexander & Papathanasiou (2017) with 107 participants, Callaghan Alexander, Sixsmith & Fellin (2015) draw upon a sub-sample from the larger scale project with further study of 21 out of the 107 participants from the larger European study. Similarly, Callaghan, Alexander & Fellin (2016)

paper draws on a UK sub-sample of 28 participants from the large-scale study. DeBoard Lucas and Grych (2011) recruited 34 participants. The remaining two studies recruited 14 participants (Georgsson, Almqvist & Broberg, 2011) and 21 participants (Goldblatt, 2003).

In terms of age of participants, the majority of studies recruited from an age range of 7-13 years old (Cater, 2007; Cater & Sjogren, 2016; DeBoard Lucas & Grych, 2011; Georgsson, Almqvist & Broberg, 2011; Georgsson Staf & Almqvist, 2015; Swanston, Bowyer & Vetere, 2014). Two studies recruited participants from the age range 13-18 (Aymer, 2008; Goldblatt, 2003). The remaining three studies' participants were aged 8-18 (Callaghan, Alexander & Fellin 2016; Callaghan Alexander, Sixsmith & Fellin, 2015; Callaghan, Fellin, Alexander & Papathanasiou, 2017).

The Aymer (2008) study included male participants only. All other studies had a mixture of male and female participants. Therefore, results from Aymer (2008) study should be considered in terms of its gender-limited transferability of findings.

Of note, many of the studies included did not report ethnicity of participants therefore making it difficult to draw conclusions about the transferability of findings across ethnicities and populations. Aymer (2008) included participants from Black, Hispanic, Puerto-Rican/ Dominican and African-American ethnic backgrounds. DeBoard Lucas and Grych (2011) sample consisted of participants who identified as African-American, Latina, Caucasian and Bi-racial in their ethnicities. Goldblatt (2003) participants were Israeli born, Jewish adolescents, whereas the Swanston, Bowyer & Vetere (2014) sample consisted of White British children.

1.3.5.4 Recruitment

Five of the reviewed studies used purposive sampling and one study used convenience sampling. However, the other five studies did not

specify their sampling methods. Use of purposive and convenience sampling across the majority of studies included limits the transferability of findings and conclusions that can be drawn at a population level.

The majority of the studies recruited through specialist DV agencies including services providing shelter and refuge to DV victims. Two studies recruited through social service agencies (Aymer, 2008; Goldblatt, 2003). Of note, three of the included studies recruited participants from therapeutic treatment programmes and therefore it is important to consider that the psychological sequelae for these participants may have potentially influenced or limited their ability to make sense of and articulate their experiences at the point of interview (Aymer, 2008; Georgsson, Almqvist & Broberg, 2011; Georgsson, Staf & Almqvist, 2015).

1.3.5.5 Design and analysis

All eleven studies included were qualitative in their design methodology and conducted interviews with children and adolescents. They all utilised semi-structured interviews with the use of open ended questions to facilitate responses. In addition to interviews, four studies used additional methods to facilitate responses from children and adolescents. Swanston, Bowyer & Vetere (2014) used Kinetic Family Drawing (KFD) in order to facilitate children's accounts; Callaghan, Fellin, Alexander & Papathanasiou (2017) encouraged verbal articulation of experiences through the use of drawings; Callaghan, Alexander & Fellin (2016) and Callaghan, Alexander, Sixsmith & Fellin (2015) incorporated family drawings, photographs and spatial maps of the children's homes in order to facilitate responses.

Three of the studies adopted Interpretive Interactionalism to analyse the data from interviews. Three studies used Thematic Analysis, one of which did so within a phenomenological framework (Goldblatt, 2003). Two studies adopted an Interpretative Phenomenological

Analysis methodology. The remaining studies adopted approaches to analysing data from interviews such as content analysis, abstraction and generalisation techniques, coding the data using a themed coding scheme.

1.3.5.6 Ethical considerations

Seven of the studies included for review reported that they had received formal ethical approval for the study. Three of the studies described having received informed consent from participants and their mothers, however they did not report formal ethical approval or guidance and did not describe any debrief procedures following interviews (DeBoard Lucas & Grych, 2011; Georgsson, Almqvist & Broberg, 2011; Goldblatt, 2003). It was not clear whether ethical issues such as debriefing participants did not occur or were simply unreported. Of note, Aymer (2008) did not report ethical approval or consideration of ethical issues. In addition, participants in this study were offered financial incentive ($20) for taking part in the study. Considering that participants from the study were from urban, low socio-economic backgrounds it would be important to consider the use of a financial incentive and how this may have influenced decisions to participate.

1.3.6 Analysis

All 11 studies were read in full in order to become familiar with the findings of each study. Results from each study were extracted and summarised, and comparisons made across studies in order to identify recurring patterns across results leading to the development of relevant themes. Themes were grouped in order to identify higher order themes.

1.4. Results

The aim of the current review was to explore what the existing body of qualitative empirical research tells us about children and adolescents' experiences of witnessing DV within their home or

immediate family, from their own perspectives. In order to answer this question, the findings of this review are presented in terms of themes which express child and adolescent participants' experience. Three themes were identified: the impact of domestic violence, coping with domestic violence and life after domestic violence. Within each theme are a number of sub-themes, each will be discussed in relation to the literature.

1.4.1 The impact of Domestic Violence

The overall impact that DV had on the different aspects of the children and adolescents' lives was a central theme across all of the papers. Within this, three sub-themes were identified: violence as familiar, impact of violence on relationships and emotional impact of violence.

1.4.1.1 Violence as familiar

Many of the papers reported the nature and extent of the violence that children and adolescents had witnessed within their homes. Aymer (2008) identified this as 'the violent-familiar context' which described the exposure that adolescents had to many forms of DV towards their mothers on a regular basis. Children described their experience of violence and abuse as becoming familiar to them, highlighting a lack of alternative models of parental interpersonal relating. DeBoard-Lucas and Grych (2011) reported that the majority of children in their study had witnessed their mothers being pushed and shoved by their partner as well as kicked, bitten or punched as part of the violent context within which they lived. Swanston, Bowyer and Vetere (2014) proposed that children were very much aware of DV within their homes which permeated into their lives in more than one way, for example children witnessed their mothers' distress following violence and lived within an environment characterised by pervasive fear and threat.

1.4.1.2 Impact on relationships

Across the studies, children's accounts were dominated by the impact that DV had on their relationships. Firstly, children's relationships with their mothers appeared to be central to many of their experiences. Children described feeling 'protective' of their mothers (Callaghan, Alexander, Sixsmith & Fellin, 2015; Goldblatt, 2003; Swanston, Bowyer & Vetere, 2014) who were perceived by some children as being more vulnerable than themselves (Georgsson, Almqvist & Broberg, 2011). Some children, as young as nine years old, recalled a desire to get a job in order to help their mothers who were victims of DV including physical and financial abuse (Aymer, 2008). Many children across studies reported feelings of concern for their mothers' wellbeing and a sense of responsibility for the protection of their mothers (Georgsson, Almqvist & Broberg, 2011; Goldblatt, 2003; Swanston, Bowyer & Vetere, 2014). In particular, children felt a sense of growing up too soon and taking on additional responsibilities at a young age such as being responsible for their mother and siblings (Swanston, Bowyer & Vetere, 2014). Some children reported feeling close to their mothers (Aymer, 2008) whereas others reported a sense of feeling let down by mothers for not protecting them (Swanston, Bowyer & Vetere, 2014). This highlights that there are differences between children's experiences of their relationship with their mothers in the context of DV.

Additionally, children's relationships with their fathers were impacted by DV which was, in all studies, perpetrated by their father towards their mother. Interestingly, there was difference amongst children's responses regarding their opinions and relationships with their father. It emerged that some children reported their thoughts and feelings towards their father as being "all bad" where others reported a more balanced perspective of violence being just one aspect of the father's personality. Additionally, some children described only positive aspects of their fathers and were dismissive of any negative

attributes (Aymer, 2008; Cater, 2007; Cater & Sjogren, 2016; Georgsson Staf & Almqvist, 2015). Children's responses were often conflicted; feeling afraid of the father (Goldblatt, 2003; Georgsson, Almqvist & Broberg, 2011) yet also feeling a sense of empathy towards him (Goldblatt, 2003). Cater (2007) described children psychologically separating their fathers' violent behaviour from him as a person, seeing him as more than his violence alone. Several studies reported that children felt a sense of being controlled by their fathers (Cater, 2007; Cater & Sjogren, 2016; Georgsson, Almqvist & Broberg, 2011).

Finally, children described their relationships with services in terms of feeling unheard, let down and dismissed (Georgsson Staf & Almqvist, 2015; Swanston, Bowyer & Vetere, 2014). Georgsson Staf and Almqvist (2015) highlighted potential implications for such dismissive responses from services for the child's future in terms of them not feeling confident in their ability to make changes in their lives. Additionally children described feeling a diminished trust in adults; specifically they reported that professionals were unable to help them with their ongoing conflicts with their fathers (Georgsson Staf & Almqvist, 2015). Although many services were involved, at times, children experienced these services as unhelpful and unable to keep them and their families safe (Swanston, Bowyer & Vetere, 2014).

1.4.1.3 Emotional impact

The emotional impact of DV on children is overwhelming and central to many of the children's accounts. The young participants described feeling a strong sense of fear and anxiety in relation to witnessing violence and living day to day within a violent home (Aymer, 2008; Callaghan, Alexander, Sixsmith & Fellin, 2015; Callaghan, Alexander & Fellin, 2016; Callaghan, Fellin, Alexander & Papathanasiou, 2017). Callaghan, Alexander & Fellin (2016) described the embodied experience of children who witness DV. At times, children described

feeling so overwhelmed by feelings of fear and panic that they felt unable to comprehend what was happening and lacked the ability to articulate their experience using words, however, their experience was evident through their bodies “shaking”, for example. Similarly, Goldblatt (2003) described a pervasive atmosphere of terror or alertness for children living with DV; a powerful sense of needing to be alert or hypervigilant to their surroundings and to their fathers’ emotional states was common (Callaghan et al., 2017; Swanston, Bowyer & Vetere, 2014). Children described feelings of concern or worry distracting them even when they were away from home, spending time with friends for example; the sense of alertness did not stop despite being away (Goldblatt, 2003). Aymer (2008) discussed children’s reactions to witnessing DV resulting in nightmares about violence and aggression, feeling afraid and extremely angry towards their fathers. A strong sense of sadness was central in many of the children’s accounts of their experience (DeBoard-Lucas & Grych, 2011), in some cases resulting in thoughts or attempts of suicide and self-harm (Aymer, 2008; Callaghan, Alexander, Sixsmith & Fellin, 2015; Callaghan et al., 2017).

Emotions such as anger and rage were expressed by children as a result of having witnessed DV (Callaghan, Alexander & Fellin, 2016; DeBoard-Lucas & Grych, 2011). Georgsson, Staf and Almqvist (2015) report that child participants in their study had felt unable to express feelings such as anger towards their father due to fear of further conflict. On the other hand, children in the Aymer (2008) study expressed anger outwardly towards their fathers by means of using violence and aggression themselves towards their father. However, it is important to take into consideration the particular cultural context for participants in the Aymer (2008) research, who experienced violence within their homes as well as their neighbourhood more broadly; it is likely that they had additional experiences of violence

being expressed outwardly outside of the home and family, perhaps in contrast to participants in some of the other studies reviewed here.

Feelings of guilt and a sense of responsibility for stopping the violence were features that emerged in several studies. Goldblatt (2003) found that children blamed themselves for not being able to stop the violence occurring, in particular one child felt directly responsible for not being present to stop the violence, her thoughts were dominated by what she should have done or said to have stopped the violence. Additionally, Georgsson, Almqvist & Broberg (2011) described child participants as having thoughts about what they could do to stop the violence, in particular children described fantasies about confronting the father and fighting back in order to make their father understand and to stop his violent behaviour. Swanston, Bowyer and Vetere (2014) similarly found that young participants felt responsible for keeping their mother safe from violence, with one child describing locking their frightened mother in the bedroom with them to prevent the father being able to get to her.

1.4.2 Coping with Domestic Violence

Throughout the 11 studies different ways of coping with DV emerged, these were categorised into two sub-themes in terms of behavioural responses and psychological strategies for coping with DV.

1.4.2.1 Behavioural responses

Aymer (2008) found that adolescents described particular ways of coping following their experiences of DV. They described taking part in activities (e.g. joining sports clubs and reading books) as a way of distracting them from their experiences. This also served to help them develop a sense of themselves as being “good” at something and subsequently increased their self-esteem. Callaghan et al. (2017) reported that children often found taking part in physical activity and sports to be a helpful strategy for coping with anger,

depression and sadness experienced as a result of witnessing DV. Callaghan et al. (2017) described this as working through emotion without conscious attention through embodied activity. Other children identified different activities such as creative drawing, poetry, listening to music or dancing as ways of coping with or expressing difficult emotions.

DeBoard-Lucas & Grych (2011) found that young participants in their study had intervened with violence by doing something to try and stop the fight (e.g. interrupting or distracting parents or attempts to physically separate them). Some children stayed in the room to watch the fight whilst others left the room where the DV was taking place. Although children differed in their responses to violence, they all described some element of behavioural response as a way of coping with their experience. Additionally, Georgsson, Almqvist and Broberg's (2011) findings reflected a similar pattern amongst children's responses to violence in that they either took themselves away, interrupted the violence or watched the violence from a distance. Although these two studies obtained different quality ratings in the present review, with DeBoard-Lucas and Grych (2011) scoring lower due to lack of clarity around participant sampling and selection processes, and failing to demonstrate the same level of rigour around data analysis as Georgsson, Almqvist and Broberg (2011), there was consistency in finding across both studies in relation to children's behavioural responses.

Finally, Callaghan, Alexander, Sixsmith and Fellin (2015) reported that children adapted their behaviours in order to make themselves less visible or hidden during violent incidents between parents. This was seen as a way of staying safe and surviving within the context of DV. Additionally, these authors identified that one way children coped with DV was by managing space within the home, children would avoid certain parts of the home which were associated with the violence they had witnessed.

1.4.2.2 Psychological strategies

Psychological strategies for coping were evident across a number of studies. Callaghan, Alexander, Sixsmith and Fellin (2015) found that children became very self-reliant after witnessing DV which was seen as a way of empowering them to resist their fathers' controlling tactics. For example, one child felt he retained some power and control by having his own knowledge and access to information which his father desired, this encouraged a strong sense of self-reliance and ability to resist his fathers' control. Swanston, Bowyer and Vetere (2014) found a similar sense of self-reliance amongst children.

Goldblatt (2003) described how children bracket off their experiences when talking to friends in order to avoid retelling painful memories, additionally they refer to adolescents' experience of blurring past painful memories as a way of coping. Similarly, Georgsson, Almqvist and Broberg (2011) described children *"avoiding disturbing memories"* by attempting not to think about the past or the violence they had previously witnessed. This resulted in children finding different ways of coping with the memories, either by thinking of something else, spending time with friends or partaking in something fun in order to distract their minds.

Another attempt to cope with violence was to make attempts to predict, understand and make sense of the violence. Callaghan, Alexander, Sixsmith and Fellin (2015) found that children carefully read the emotions and moods of their father in attempts to try and predict his responses in terms of what might trigger violence. Similarly Swanston, Bowyer and Vetere (2014) identified that children witnessing and living with DV are constantly thinking about what might happen next and trying to understand hidden intentions of their father, describing their participants as *"trying to predict the unpredictable"* in order to gain some sense of control over their experience. Georgsson, Almqvist and Broberg (2011) similarly

described children's attempts to understand their fathers' violence in order to make sense of his behaviour. In addition to making sense of violence, DeBoard-Lucas & Grych (2011) also found that participants considered different reasons for occurrence of the violence and attributed blame for the violence either to the victim (for provoking the perpetrator) or to some aspect of the perpetrators personality (e.g. "they're mean" or "jealous"), highlighting those children's attempts to make sense of the violence they witnessed.

Cater (2007) described children's conceptualisation of their father's violence, which is one way of understanding the violence and trying to make sense of their fathers' behaviours. Children differed in their understanding of their fathers' violence; some defined him as "bad" and a violent person, others saw violence as just one aspect of their father, whilst others separated the father's violence from other more positive aspects of his personality.

1.4.3 Life after Domestic Violence

Life after witnessing DV seemed to reflect a sense of resilience and strength amongst the children as well as positive thoughts about the future despite their experiences. Children felt as though experiencing violence allowed them to make better decisions for themselves and their own families in the future (Goldblatt, 2003). All children in Swanston, Bowyer and Vetere's (2014) study spoke about feeling that the future is brighter after no longer being subjected to DV, which they related to an overarching sense of safety and no longer needing to worry for themselves and their families. Finally, one female participant from Callaghan, Alexander, Sixsmith and Fellin (2015) had a vision of her future life as an independent female who did not need to rely on men and she felt positive about this, demonstrating her sense of herself as strong and independent as a result of her experiences.

1.5 Discussion

1.5.1 Significance of results

1.5.1.1 Impact of domestic violence

Impact on relationships

Participant accounts demonstrated differences in their relationships towards their fathers. Some children saw their father as either “all bad”, others had a more integrated view of their father as having different characteristics or aspects of the self, while some children focussed just on the positive aspects of their father and avoided discussing the negative aspects despite the violence he displayed. Psychodynamic theory describes such processes of idealisation and splitting as immature defence mechanisms (Frederickson, 2013). For example, children appeared to ‘split’ their experiences of their father as ‘all bad’ or ‘all good’. Although some participants across the studies were able to integrate their experience and had a more balanced view, this was not the case for many others. Moreover, those children who experienced their father as ‘all good’ could be seen as ‘idealising’ their father as a defence mechanism aimed at protecting themselves from his negative attributes. Acceptance of the negative aspects would potentially be experienced as a loss of the “good father” which would likely be too painful to process and cope with. Children’s experience in the present study could also be indicative of denial and dissociative experiences which, occur following trauma in childhood (Terr, 1991).

Participants in a number of the studies also described a change in relationship with their mothers, feeling as though they were responsible for protecting their mothers. Ainsworth and Bell (1970) developed three main attachment styles which were a result of children’s early interactions with their mothers. Of the three, an ‘avoidant’ attachment style is characterised by the child’s independence both physically and emotionally and reliance on themselves rather than on their attachment figure. The caregivers of

children who display avoidant attachment styles are likely to have been unavailable during times when the child felt emotional distress (Stevenson-Hinde & Verschueren, 2002). Mothers experiencing DV are likely to be experiencing their own trauma, potentially compromising their ability to be emotionally available for their children. Children across studies in the present review recognised their mothers' vulnerability and felt a need to protect both mother and self, resulting in a sense of self-reliance. Although this is an adaptive coping mechanism during times of distress, it is known that children with avoidant attachment styles can have difficulties with adult relationships later in life (Bowlby, 1969). In particular, children who have witnessed DV may feel a lack of trust in others to care for them or protect them which could result in a fear of emotional connection during adulthood (Godbout, Dutton, Lussier, & Sabourin, 2009).

Overall, it is important to note the differences amongst children's experience of their relationships with parents. Difference amongst children's reports highlights the importance of listening to each child's perspective and experience of witnessing DV on an individual level and allowing this to inform any support offered.

Emotional impact

The adverse emotional impact of witnessing DV is clear from the results of the current review. As previously highlighted by Saunders (2003), experiences of violence during childhood is associated with many difficulties later in life, including mental health problems such as post-traumatic stress disorder, anxiety and depression. The present review found that children who witness DV within their immediate family experienced overwhelming feelings of sadness and fear which led to self-harm, thoughts of suicide and responses such as nightmares and physiological bodily responses, all of which could be linked to mental health problems. Given findings from other research indicating that such problems tend to persist into adulthood (Geffner, Igelman & Zellner, 2013; Henning et al., 1996), this

highlights a need for early intervention and support for these children to reduce the likely impact on their future development.

1.5.1.2 Coping with domestic violence

Behavioural responses

Behavioural responses were found to be a key feature of how children responded or coped with DV. Interestingly, these responses lend themselves to two contrasting interpretations: on the one hand, behavioural responses such as playing sport, reading or drawing could be viewed as a means of avoiding difficult thoughts and feelings in relation to their experiences; on the other hand, these strategies could be viewed as useful and perhaps healthy ways of expressing and processing traumatic emotions and memories which are not easily expressed through talking (Kilpatrick & Williams, 1997). Additionally, it is important to consider that coping with DV whilst it is still occurring is likely to be very different from coping with DV after leaving the violent context. For example, findings from some of the reviewed studies demonstrated that children exhibit different behavioural responses to DV while it is happening and it is important to acknowledge that these behavioural responses are likely to be informed by a need to survive the experience and desire to protect mother and self, rather than being based on more carefully thought through decisions.

Psychological strategies

A number of studies highlighted children's attempts to make sense of their fathers' violence. In cases where blame is externally attributed, these attempts may be seen as serving a protective function for children. For example, if the child can attribute the father's violence to his personality or other characteristics or alternatively as a result of his previous life experiences, this could help to take the element of self-blame or fault away from the child. Furthermore, in cases where blame is attributed to the mother, this serves to direct blame away from the child and could also been seen as protective. Findings from

previous research indicates that self-blame can have consequences for children's mental health (Creamer, 1990) and therefore, such attempts to understand violence could be useful in reducing the impact for the child's mental health.

1.5.1.3 Life after domestic violence

Research suggests that experiencing DV in early childhood is associated with perpetrating violence later in life (Wallace, 2002). Interestingly, the present review found that children demonstrated resilience, felt a sense of survivorship and had positive aspirations for a different future without violence. It is important to acknowledge that not all children feel positive about the future and are likely to need to work through their emotions and feel validated before getting to the stage where they feel positive about the future or even sufficiently safe to consider the future. The findings in this area highlight the resilience of participants across studies, and point to the need for early intervention by services to support children both to feel validated and safe and to facilitate a positive engagement with choices relating to their own futures.

1.5.2 Research limitations

Several studies (Aymer, 2008; De-Board Lucas & Grych, 2011; Georgsson, Almqvist & Broberg, 2011; Georgsson Staf & Almqvist, 2015) recruited children who had received therapeutic interventions and, as a result, may have been more psychologically minded and able to discuss their experiences. It is possible that findings from those studies may be biased and may lack transferability to other children who witnessed DV but have not received therapeutic intervention.

It is also important to consider ethical implications for children participating in research, Aymer (2008) did not report or discuss ethical considerations in relation to the use of payment for

adolescents to take part in the study. Participants in the Aymer (2008) study had clearly grown up in a deprived neighbourhood and money was a salient topic within their accounts. For future similar research in socially deprived contexts, ethical implications of payment should be considered more carefully.

Finally, it is important to bear in mind that the present review considered the qualitative evidence base, and as such the review findings should not be considered in isolation, but should rather be considered together with findings from quantitative research and reviews of evidence in this area, in order to best inform future research and clinical directions.

1.5.3 Review limitations

The current review focussed on studies which examined children's accounts and therefore excluded studies which analysed children and mothers' accounts jointly. Thus, these potential additional sources of data were not considered, in line with the aim of understanding the child's perspective on their experience of witnessing DV. In addition, the present review was restricted to studies where participants were aged between 7 and 18 years old. The decision to exclude studies which had any participants above the age of 18 and below the age of 7 may have resulted in potentially relevant data being excluded from the review, but it was felt that there was sufficient rationale for decisions made relating to the age range of participants included in the review. Finally, the present review excluded studies where the aim was to explore culture specific aspects of DV, given that attitudes and acceptance towards violence can be distinct across cultures and have different meaning in relation to culture and religion (Douki et al. 2003; Fischbach and Herbert 1997).

1.5.4 Clinical implications

The current results highlight the importance of early intervention and support for children who have witnessed DV. Moreover, thorough assessment of the child's experience and needs is essential in order to take account of individual differences in experience. Any contact from services should aim to help the child to feel listened to, understood, validated and safe in order to increase their confidence in services and professionals, particularly in light of our knowledge that children are already limited in their opportunity to seek help and support independently (Golden, 2007). Thus, positive interactions with services are of particular importance, given the potential impact of negative interactions with services on the child's trust and confidence.

In terms of interventions, these should be tailored to meet the individual needs and requirements of the children. That said, there are areas which could be a focus for intervention. For example, in light of the impact that DV has on children's relationships with their mothers, interventions could focus on fostering positive relationships between children and their mothers in order to foster attachment and trust. Additionally, given the resilience demonstrated by children, professionals could focus on facilitating children's utilisation of internal resources for coping in order to support them to feel able to move forward following DV. Areas such as social and peer support, activities (e.g. sport, music, art) should be encouraged alongside psychological support for the children to help them to process their emotional experiences.

Finally, indirect support through additional training for services and professionals should be considered in order to promote awareness of the impact of DV from the child's perspective and to develop individualised and tailored interventions to meet their needs (Szilassy et al., 2016).

1.5.5 Future research

To build on and further develop the existing evidence base, future research should consider specific aspects of experience, for example the impact of DV on the relationship with the mother and how this influences the child's attachment relationship or the impact of DV on the child's sense of self.

Future qualitative research could utilise research designs which follow a cohort of participants over time, conducting interviews at different time points in order to understand the impact of witnessing DV over time.

In recommendation from the present review, future researchers should consider recruiting narrower age range of participants, as experience is likely to be influenced by the child's developmental stage (e.g. an adolescent's experience may differ considerably from a younger child due to navigating other factors in their lives such as puberty or social status).

Additionally, small scale research could be conducted within existing services in order to evaluate the support and service offered, this could help to identify areas for development within service. In particular, researchers should seek to include children in research and service development.

1.6. Conclusion

The present review set out to critically evaluate qualitative research exploring the experiences of children who have witnessed DV from the perspective of those children and young people. Findings from the review indicate that DV can impact upon many aspects of a child's life, including their relationships with others and their emotional and psychological wellbeing. Additionally, evidence from the qualitative studies reviewed highlights children's ability to cope

with their experiences and show resilience in the face of adversity. Services and professionals should look to assess and support the child holistically, prioritising early intervention and taking into consideration the detrimental impact of witnessing violence as well as affected children's capacity for resilience and hope for the future.

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Chapter Two:

Exploring the lived experience of staff exposed to violence from Looked after Children in residential care

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2.1 Abstract

Aim: The present study aimed to explore the lived experience of staff exposed to violence from Looked after Children (LAC) in residential care. **Method:** Eight participants were recruited across four local authority residential care homes. Participants were interviewed using a semi-structured interview guide and data from interviews was analysed using Interpretative Phenomenological Analysis. **Results:** Data analysis revealed three superordinate themes: the impact of violence, coping with violence and sense making in a violent context. Eight subordinate themes are identified and discussed. **Conclusion:** Findings highlight the adverse impact of violence for residential care staff working with LAC. Future research and clinical implications are discussed.

Key words: Violence, LAC, residential staff, residential care, support workers, lived experience, IPA

2.2 Introduction

2.2.1 Looked after Children and residential care

A ‘Looked after Child’ (LAC) or child in care as defined by the Children’s Act (1989), is a child who is being looked after by their local authority for more than 24 hours. This includes living with foster parents, with parents under supervision of social services, in residential children’s homes or other settings such as schools or secure units (NSPCC). Department for Education (DfE) statistics indicate that 62% of children in care have been abused or neglected, 15% have come from dysfunctional family backgrounds, 8% from families in acute stress, while 7% of children are in care due to absent parenting (DfE, 2017). During 2017, 7890 children were placed in secure units, residential children’s homes and semi-independent living accommodation.

It is widely recognised that LAC often present with significant attachment issues (Ruff and Baron, 2012) which results in high levels of psychological distress, anxiety and aggressive behaviours, both physical and verbal (Connor, Doerfler, Toscano, Volungis & Stiengard, 2004; Falshaw and Browne, 1997; Mosseri, 2008). Additionally, children looked after in residential care have higher levels of emotional and behavioural difficulties and are more likely to have poorer mental health outcomes than other LAC, such as those in foster care (DfE, 2014; Meltzer, Corbin, Gatward, Goodman & Ford, 2003).

Residential care staff working within non-healthcare settings assist in the personal care of children and young people, as well as providing support with the development of self-help, social and independent life skills, as directed by the child’s care plan. Cahill, Holt and Kirwan (2016) state that “it is the task of the care staff to provide a safe and nurturing environment for young people by managing the risk through surveillance as well as engaging in and promoting positive relations with the residents.”(p.219).

The relationship between residential care staff and children in care has been found to be essential to the child's outcomes (Moses, 2000). Moses (2000) suggest that therapeutic interactions between staff and children have the ability to provide a corrective emotional experience for the children, thus emphasising the importance of such relationships. At times, the relationship between staff and children becomes difficult, resulting in the child acting violently or aggressively towards the carer. Such violence can be defined as:

> Any incident in which a person working in the care sector is verbally abused, threatened or assaulted by a service user, member of the public or a member of staff arising out of the course of their work (Institute of Public Care, 2013, p.2).

2.2.2 Violence in Health and Social care

Violence towards staff is common within the health and social care professions. NICE (2015) reports that between 2013 and 2014, 68,638 assaults were recorded towards NHS staff in England, the majority of which (69%) took place in mental health or learning disabilities services (NICE, 2015). Institute of Public Care (2013) found that violence towards social care staff is a key issue due to the impact it has on recruitment and staff retention. Their research found that approximately 93% of staff working in social care in England experienced verbal abuse and approximately 56% experienced physical abuse. McAdams (2002) highlights increased levels of violence in residential care resulting in a lack of self-worth, stress and high sickness levels among staff. Colton and Roberts (2006) highlight the lack of research carried out with staff working in residential care and difficulties with staff retention; in particular, issues related to the violence and verbal abuse directed towards staff were highlighted.

Research suggests that violence towards staff can affect their capacity to work effectively and can lead to increased levels of burnout (Littlechild, 2005; Winstanley & Hales, 2014). Additionally,

violence towards care staff is also thought to impact upon quality of patient care (Arnetz & Arnetz, 2001).

Very few studies have been carried out which look specifically at violence perpetrated by children towards staff caring for them, however, Newhill and Wexler (1997) found that adolescents were the most common perpetrators of physical violence (56%) towards social workers in child and family services. Additionally, Falshaw and Browne (1997) studied children in secure accommodation and found that the most common victims of their violent behaviour were male and female care staff working in residential care homes.

2.2.3 Impact of violence on staff

Research has been carried out into the impact of violence perpetrated by children towards staff carers. Winstanley and Hales (2014) carried out a survey of social workers who care for children in residential homes. They found that violence resulted in higher levels of emotional exhaustion and depersonalisation in staff, which negatively impacted on empathy towards the children. Similar themes of emotional exhaustion and depersonalisation were found in a study by Kim, Ji, and Kao (2011). Barling, Rogers and Kelloway (2001) developed a model which focused on mediating factors in violence directed towards care staff perpetrated by children with behavioural difficulties, finding that fear, negative mood and sense of justice were mediating factors for job commitment and neglect of job role as well as for interpersonal job performance. Similarly, Robson, Cossar & Quayle (2014) found that feelings of anger, fear and anxiety were the most commonly reported effects of client violence towards staff. Similar themes of negative emotional reactions, changes in feelings towards the work and changes in how practice is conducted have been found elsewhere (Newhill & Wexler, 1997).

2.2.4. Rationale

Much of the research on violence towards staff has been conducted in health-care settings such as inpatient wards and learning disabilities services (Agervold & Anderson, 2006; Robson, Cossar & Quayle, 2014). Despite evidence suggesting that violence against staff working within children's social care settings is an ongoing cause for concern, very little research has been conducted in this area. The few studies investigating violence perpetrated by children towards support staff have been quantitative in methodology with a noticeable absence of focus on staff members' lived experiences of violence within their caring role. A review of evidence by the Institute of Public Care (2013) has highlighted the need for further research into how staff working within the caring profession cope with violence and threat and the impact that this has on them. The present study is the first empirical paper exploring residential staff experiences of violence. The present study aims to address the gap in the literature by using Interpretative Phenomenological Analysis (IPA) to explore the lived experience of staff exposed to violence by LAC in residential care.

2.2.5. Aim and research question

This research aims to explore the lived experience of staff who have experienced violence directed towards them whilst working with children in residential care, examining the impact of such violence on staff and seeking to understand how they cope with their experiences.

Specifically, the present study aims to answer the following research question: What is the lived experience of residential support staff who have been subject to violent behaviour from children in their care?

2.3. Methodology

2.3.1. Research design

The research question of the present study focusses on subjective personal experience and can only be appropriately addressed by means of exploratory qualitative research. This research comes from an interpretivist epistemology which places emphasis on individuals' subjective experiences and developing insight into perceptions, experiences and meaning (Ritchie, Lewis, Nicholls & Ormston, 2014). Interpretivist research is largely inductive in that the approach is concerned with generating new knowledge which emerges from the data (Ritchie et al. 2014).

The current study adopted an Interpretative Phenomenological Analysis (IPA) methodology, a qualitative research design which aims to examine the way in which people make sense of their experiences (Smith, Flowers and Larkin, 2009). Although IPA shares similarities with other methods of analysis, such as Grounded Theory, IPA looks specifically at the detailed analysis of lived experience of a small number of participants describing first-person accounts of their experience (Smith, Flowers and Larkin, 2009). IPA is driven by hermeneutics which describes how a person's own views, pre-conceptions and opinions influence the way in which data is interpreted and new meaning emerges (Smith et al, 2009). Other phenomenological methods place emphasis on describing and presenting common themes, whereas IPA embraces both convergence and divergence (commonalities and differences) across people's experiences (Smith et al, 2009). The aim of the present research is not to develop theory but rather to focus on personal meaning and sense making of individuals who share a particular experience in order to allow their voices to be heard. With this in mind, IPA is the best placed methodology to answer the research question posed by the present study, as it seeks to describe the

essence and structure of lived experiences rather than seeking explanatory models (Starks & Brown Trinidad, 2007).

2.3.2. Participants

2.3.2.1 Sampling method

The essence of qualitative research is the naturalistic study of real people in natural settings (Marshall, 1996). Commonly within qualitative research a non-probability sampling design is adopted whereby the sample is selected based on subjective judgement of the researcher rather than random selection (Marshall, 1996). In accordance with IPA research design, the current study recruited participants based on principles of purposeful sampling, in which the researcher actively selects a homogenous sample in order to directly answer the research question (Marshall, 1996; Smith et al., 2009).

2.3.2.2. Inclusion and Exclusion Criteria

Table 2.1 inclusion and exclusion criteria

Criteria	***Include***	***Exclude***
Staff status	Work in children's residential home	Staff working in: Community Services Secure units Hospitals
Staff working arrangement	Permanent staff	Agency staff
Time scale of violence	Experienced violence within the last 12 months	Experienced violence over 12 months ago
Type of violence	Verbal and physical violence	Sexual violence
Age of children displaying violence	10-17 years	>17 years

Utilising the sampling design described above allowed for the selection of appropriate participants based on the inclusion and exclusion criteria (Table 2.1)

Staff working in residential children's homes were included in the study. Staff working in a community setting, secure children's units or

children's hospitals were excluded from the study due to the nature and specificity of the research rationale and question.

Permanent staff were included in the study as they would have had an opportunity to form therapeutic relationships with the children in their care over time. Agency staff were excluded from the study as they are less likely to have had opportunities to form substantial therapeutic relationships with children due to the short-term nature of agency work.

Individuals' who have experienced violence within 12 months of recruitment were included in the study. Staff who experienced violence that occurred over twelve months ago were excluded from the study due to anticipated difficulties in recalling detailed information about their experience.

Fundamental to answering the research question, those individuals who have experienced physical or verbal violence were included in the study. Although it is acknowledged that sexual violence towards staff does occur within social care settings, prevalence rates indicate a higher rate of physical (56%) and verbal violence (93%) compared with sexual violence and harassment (29%) (Harris & Leather, 2012). Therefore, the present study focussed on physical and verbal violence and excluded sexual violence. In addition, experiencing sexual violence is likely to have added complexities (e.g. experience of shame, guilt and sexual trauma) (Vidal & Petrak, 2007) and therefore warrants individual research exploring these experiences. For the purposes of the present study, violence is defined, in line with the Institute of Public Care definition, as "Any incident in which a person working in the care sector is verbally abused, threatened or assaulted by a service user, member of the public or a member of staff arising out of the course of their work'' (Institute of Public Care, 2013, p.2).

The typical age range of children in residential care is between 10 and 17 years (DfE, 2014) and therefore, individuals who have

experienced violence and aggression from children within this most representative age range were included in the study.

2.3.2.3. Sample size and participant characteristics

Eight participants including residential support workers and home managers with direct support work responsibilities as part of their role were recruited from four residential care homes under one governing local authority in the UK. IPA methodology is concerned with in-depth analysis and therefore focusses on quality of data rather than quantity (Smith et al., 2009). In line with this, eight participants was deemed to be an appropriate sample size in order to provide sufficient in-depth data, and to allow for an analysis demonstrating both convergence and divergence (Smith et al., 2009).

Table 2.2 Participant demographic information

Participant pseudonym	***Gender***	***Ethnicity***
Sam	Male	White British
David	Male	White British
Rob	Male	White British
Elaine	Female	White British
Amy	Female	White British
Charlie	Male	White British
Ian	Male	White British
Craig	Male	White British

Table 2.2 outlines participant pseudonyms, gender and ethnicity. The majority of participants in the current study were male (n=6) with fewer female participants (n=2). All participants described themselves as White British. Participants ages ranged from 25-59 years old (Mean=43.8). Two participants were Residential Home Managers, one participant was Assistant Home Manager and five

participants were Residential Support Workers. All participants were involved in the day to day care duties, in addition, those with managerial roles also took part in additional tasks related to their managerial positions. The majority of participants had extensive experience in residential care for Looked after Children (9 years + experience). Two participants had worked in residential care for less than 1 ½ years at the time of interview. The mean length of participant experience in LAC residential care was 11 years.

2.3.3. Materials

A ‘Participant Information Sheet’ (Appendix D) and ‘Consent Form’ (Appendix E) were developed prior to recruitment in order to ensure that participants were able to provide informed consent to take part in the current study. The ‘Participant Information Sheet’ provided the participant with information about the study, while the Consent Form corresponded with the ‘Participant Information Sheet’ and ensured that participants fully understood this information and had opportunity to ask the researcher any questions before proceeding to give informed consent to participate in the study.

A semi-structured interview guide was developed (see Appendix F) in close collaboration with the supervision team and was informed by the aim of the current study as well as by findings from previous research in this area. In keeping with IPA methodology, questions in the interview guide were designed to be open ended and non-leading in order to allow participants to describe their in-depth experience (Smith et al., 2009). General probes such as “Can you tell me more about that?” were adopted in order to encourage elaboration from participants with minimal prompting.

A ‘Debriefing Sheet’ was developed (see Appendix G) in order to thank participants for their contribution to the research and to provide information on relevant sources of support.

2.3.4. Procedure

Initially, a number of options for recruitment were pursued including two private sector care providers and one local authority care provider. Providers were contacted via telephone and email correspondence. Access to participants was only granted by one local authority provider. The Residential Group Manager from the local authority provider was contacted via email and sent a letter (Appendix H) with information about the research, a copy of the 'Participant Information Sheet' and 'Consent Form'. The Residential Group Manager granted gatekeeper approval for the researcher to contact the individual residential home managers, who were contacted individually and provided with information about the research, participant information sheet, consent forms and details regarding the inclusion and exclusion criteria for their information. Approximately one to two weeks following contact, Residential Home Managers either made contact with the researcher or the researcher made follow up contact with managers. Managers discussed the research with staff during a team meeting to allow staff to express initial interest in the study. Once interested staff were identified, all further contact with those potential participants was directly between the lead researcher and the staff member. All staff who had expressed interest in potentially participating met the eligibility criteria for the study. Each person was provided with the participant information sheet at least 24 hours prior to the interview and prior to providing consent. Adequate time was allocated to answering any questions participants had prior to gaining informed consent. A convenient interview time and date was arranged and participants were asked to choose a preferred location for the interview. Where relevant, lone working guidelines were followed.

2.3.4.1 Interview procedure

Participants had the opportunity to review the participant information sheet and ask any questions. Once the researcher was satisfied that

the participant was happy to take part in the study, they were given a consent form to read through and sign (Appendix E). Participants were asked additional demographic questions (age, gender, ethnicity, job title and length of experience). Participants were interviewed alone by the researcher between October 2017 and January 2018. Interviews were audio recorded and lasted between 47 and 77 minutes (average 61 minutes). At the end of each interview the participant was provided with the debrief document (Appendix G) and asked how their experience had been, support services were verbally highlighted and provided in writing on the debrief sheet should these be required. Participants were asked if they would like to be contacted to receive the final write up to which all participants agreed that they would like to see the final write up of the study. Participants were thanked for taking part in the study.

2.3.5. Data analysis

Each interview was audio recorded and transcribed verbatim; these recordings were subsequently destroyed following transcription. All identifiable information was removed and participants were provided with pseudonyms used throughout transcription. Data was then analysed following IPA methodology in line with guidance by Smith et al. (2009) (see appendix I). An example section from a coded transcript is provided (appendix J) along with emergent themes for one of the eight participants (appendix K)

In order to enhance the quality and reliability of data analysis an independent researcher coded a section of transcribed data in order to highlight similarities and differences between codes and themes arising from the data. Additionally, coding, emergent themes and final themes were discussed with the research supervision team in order to gain feedback and have reflective discussions around the data analysis.

2.3.6. Ethics

Ethical approval was granted by Coventry University Ethics (appendix L). In addition to this, the study was conducted in line with the British Psychological Society (BPS) Code of Ethics and Conduct (BPS, 2009) and Code of Research Ethics (BPS, 2010). Participants were provided with full information about the study and given time to consider this along with any questions they had before providing informed consent. Additionally, participants were informed of their right to withdraw from the study. Participants' confidentiality was maintained throughout the research.

2.3.7. Researcher's position

The lead researcher is a Trainee Clinical Psychologist employed by a local NHS Trust. The researcher has previous experience working as an Assistant Psychologist in residential care for Looked after Children. The researcher, however, had no prior involvement with the local authority or residential care homes participating in the current study.

A bracketing interview was conducted in order to bring to the researcher's attention, areas of bias or potential areas of tension which could influence the data analysis. The researcher held the opinion that the concept of resilience was likely to play an important role for staff working in residential care, in particular, that resilience develops with length of time a person has worked in residential care. The researcher felt that there may be a lack of in-depth supervision for staff or that supervision was unlikely to focus on the emotional impact of working with violence. It was important for the researcher to gain awareness of their own subjective position prior to conducting the analysis, and the bracketing interview served to help achieve this.

2.4. Results

Table 2.3 Superordinate and Subordinate Themes

Superordinate Themes	**Subordinate Themes**
Theme 1: The impact of violence	1a) *"it almost makes it harder to work with the young person"* 1b) *"the whole time I was absolutely petrified"* 1c) *"The ramifications of it was days after"*
Theme 2: Coping with violence	2a) *"You have to put on a brave face"* 2b) *"a gear clicks in and you know what to do"*
Theme 3: Sense making in a violent context	3a) *"you need to try and unpick what's going on there"* 3b) *"I'm a resilient person"* 3c) *"it's like become the norm and I think it's just like…residential"*

Data analysis resulted in three superordinate themes, each with a number of subordinate themes. A summary of themes is presented above in Table 2.3. Themes are discussed and points of convergence and divergence are highlighted. Extracts from interview transcripts are used in order to represent participants' lived experiences.

2.4.1 Theme 1: The impact of violence

All participants described various ways in which violence impacts on them and their work. For several participants, maintaining genuine emotional connections with the children felt challenging after experiencing violence. Often participants felt a sense of responsibility to protect the children from their own emotions. All participants talked about the immediate emotional impact of violence, however, for

many the emotional impact and effect on their wellbeing was delayed.

2.4.1.1 1a) *"it almost makes it harder to work with the young person"*

Participants expressed how maintaining genuine therapeutic relationships with children often felt difficult following violent incidents. In particular, participants explained how they often distance themselves physically and emotionally from the child following a violent incident. Rob explained how violence influenced his emotional reaction to the child:

> It almost makes you on edge and it almost makes it harder to work with the young person because you are already distancing yourself from them because you don't want to get too close because you're thinking "hmmm is this going to be the time that she is going to hit me?" (Rob, line 151-153)

Rob described feeling *"on edge"* and fearful of becoming *"too close"* to the child in case they reacted with violence. Similarly, Craig described needing space and time away from the child following violence:

> If a young person had just tried to punch me and then they want a hug afterwards…I might not give them a hug…I might say "not now, I'm not in the right…I need a bit of time or space" (Craig, line 333-334)

Craig's comment points to a need for time and space to process his own emotional reaction before being able to provide emotional support for the child.

Amy described a feeling of anger towards the child following a violent incident in which her hair was set on fire by a young male in her care:

> I wasn't interested and not capable of doing anything other than meeting his basic needs, I didn't want to spend time with

> him, I didn't want to invest in him and I was quite angry (Amy, line 222-224)

Clearly, the deeper and more therapeutic relationship had been affected for Amy who felt compromised in her ability to provide a genuine emotional connection following violence. Indeed, this resulted in a more superficial relationship where Amy only felt able to meet the young person's basic care needs.

Participants often appeared to feel a sense of responsibility to not exacerbate the strained relationship following violence. Several participants expressed a sense of responsibility for protecting the children from their own emotional reaction.

> I was far from happy that it happened but all you ever want is that if they do something wrong is to realise it's wrong, not do that again and if they are making the attempt to be sorry, to apologise, then what sort of person would you be if you held that against them? (David, line 321-324)

Here, David talks about the relationship with a child, his use of the term *"far from happy"* suggests he was unhappy, possibly even angry about the violence yet he felt it would be wrong for him to hold this against the child or that such a response would indicate something negative about his character. Interestingly, David later goes on to talk about how he continued working with the child:

> I had come to do a school run actually, in fact, ironically I think I dropped the person off that had caused that problem (laughs) umm that's what I mean about not taking it personally (David, line 357-358)

David's laughter whilst explaining this and use of the word *"ironically"* suggests some discomfort or tension with the idea of carrying on as normal with the child. Although David was clearly able to continue with his job, there was a suggestion of the tension that can be present following violence.

Elaine similarly describes trying not to let violence interfere with the therapeutic relationship but expresses her difficulty with this:

> Ummm…(laughs)…as a rule of thumb we try not to interfere with your relationships but it does…it has to…umm I think a lot of the time we pretend everything is okay (Elaine, line 309-310)

Elaine's use language such as; *"it has to"* suggests some level of certainty that, as a human, she believes that you cannot experience such violence without consequences on the relationship with the child.

2.4.1.2 1b) *"the whole time I was absolutely petrified"*

All participants talked about the immediate impact of violence on their emotions. Their accounts were often marked by an overarching fear or anxiety, often anticipatory anxiety for what was about to happen due to the unpredictable nature of the violence displayed. Sam explained how anxiety was felt during such situations, although not overtly expressed, he described feeling:

> Like a swan, on the surface everything is calm but underneath you're flapping (Sam, line 166).

Similarly, Charlie described a physiological reaction of feeling his heart beating faster whilst in a violent situation, although Charlie did not feel that the situation was *"serious",* he still experienced the associated anxiety:

> My heart was going like the clappers (laughs) and it wasn't a really serious incident (Charlie, line 98-99).

Anxiety was often anticipatory for participants; the fear of what could happen had started before violence occurred. There appeared to be a sense of knowing when violence was likely to occur. Sam and Ian both described anxiety building up before violence:

> …so you come onto shift already anxious…" (Sam, line 238)

> …when we walked in ummm your anxiety goes up, three or four gears and you've not even got to anything yet…but you know you're going to get there… (Ian, line 54-56).

Rob described an incident with a young female, his account reflected his sense of danger and threat in this situation where he did not feel safe. This led to feelings of anxiety and support seeking from other colleagues:

> she was assaulting people and it makes you anxious thinking "well where is the other member of staff" and you're looking over your shoulder to make sure that when you are with the young person that there is someone there (Rob Line 169-171).

2.4.1.3 1c) *"The ramifications of it was days after"*

Many participants described the emotional and psychological impact of violence as being delayed, it seemed for many that the impact came in the hours, days and weeks following violent incidents. There was a common sense of realisation of the seriousness and potential danger. Rob explained that:

> It's afterwards when you've got time and when the situation is all resolved or whatever happens you sit there and go….it's then when you think or you think about "lucky this never happened" (Rob, line 197-199)

It appeared as though for Rob the realisation after the violence forced him to reflect on what could have happened. This seemed to have led Rob to think about how he counts himself "lucky" not to have experienced something worse. Amy described a similar experience of being in a state of shock and going over what happened while imagining what could have happened in her mind:

> I think I was just in absolute shock at the time and then when I came home I was just like, it sort of upset me a bit, I was just like oh my god this child has like done this, and I am just like, I was just sort of then thinking of all the scenarios that could have happened (Amy, line 176-178).

Elaine described feeling *"upset"* and crying following violence. She spoke about processing this emotion on her own, it seemed as though Elaine felt unable to do this with other people. Additionally, Elaine expressed having to get up and do it all again the next day, reflecting the limited space or time she had to process the emotion she was experiencing:

> And it can be upsetting, you know, later on when you think about it you can get emotional and cry about it and be upset about it but for me, I am umm, I don't know about anyone else but that is usually when I am on my own so you know….and then you get up the next day and do it all over again… (Elaine, line 181-182)

Participants spoke about their experiences following violence and the impact this had on their emotions and life outside of work:

> …umm the young lad that assaulted me, I was actually scared to go out of my house just in case he was around my area (Elaine, line 78-79).

Elaine became tearful during the interview when describing the impact one young male had on her. Following the violence she needed time away from work and counselling. Elaine described feeling afraid of leaving her house and she found herself thinking about the violent incident often. Amy also found herself to be similarly affected by her experiences of violence:

> I was having nightmares at one point about this kid…and I really couldn't believe it. I had to go into work and say I was having nightmares about him…and every time the phone would ring at work I would have this fear that it was a call to say he was coming back… (Amy, line 181-182)

Both Elaine and Amy appeared to experience trauma related symptoms following violence characterised by nightmares, high levels of anxiety and hypervigilance as well as a sense of fear experienced in their day to day lives.

2.4.2 Theme 2: Coping with violence

All participants spoke about a sense of putting their emotions to one side in order to be able to do their job and cope with violence. Many participants also felt that it was important to talk about how they are feeling and reflect on violence and its impact, although their accounts often showed examples of blocking out and not expressing emotion. This appeared to be an area of conflict for participants as they were clear that in order to cope emotions had to be neglected whilst at the same time they felt it was not good to *"bottle up"* emotions. Additionally, participants spoke about an instinctive reaction in violent situations in which adrenaline kicks in and they knew what they needed to do.

2.4.2.1 2a) *"You have to put on a brave face"*

All participants spoke about feeling a sense of anxiety or fear but having to disguise this in order to either protect the child or to not react to the child's behaviour. Sam spoke about this process of putting on a *"brave face"* in order not to show the children his feelings:

> You kind of you have to put on a brave face, you can't let them know that it's, you know, that you are feeling in that situation (Sam, line 161-162)

It seemed as though Sam felt that he shouldn't show vulnerability in front of the child, perhaps fearing that showing vulnerability may interfere with being able to appropriately resolve the situation. Similarly, Rob spoke about a *"brave face":*

> You just try and put a brave face on it really if I am honest, you just have to try and lock it away and just get on with it (Rob, line 372-373).

Rob's use of the words *"lock it away"* appear to relate to locking away his feelings. The use of the term *"brave face"* suggests having to mask or disguise underlying emotion. There was an overall sense that participants did not want the emotions to interfere with their relationships with the children or the care they needed to provide. However, as Ian indicated this can often feel as though they are required to be *"superhuman"* or a *"robot"* as it can feel difficult to ignore your own emotional reaction:

> People explain to you that you shouldn't be superhuman but that's exactly what you're being you know…you are being umm you are being to a degree a robot…where you have to put your emotions aside for the sake of somebody else's emotions (Ian, line 154-157).

2.4.2.2.2b) *"a gear clicks in and you know what to do"*

Seven participants spoke about the instinctive reaction to violence which allowed them to cope and know what they needed to do. This appeared to serve an important function as it allowed them to carry on with their work in the face of violence and high emotion. Many of the participants spoke about adrenaline *"kicking in"* which seemed to be linked to an instinctive, primitive reaction whereby they continued to work on *"auto pilot"* in order to protect themselves, their colleagues and the children in their care. David described how his heightened alertness and his body's natural physiological reactions helped him to protect himself, the young people and his colleagues from harm:

> I think it's because you are in a heightened state of alert you know and ultimately in any confrontational situation it's, well you don't want yourself to get hurt, other young people or staff to get hurt (David, line 85-87)

Charlie, Elaine and Rob all described similarly how they coped with violence, demonstrating their ability to be able to carry on:

> You just instinctively do what you need to do (Charlie, line 90)

> I think in the moment just adrenaline kicks in and you just do what you do (Elaine, line 179)

> I go just go into auto pilot and just deal with what's in front of me (Rob, line 196-197).

This ability to be able to carry on in the face of adversity serves an important coping and protective function for participants. Their natural physiological reactions appear to take over and allow them to instinctively protect themselves and others.

2.4.3 Theme 3: Sense making in a violent context

Sense making was apparent across participants' accounts. Of fundamental importance for participants was to try and understand why the children and young people displayed violent behaviours; doing so appeared to allow them a sense of understanding and empathy towards the child. It became clear that when participants couldn't understand or make sense of violent behaviour, this felt particularly difficult for them and often these children remained in their thoughts, as though they were unsolved puzzles. Additionally, making sense of themselves within the violent context and understanding the wider context of residential care was a theme throughout participants' accounts.

2.4.3.1 3a) *"you need to try and unpick what's going on there"*

Understanding why the children displayed violence was a central theme throughout. There was often a desire to understand or

demonstrate a level of understanding of why the children were violent. This appeared to be important to participants and helped them to make sense of the violence. David talked about a young girl in his care:

> We had another girl that would lash out umm try to swing punches, we had it continuous for three weeks but it taught me after that point when she opened up she did it because she was pushing us away, she didn't want to get close because she didn't want to form an attachment and then find that she had got to lose something else in her life (David Line 435-438).

He demonstrates his way of making sense of the violence by getting in touch with the child's emotional experience which allows him to see it from a different perspective, in this case, the child's perspective, facilitating a more empathic understanding of the child's (violent) behaviour. Similar to many other participants, Amy demonstrated her ability to connect empathically to the child's previous life experiences which appeared to promote understanding and empathy:

> …oh they have had a terrible childhood, they've not received nurture, they haven't learnt how to socialise they don't know how to get attention any other way than this (Amy, line 136-138).

It appeared as though developing an empathic understanding helped the violence to feel less personal to staff, as demonstrated by Charlie who was able to see that the child may not necessarily wanted to be violent:

> I know she's been through trauma and she probably doesn't mean it (Charlie, line 33-34).

Several participants talked about times when they did not feel able to understand or *"get to the bottom"* of why the child had been violent:

> It's almost like…okay, you tried to deal with the behaviour as opposed to trying to understand what was causing the behaviour and it's almost like I felt I missed that one but that might just be me being hard on myself (David, line 440-442).

For David, not understanding in this case appeared to lead to self-criticism, as though he had somehow missed an opportunity to understand the child's behaviour. It appeared as though David felt he should have been able to understand or make sense of the violence sooner, as though the child was a puzzle that needed to be solved and it was his responsibility to do so.

Similarly, Craig described how a child who had been violent towards him stuck in his mind as he was not able to understand why he behaved in that way:

> …there was no rhyme or reason for why he behaved in that way…do you know, you know everything was going well and so that sticks in my mind is…why? (Craig, line 76-77)

It seemed as though Craig felt he needed to understand or get to a conclusion about the violence which he was not able to do. This meant that the child stayed in his thoughts for much longer than usual.

2.4.3.2 3b) *"I'm a resilient person"*

All participants spoke about their sense of themselves as resilient and able to cope with violence and to keep coming back to work in spite of this. Many participants seemed conflicted in that they felt they were resilient, however, the repeated violence they experienced made them question their sense of self as strong or resilient.

Sam had a sense of himself as being a resilient person which enabled him to make sense of how he continued to do the job:

> I am naturally quite a resilient person, before this job I spent 6 ½ years in the army. So, I am quite a resilient person anyway (Sam, line 420- 421).

Later in the interview Sam appears to have some doubt or question himself in relation to needing access to emotional support at work. It appears that Sam had previously seen himself as being able to cope on his own without support:

> It was good but again it was something…maybe I wasn't…I have always just got on with things you know so I've not maybe always talked about my thoughts and feelings, I've always just got on with things and that served me alright for 30 odd years but then it kind of got to the point when I was ready to talk to somebody about things and work through it (Sam, line 631-634)

Similarly, Rob spoke about being a strong and resilient person who is able to cope with the violence in residential care:

> I think you've got to have strong resilience and if you haven't got resilience you won't last very long in residential if I'm honest (Rob, line 102-103)

Later in the interview, Rob expressed that even though you can be a resilient person that this can often be challenged in the most difficult situations:

> you can be the most resilient person in the world but when it is relentless and if you are the one that is targeted the yeah it can get to the stage where you think, I am not going in I am going to phone in sick today I just can't deal with that today (Rob, line 321-323)

Charlie spoke about feeling as though he needed to be stronger as a person in order to survive in residential care, although he felt

conflicted as he recognised that he is was not able to change who he was as a person:

> That's as stand up and defiant as I can be really because it's not in your nature, they say do this and do this but you can't just change who you are (Charlie, line 228-229).
>
> I have got to toughen up, I realise I have to toughen up (Charlie, line 232-233).

2.4.3.3 3c) *"it's like become the norm and I think it's just like…residential"*

There appeared to be a level of acceptance of having to face and deal with violence as being part of the job amongst participants. Although they did not agree that it was okay or right for them to experience violence, they all felt that it was part of their job role and *"expected"* in residential care. Elaine appeared to have internalised this expectation:

> I think I am just programmed now to just deal with it (Elaine, line 66).

Elaine's use of the word *"programmed"* suggests she feels like a robot who has to just deal with the violence that comes at her. There appears to be a detachment from emotion in her statement, almost as though Elaine is so used to the violence she no longer reacts to it emotionally.

In contrast, Craig expressed disapproval at the levels of violence experienced by staff in residential care, he understood it to be a "cultural" aspect of residential care but did not agree that this should be accepted:

> …it is a cultural thing and I just think it's not right and I think it will get worse before it gets better (Craig, line 419).

2.5. Discussion

The present study found three superordinate themes which will be discussed in relation to the existing empirical literature and theoretical knowledge.

2.5.1 Impact of violence

Therapeutic relationships with LAC in residential care have been found to be of upmost importance and priority due to the close connection of positive therapeutic relationships with child outcomes (Moses, 2000). Staff participants in the present study found it challenging to maintain interactions and genuine connection with children immediately following the violence which is likely to impact upon the therapeutic relationship, at least in the short term. LAC have often experienced rejection, neglect and abuse in their past leading to attachment difficulties (DfE, 2017), therefore, any subtle changes in their relationships are likely to be experienced negatively by children.

Additionally, participants recognised the immediate and delayed impact of such violence for themselves. Literature suggests that psychological responses to trauma are similar across different situations (Davidson & Jackson, 1985), and psychological sequelae described by participants in the present study (e.g. nightmares, withdrawal from external world and increased anxiety and startle response) are similar to symptoms of post-traumatic stress (Davidson & Jackson, 1985; Gibson et al., 2017). Therefore, it is important to consider whether the experience of violence for residential staff may impact on their emotional and mental health both in the short term and in the long term. Linked to this, emotional exhaustion has been found to lead to burnout amongst care staff (Littlechild, 2005; Maslach, 1978; Winstanley & Hales, 2014), burnout can result in staff losing feelings of concern for clients and potentially treating them in a detached or dehumanised manner. This highlights the importance of ensuring staff feel able to take time away from the

children to process their own emotions, allowing them to be emotionally available for the children.

2.5.2 Coping with violence

One of the ways in which participants coped with their experiences of violence was to block out emotions or put them to one side (e.g. putting on a “brave face”) in order to carry on with their work. It is likely that this serves as an effective short-term protective defence mechanism for participants, however, research suggests that limited emotional expression can lead to difficulties with mental and physical wellbeing (Gross & Levenson, 1997). However, addressing this may not be straightforward, as research has also found that emotional expression differs across occupations in relation to what is deemed culturally acceptable within that organisation, suggesting that how an individual member of staff responds may be influenced by the organisational culture (Bar-On, Brown, Kirkcaldy & Thome, 2000).

2.5.3 Sense making in a violent context

Understanding the violence and why it occurs was important for participants in the present study. It seemed as though this served to explain the violent behaviour in a way that helped staff both to empathise with the child and to feel the violence was not personal. Psychological formulation provides a means to understanding clients’ difficulties from a psychological framework, which often involves thought about the child’s past experiences (BPS, 2011). In particular, research has shown that attachment theory, developed by Bowlby (1973) provides a helpful framework from which to understand LAC behaviours and develop subsequent interventions and practice (Moses, 2000). Although it is important for staff to understand the child’s behaviour, it is also important that staff do not minimise the impact of such violence and are provided with space and time to able to think about and process the personal impact of these experiences.

Participants had a sense of themselves as resilient and strong individuals which was subsequently questioned when dealing with violence. McAdams (2002) highlight that increased levels of violence in residential care often results in staff having a lack of self-worth. It is important to consider the implications of violence on staff members' sense of self and to provide psychological support in order to develop and maintain their resilience levels.

The present study found that participants experienced violence as the "norm" and part of their job. Research indicates that violence is common in residential care due to the nature of children's past experiences (Connor et al., 2004; Falshaw and Browne, 1997; Mosseri, 2008). Although violence is common, it is important to recognise the implications of violence for staff and ensure staff are emotionally equipped to cope.

2.5.4 Gender differences

Of note, the present study recruited more males than females. Initially, this could appear to contradict gender theories which, suggest females more frequently express emotions than males (Street & Dardis, 2018). However, throughout the interviews the female participants were more willing to express emotion in relation to the traumatic impact violence had on them, whereby male participants expressed less detail of the emotional impact and focussed more on expressing bravery in the face of violence. This is similar to previous findings in relation to gender differences and expression of emotion following traumatic experiences (Street & Dardis, 2018) and should be considered alongside results of the present study.

2.5.5 Clinical implications

The findings from the present study highlighted the emotional impact that violence can have on staff working with children in care. Additionally, it has drawn attention to the ways in which staff cope

with violence by becoming skilled at masking their emotion and reacting instinctively to violence. These findings have important clinical implications for staff working in LAC services. In particular, it has demonstrated the need for psychological support for staff to promote their emotional wellbeing. Additionally, staff training on self-care and emotional wellbeing could encourage staff to pay attention to and take care of their emotional health.

As well as training, thought should be given to additional support services for staff such as reflective practice groups and individual support sessions with trained psychologists or counsellors following violence within work.

Staff placed importance on understanding the children's violence and therefore this highlights the importance of making time and space for complex case discussions and formulation sessions informed by attachment theory and practice. These groups should encourage staff to reflect on their emotions as well as develop an understanding of the child in order to promote empathy and potentially reduce the personal implications for staff (Briggs, 2012; Bruce, Horgan, Kerr, Cullen & Russell, 2016; Silver, Golding & Roberts, 2015).

The present findings indicate that consideration should be given to policies and procedures within LAC residential care, in particular procedures in place following any serious violent incident in order to provide staff with additional time to process the emotional impact.

2.5.6 Limitations

The present study recruited participants from one local authority and therefore findings may not be transferable to private sector organisations or other local authority care providers. Each organisation is likely to be different and thus have different policies and practice influencing staff experience.

One limitation of the present study is that the majority of participants were male (n=6) with only two female participants, therefore, males

are overrepresented in this sample. Additionally, all participants identified as White British and therefore it is important to consider differences in experiences or perceptions of violence across cultures. Hence, results from the present study may not be transferable to work with LAC in other countries or different cultural contexts.

Many of the staff in the present study had worked in residential care for a number of years and therefore are likely to have found their own coping strategies which allow them to continue to work with violence. It would be interesting for future research to consider staff members who have recently started working in residential care as they may have different or less developed coping strategies. It would also be interesting to consider whether this might contribute to high staff turnover (Colton & Roberts, 2006).

2.5.7 Future research

The present study highlighted the lack of qualitative research with residential support staff working in LAC services. Future research could build on the findings from the present study by conducting research with female residential staff to identify any potential gender differences in experiences of and coping with violence from LAC.

In addition, results from the present study suggest that violence towards staff is ‘expected’ in residential child care. Future research could build on this finding by conducting research with managers or key stakeholders to investigate whether this expectation is present at management and senior management levels in organisations that care for LAC, to better understand perceptions among senior staff and to identify ways of addressing expectations at an organisational level. Such research is crucial if violence is expected to change within residential care.

The present study focussed on physical and verbal violence and therefore future research should focus on sexual violence towards staff working in residential care. Research could address their

experiences of being exposed to sexual assault and sexual harassment by children in their care. This is likely to provide some important insights into the potential similarities and differences in experience of physical and sexual violence and subsequently help to tailor support offered to staff.

Finally, the present study focussed on residential staff from local authority care homes. Replication studies with private sector care staff would serve to capture the opinions of staff within different residential contexts in order to further develop our understanding of their experience of violence.

2.6. Conclusion

The present study aimed to explore residential staff members' lived experience of violence whilst caring for LAC. Qualitative methodology was employed and data analysis using IPA resulted in three superordinate themes: the impact of violence, coping with violence and sense making in a violent context with a number of subordinate themes which reflected staff members' experiences. The results have important clinical implications in terms of supporting the psychological wellbeing of staff working with LAC in residential care. In particular, results highlight the importance of staff emotional wellbeing and supervision as well as proactive training and support in order to provide the best level of care for children. Future research should build on findings from the current study in order to further our understanding of the impact of violence within LAC settings.

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Chapter Three: Reflective paper

Providing a secure base: reflections on conducting research in the field of developmental trauma

Word count: 3065

3.1. Introduction

The previous two chapters have focussed on children's experiences of DV and staff members' experiences of violence within LAC residential care. The present chapter is a reflective paper which aims to explore, from the researcher's perspective, the research process, including the challenges faced and reflections for future practice as a Clinical Psychologist working with children who have experienced developmental trauma. As the researcher, I aim to reflect on my own thoughts, feelings and experiences as well as those of my participants in line with relevant theory and literature. In particular, I will draw on attachment theory to illustrate pertinent processes and experiences throughout.

It is widely recognised that reflective practice holds a valuable place within the role of Clinical Psychologist (BPS, 2017). Reflective practice is often integrated into clinical work as a Trainee Clinical Psychologist and beyond qualification as a Clinical Psychologist. In addition to clinical work, reflective practice has been an integral aspect of the doctoral research process I have been engaged in while completing the present thesis. In particular, the BPS (2017) highlight supervision as a space for thinking openly and considering others experiences. The following reflective paper seeks to demonstrate the usefulness of supervision as a space to reflect on personal and professional issues as well as considering the experience of others within this framework.

3.2. Reflections on the research process

3.2.1 Developing a research idea

Developing a research idea was not something that came naturally or easily to me. I had always seen myself and my identity as a clinician, working directly with individuals in need of support and care. I had preconceived ideas about research not necessarily being something I would be particularly good at or have a great deal of interest in.

Therefore, the first hurdle of developing an idea made me feel vulnerable and fearful about whether the idea would be ‘good enough’. Interestingly, I needed someone to contain my emotions during this time and provide me with some support and reassurance, my own ‘safe base’ which was provided in the form of my research supervisor. With this support, I began to talk about personal areas of interest. Initially I noticed my urge to conduct research within a LAC setting; in particular, I wished to focus on conducting research with the children themselves. It soon became clear that this would hold many challenges which felt too difficult to face within the limited time frame for this research. Those challenges included the uncertainty of gaining access to child participants due to the potential ethical dilemmas when conducting research with a particularly vulnerable population of children (Gorin, Hooper, Dyson & Cabral, 2008). Additionally, when reflecting on my previous job role as an Assistant Psychologist working with LAC services, I thought of the children and the staff I had worked with. Residential care is often not viewed as a settled and secure placement for LAC and therefore asking children to discuss their experience is likely to evoke an emotional reaction which they may feel too unsettled to tolerate. Therefore, I questioned the ethical implications and the potential adverse impact of conducting research directly with LAC, and I began to think about ways in which I could conduct meaningful research which would still have useful clinical implications for the children.

Whilst considering my previous role as an Assistant Psychologist, I recalled conversations with the residential staff who spoke about their experiences of their work. I vividly remember one occasion when I arrived at a residential care home to carry out regular weekly sessions with the children. Upon arriving at the home, I noticed windows boarded up and shattered glass on the floor. I felt an instant sense of anxiety and worry about what had happened. Following discussions with staff, it was clear that they had experienced twelve hours of relentless violence and emotional dysregulation from the

children. This included verbal abuse, physical violence to staff and property damage. I walked into the staff office with a look of disbelief and shock asking “what has happened here?”, the staff looked at me and laughed, stating “if we don’t laugh, we will cry”. They appeared drained both emotionally and physically. It was at that moment that I wondered how the staff cope with the challenges that they are often presented with in their work. This led me to question how they cope, make sense of their experiences and continue to do the job they do, given the significant levels of violence they experience on an ongoing basis.

Evidence suggests that LAC need security and stability in order to feel safe and develop emotionally. More often than not the children who are placed in residential child care have experienced numerous placement breakdowns, a sense of loss, abandonment and instability. Residential staff are essentially asked to become therapeutic parents for these children (Silver, Golding, & Roberts, 2015). I started to give a lot of thought to whether such complex presentations and associated violent behaviour may contribute to high staff turnover and whether gaining a better understanding of staff member’s experiences of violence might be a viable focus for a research project. I also wondered if anything could be done to support the staff to remain in their roles and be emotionally available for these children, thus resulting in potential improved outcomes for the children.

This began the premise for my research idea, which I eventually developed into the formal research question: what are staff members’ experiences of violence in looked after children’s residential care?

3.2.2 Recruitment

Interestingly, I began the process of recruitment with the mind-set that private companies would be most easily accessible and willing to take part in the research. Initially, I had hoped that I might be able to return to my previous employer and recruit from their service.

Unfortunately, due to a serious incident at the time, I was told I could no longer recruit from that service. I noticed at that time that there had been an article published in the local newspaper regarding the serious incident which involved support workers resorting to locking themselves in the staff room, “terrified” and “losing control” of the children’s behaviour which had been extremely aggressive and violent. This further highlighted, for me, the importance of the research and why it was essential to explore staff members’ experience of violence. It seemed as though the children had become feared in this instance and the staff became fearful, perhaps mirroring the power dynamics once experienced by the children in their often traumatic past (Walker, 2007). Following this, I began to search for additional options for recruitment, one further private company expressed their interest in being involved in the research and therefore I went to meet with this large private provider of residential care. They felt the research was interesting and important and expressed interest to be involved. However, following our meeting I was asked if I could provide feedback which would be specific to their staff following interviews as they were keen to understand their staff experiences. In addition, they hoped as the lead researcher that I would be able to feed-back directly to them if I had concerns about staff members following interviews. Unfortunately, due to ethical boundaries and concerns this raised about participant confidentiality, a decision was made within the research team to decline to provide this additional information. I offered to feed back the results of the entire dataset which would be combined with other participants recruited from different providers. Unfortunately, I did not receive a response from the private provider. In the meantime, much to my surprise, I had received a response from the local authority who granted permission and access to staff participants. I now realise that I had preconceptions about local authority, social care based on my understanding of the immense pressure and demand on their time. I had assumed it would be more

difficult to access participants, however, I was pleased to discover that this was not the case in this instance. The local authority senior management were very keen throughout to support this research and were open to their staff taking part. The process from this point appeared very transparent and trusting, participants appeared able to talk to me about the challenges they faced in their jobs and were able to talk about the positive aspects of their jobs, including that all of the participants valued working within the local authority.

3.2.3 Interviews

During interviews, I felt strongly engaged with participants' experiences and stories. I was very curious and interested in what it was like from their perspectives and found myself wanting to ask more, I had to be aware of this dynamic as I did not want to deviate from the researcher role and had to remind myself that I was not there as a clinician. I focussed on allowing participants space and time for their experiences to emerge without tainting them with my own interpretations and meaning. Throughout data collection, I developed a strong sense of empathy towards participants for the level of violence and emotional distress they had dealt with over the time they had worked in LAC services. I was struck by their resilience in coping with this, yet also by their vulnerability and fragility of their own emotions. I could not help but draw comparisons across staff and the children they worked with. My previous experiences of LAC demonstrated just how resilient the children are, having been through extremely traumatic experiences in their childhoods, yet they were still able to engage and form relationships with other humans and adults which I found remarkable. This process seemed to parallel a process in the staff who care for them in terms of the ability of support staff to provide ongoing care and meaningful relationships for the children following emotional distress, which I also found remarkable.

This was not the only parallel I noticed during interview process. It also became apparent that many transference processes were at play, similar to those described by Briggs (2012). For example, one staff member described feeling rejected and useless when caring for the children. They described a sense that their emotions were being manipulated. I began to consider this in relation to how the children felt in their earlier childhood: rejected, not worthy of care or love and emotionally confused. It was interesting and noteworthy to see how these projections had manifested themselves in staff experiences of the children.

Overall, I noticed a marked increase in my empathy for staff working on the ground, dealing with challenging behaviours, violence and often very emotional dynamics on a daily basis. I noticed my own sense of guilt at how fortunate we are as Clinical Psychologists with regular supervision, support, understanding and encouragement to explore emotions within a protected space and time. I began to realise that this fortunate position could allow us to be able to provide containment, security and space for other professionals in order to continue the care and support.

3.3. Clinical Psychology in LAC services

Recommendations have been previously published by the BPS (2015) regarding psychological services for children, young people and their families. Included within this were recommendations for working psychologically with children and families with complex social care needs (Silver, Golding, & Roberts, 2015), including LAC. Interestingly, the recommendations from the documents are consistent with my own personal reflections based on the findings from my empirical study. In particular, the document highlighted that therapeutic change comes within relationships and thus advocates that support be offered proactively to carers. Similarly, Winnicott and Britton (1957) highlight the importance of a healing environment for children, therefore support for staff that work in these contexts should

be a priority in residential care. The empirical paper from the present study found that staff placed importance on making sense of the children's behaviours, the BPS (2015) document recommends promoting carers understanding of complex developmental trauma through training and consultation support and therefore closely reflects recommendations from the present study. From a Clinical Psychology perspective, it appears that we are often best placed to provide a safe reflective space for staff to be able to develop shared formulations and to talk about the emotional impact that the child's behaviours have on the staff themselves.

3.4. Implications for future practice

3.4.1 Indirect intervention

Current research (BPS, 2015; Winnicott & Britton, 1957) as well as the present study have highlighted the need for predominantly indirect intervention in LAC services. This can feel unusual as a Clinical Psychologist as a huge part of our work is often therapy, either one to one, with families, couples or groups. However, this highlights an exciting area of professional development for myself, with my final trainee placement working with LAC services. The opportunity for indirect work in LAC services is vast, as Clinical Psychologists we have the opportunity to spread support through development of reflective practice groups, providing supervision and training for staff and also future potential for providing therapeutic support to staff who have experienced traumatic events at work, including violence. Although therapeutic interventions have been developed for LAC, these are often more appropriate when the child is in a settled foster or adoptive home (Becker-Weidman, & Hughes, 2008). For those children in residential care, direct therapeutic intervention is often considered to be through the development of meaningful therapeutic relationships with staff and the therapeutic milieu of the residential home (Moses, 2000; Winnicott & Britton, 1957). Thus, the focus of psychological support in residential care

should be on ensuring staff are able to provide meaningful relationships and a healing environment for children.

3.4.2 Secure base for staff

Briggs (2012) highlights the importance of support for staff in order to ensure that their emotional distress is adequately contained. They also highlight the importance of regular supervision and consultation for professionals working in residential care. Consultation is highlighted as a useful way of working with staff to help them to understand children's distress and pain and potential reasons behind their often extremely challenging behaviours. However, this can often come at a cost for staff as recognition of this distress and pain can add pressure to them to feel they need to fix or solve the child's emotional pain (Briggs, 2012). Briggs (2012) recognised that in asking staff to be open to the children's experience they are placing themselves in an emotionally vulnerable position, therefore, require their own safe base in the form of management or supervisor to provide containment thus enabling them to provide emotional containment to the children in their care. Reflecting on this process brings to mind the common 'oxygen mask' metaphor whereby passengers on an aeroplane are required to place their own oxygen mask on before they place others' on, including their own children's masks. The reason for this is for those people to be able to survive in order to help others'. If they simply put the oxygen mask on their child for example, they may not survive to be able to support their child further. In my opinion, similar can be said for the staff working in LAC residential who are often required to provide 'therapeutic parenting' for children (Gallagher & Green, 2012; Silver, Golding, & Roberts, 2015). Conducting the present study opened my eyes to the reality that staff themselves require proactive emotional support in order to provide the essential emotional support for the children in their care.

3.4.3 Importance of attachment

> "The propensity to make strong emotional bonds to particular individuals is a basic component of human nature" (Bowlby, 1988a, p. 3).

Attachment and developmental trauma have featured heavily in both my empirical study and in the literature review I conducted. Attachment has always been an area which I have personally and professionally placed emphasis on. Conducting this research has served to strengthen the importance that I place on attachment relationships. Understanding children's experiences of DV and understanding the impact of interpersonal violence on staff has highlighted to me the importance of relationships, not only the fundamental attachment relationship between a child and their caregiver but also the importance of social relationships with friends and extended support networks. From my own reflections, relationships form the basis of how we think about ourselves, others and life events or situations we may find ourselves in. Relationships with other human beings are also often what help us to continue with what is important to us. Other people help us to feel safe when we are afraid, to feel confident when we are lacking in confidence and to feel connected when we feel lost and alone. I have had experience of these connections throughout life and relationships with others have been particularly important for me during this research process. In particular, my relationship with research supervisors has supported me to develop my skills and ability and my relationship with family and friends has encouraged me to continue when things have become challenging. For my participants, their relationships with their colleagues and families were important in supporting them with the challenges of their job role. Similarly, for children who have experienced developmental trauma, protective relationships in their lives helped to improve their future outcomes. In light of this, I will continue to value the importance of human connection and relationships both in my clinical work and in my personal life. I will

continue to ensure that I am sensitive to those individuals who I meet that have had difficult experiences with relating to others due to their past experiences.

3.4.4 Importance of research

I began this research process feeling that I lacked the skills and ability to be able to conduct useful research in clinical settings. I have now learned and have developed a greater understanding of the impact such research can have on clinical practice. My preconceived ideas about research have been challenged throughout this process and I now more clearly recognise the importance of research for clinical practice.

3.5. Conclusion

The present paper aimed to reflect on the challenges of and learning from the research process. The present thesis has taught me a great deal about research and its close relationship with clinical practice. In particular, through my own empirical investigation, I have developed a greater understanding of the role of Clinical Psychologists working in LAC residential services. Reflecting on this thesis has highlighted the overall learning experience which I endeavour to take forward into my future practice as a Clinical Psychologist.

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Appendix A: Certificate of Ethical Approval for Literature Review

Certificate of Ethical Approval

Applicant:

Claire Sweeney

Project Title:

Experiences of children and adolescents who witness domestic violence: a systematic review of qualitative literature

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

09 November 2017

Project Reference Number:

P61588

Appendix B

Quality Assessment Framework- qualitative research

(Caldwell, Henshaw & Taylor, 2005)

Scoring: 0=Criterion not met 1= Criterion partially met 2= Criterion met

Highest possible scoring= 36

Mid score= 17 which will be used as a cut-off point. Any studies scoring below 17 will be reviewed as to whether they meet the requirement for inclusion in the review. All studies scoring 17 and above will be included in the review as they meet the minimum standard for quality assessment.

1. Does the title reflect the content?
2. Are the authors credible?
3. Does the abstract summarise the key components?
4. Is the rationale for undertaking the research clearly outlined?
5. Is the literature review comprehensive and up to date?
6. Is the aim of the research clearly stated?
7. Are all ethical issues identified and addressed?
8. Is the methodology identified and justified?
9. Are the philosophical background and study design identified and the rationale for choice of design evident?
10. Are the major concepts identified?
11. Is the context of the study outlined?
12. Is the selection of participants described and the sampling method identified?
13. Is the method of data collection auditable?
14. Is the method of data analysis credible and confirmable?
15. Are the results presented in a way that is appropriate and clear?
16. Is the discussion comprehensive?
17. Are the results transferable?
18. Is the conclusion comprehensive?

Appendix C: Quality assessment checklist results (Caldwell et al., 2005)

Met criterion= 2, partially met criterion= 1, not met criterion= 0

Framework assessment criterion	Aymer (2008)	Callaghan, Alexander, Sixsmith & Fellin (2015)	Callaghan, Alexander & Fellin (2016)	Callaghan, Fellin, Alexander & Papathanasiou (2017)	Cater (2007)	Cater & Sjogren (2016)
1. Does the title reflect the content?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
2. Are the authors credible?	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
3. Does the abstract summarise the key components?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
4. Is the rationale for undertaking the research clearly outlined?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
5. Is the literature review comprehensive and up to date?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
6. Is the aim of the research clearly stated?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
7. Are all ethical issues identified and addressed?	Not met (0)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
8. Is the methodology identified and justified?	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)

9. Are the philosophical background and study design identified and the rationale for choice of design evident?	Not met (0)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial (1)
10. Are the major concepts identified?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
11. Is the context of the study outlined?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
12. Is the selection of participants described and the sampling method identified?	Yes (2)	Partial (1)	Partial (1)	Yes (2)	Yes (2)	Yes (2)
13. Is the method of data collection auditable?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
14. Is the method of data analysis credible and confirmable?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
15. Are the results presented in a way that is appropriate and clear?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
16. Is the discussion comprehensive?	Yes (2)	Yes (2)	Partial (1)	Yes (2)	Yes (2)	Yes (2)
17. Are the results transferable?	Partial (1)	Partial (1)	Partial (1)	Partial (1)	Partial (1)	Partial (1)
18. Is the conclusion comprehensive?	Yes (2)	Yes (2)	Partial (1)	Yes (2)	Partial (1)	Partial (1)
Score:	**29**	**34**	**32**	**35**	**34**	**33**
Kappa:		**K=1.00**	**K=1.00**			**K=0.77**

Framework assessment criterion	Deboard Lucas & Grych (2011)	Georgsson, Almqvist & Broberg (2011)	Georgsson Staf & Almqvist (2015)	Goldblatt (2003)	Swanston, Bowyer & Vetere (2014)
1. Does the title reflect the content?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
2. Are the authors credible?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
3. Does the abstract summarise the key components?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
4. Is the rationale for undertaking the research clearly outlined?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
5. Is the literature review comprehensive and up to date?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
6. Is the aim of the research clearly stated?	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Yes (2)
7. Are all ethical issues identified and addressed?	Not met (0)	Partial (1)	Yes (2)	Not met (0)	Yes (2)
8. Is the methodology identified and justified?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
9. Are the philosophical background and study design identified and the rationale for choice of design evident?	Partial (1)	Not met (0)	Yes (2)	Yes (2)	Yes (2)
10. Are the major concepts identified?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)

11. Is the context of the study outlined?	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Yes (2)
12. Is the selection of participants described and the sampling method identified?	Partial (1)	Partial (1)	Partial (1)	Yes (2)	Yes (2)
13. Is the method of data collection auditable?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
14. Is the method of data analysis credible and confirmable?	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
15. Are the results presented in a way that is appropriate and clear?	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
16. Is the discussion comprehensive?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
17. Are the results transferable?	Partial (1)	Partial (1)	Partial (1)	Partial (1)	Partial (1)
18. Is the conclusion comprehensive?	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Score:	**28**	**31**	**34**	**31**	**35**
Kappa:			**K=0.64**	**K=0.83**	**K=1.00**

Appendix D

Participant Information Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7765 7688

Programme Director
Doctorate Course in Clinical Psychology
Dr Eva Knight
BSc Clin.Psy.D. CPsychol

Participant Information Sheet- V1

WARWICK
THE UNIVERSITY OF WARWICK

Coventry University

Participant Information Sheet

Title of Research: Exploring the lived experience of therapeutic support staff who have experienced violence perpetrated by looked after children in residential care

You are invited to take part in this research project exploring the experiences of support staff who have experienced violence towards themselves perpetrated by children in their care.

The research forms part of a thesis project led by Trainee Clinical Psychologist Claire Sweeney. The project is undertaken as part of the Clinical Psychology Doctorate training at Coventry University and The University of Warwick.

The aim of this research is to understand more about support staff members' experiences of violence from children they are caring for as part of their role. Before deciding to take part in the research it will be important for you to read the following information so that you can make an informed decision as to whether you would like to go ahead with the research.

Please take time to read the following information, if there is anything you are unsure about, please do not hesitate to ask the lead researcher (Claire Sweeney) for further details or clarification. Following this, please take as much time as needed to decide whether you would like to take part in the research.

Why have I been invited to take part?

You have been invited to take part in the research because:

- You currently work as a permanent member of staff in a children's residential home
- You have experienced violence towards you (either physical or verbal aggression) in the last 12 months of working in this role

Do I have to take part?

It is entirely your decision whether to take part in this research. There will be no consequences if you choose not to take part. If you do decide to take part you are free to withdraw without having to give any reason for doing so. However, due to data analysis and write up of the thesis you can withdraw consent up until 31st January 2018 when data analysis will be completed.

What will I be asked to do if I take part?

If you agree to take part you will be invited to attend an interview with Claire Sweeney (lead researcher), which will take place at a venue of your choice.

You will be given this information sheet in advance of meeting with Claire (at least 24 hours prior to the meeting). During the meeting you will be asked to complete a consent form based on this participant information sheet. Following this, you will be invited to take part in an interview which is likely to last approximately 90 minutes. The duration of the interview will, however, be determined by the information shared.

The interview will focus on questions which explore your own personal experiences of violence perpetrated towards you by the children that you care for in the residential home that you work. In order to capture the interview, a digital voice recorder will be used and the interview will then be transcribed and subsequently analysed. You do not have to share information if you do not wish to and you will also be able to stop the interview at any point.

What are the possible advantages of taking part?

Your participation in this study will hopefully help others to understand more about the experiences of support staff in residential care homes with looked after children. This may in turn help to develop awareness and potential support for staff working in residential care for looked after children.

What are the possible disadvantages of taking part?

The researchers do not anticipate any disadvantages to taking part in this research, however, it is possible that you may experience distress or emotional upset at being asked questions regarding your experiences of violence. If this is the case, you are advised to contact your GP about this. In addition, other sources of support to discuss feelings of distress are listed below.

Mind- http://www.mind.org.uk/

Samaritans- http://www.samaritans.org/ or contact by phone: 116 123 (free to phone from both mobile and landline)

You can also get in touch with Samaritans by emailing jo@samaritans.org

If you wish to make a complaint you can talk to the principal investigator directly, the academic supervisor, or you can use the Coventry University Complaints procedure, accessible via the following link:

http://www.coventry.ac.uk/life-on-campus/the-university/key-information/registry/complaints-and-compliments/

Will my information be kept confidential?

In order to ensure confidentiality, pseudonyms (false names) will be used for the publication of this research. No personally identifiable information will be used.

All data will be recorded, stored and maintained in line with data protection laws. This means that the recordings will not be available to anyone other than the researcher using them for analysis purposes. Digital recordings will be transcribed and anonymised to protect participants' identity. Once transcribed, the recording will be permanently erased. Transcripts together with any other data from the study will be stored in a secure room at Coventry University. Once the research is completed the transcripts of participant interviews and other data will be kept for five years in a secured room and then destroyed. Breaches in confidentiality will only occur if the chief investigator is made aware that there is a risk to the safety of yourself or another. This is in line with the British Psychological Society's Code of Ethics and Conduct (2009).

What will happen to the results of the research?

This research study is being completed as part of the Clinical Psychology Doctorate programme at Coventry University and The University of Warwick. As part of this training, Claire Sweeney will write a report on the results which will form part of the final thesis. In addition, it is hoped that the findings will be published in a relevant academic journal and/or disseminated at academic conferences.

Who has checked over the study to make sure it is okay to go ahead?

The University of Coventry Research Ethics Committee.

Contact for further information?

If any information has been unclear or you wish to seek further information with regards to this research, please find the relevant contact details below:

Claire Sweeney, Trainee Clinical Psychologist, Clinical Psychology Doctorate, Health and Life Sciences, James Starley Building, Coventry University, Priory Street, Coventry, CV1 5FB

Email: Sweene21@uni.coventry.ac.uk

Dr Anthony Colombo, Clinical Psychology Doctorate, Health and Life Sciences, James Starley Building, Coventry University, Priory Street, Coventry, CV1 5FB

Email: hsx412@coventry.ac.uk

Dr Tom Patterson, Academic Director, Clinical Psychology Doctorate, Health and Life Sciences, James Starley Building, Coventry University, Priory Street, Coventry, CV1 5FB

Email: aa5654@coventry.ac.uk

Contact number: 02477 658 328

Appendix E: Consent Form

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7765 7688

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

Participant consent form- V1

WARWICK
THE UNIVERSITY OF WARWICK

Coventry University

Participant Consent Form

Research project title: Exploring the lived experience of therapeutic support staff who have experienced violence perpetrated by looked after children in residential care.

Name of Participant: Name of Investigator:

I confirm that I have read and understood the information sheet for the above study and have had the opportunity to consider the information (at least 24 hours), ask questions and have had these answered satisfactorily.

Please Initial Box ☐

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

Please Initial Box ☐

I understand that all the information I provide will be treated in confidence, and anonymously.

Please Initial Box ☐

I understand that the information that I provide will be transcribed, anonymised and analysed as is required by this research study and that in line with the Data Protection Act (1998) the transcripts of interviews and any other data will be destroyed after five years.

Please Initial Box ☐

Dean of Faculty of Health and Life Sciences
Professor Guy Daly | Coventry University | Priory Street | Coventry CV1 5FB | Tel 024 7679 5805

Head of Department of Psychology
Professor Robin Goodwin | University of Warwick | Coventry CV4 7AL | Tel 024 7652 2484

www.coventry.ac.uk

Participant consent form- V1

I understand that this consent form will be kept secure from unauthorised access, accidental loss or destruction.

Please Initial Box ☐

I agree to anonymised excerpts from my interview transcript being quoted verbatim in reports and publications related to the study.

Please Initial Box ☐

I agree to participate in the above study.

Please Initial Box ☐

Appendix F: Interview Guide

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7765 7888

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

Interview Guide- Version 1

WARWICK
THE UNIVERSITY OF WARWICK

Coventry University

Interview Guide

1. **Broad area:** Can you tell me to what extent (if any) violence/ aggression plays a part in your role as support worker?

   Prompts: What is this like? How do you cope?

2. Can you tell me about a time when you have experienced violence/ aggression directed towards you from a child in your care?

   Prompts: Can you briefly describe what happened?

3. Can you describe how it affected you at the time?

   Prompts: What was it like for you? / How did you feel? / How did you react at the time?

4. Since this time do you feel that this experience has continued to affect you in any way?

   Prompts: if yes, can you tell me about this?

5. How do you feel that this experience has impacted upon your work/ job role if at all?

   Prompts: How do you feel going to work? Whilst at work? After work when you are at home?

6. How do you feel this experience has impacted upon your relationship with the child, if at all?

   Prompts: Has the relationship changed? If so, in what way? How do you feel about that?

7. Can you describe what happened in your workplace following the incident?

   Prompts: How do you feel about the way it was managed?

8. How do you feel you have coped since the incident?

   Prompts: What were your personal ways of coping? Have you received support? If yes, how did you find this?

9. Is there anything else about your experience of violence or aggression from the children that you care for that you would like to tell me about or that you feel is important or relevant?

General interview prompts:

Could you tell me a bit more about that?

What did that mean to you?

How did you feel?

What were you thinking when that happened?

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Head of Department of Psychology
Professor Robin Goodwin | University of Warwick | Coventry CV4 7AL | Tel 024 7652 2484

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Appendix G: Debriefing Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 7688

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin Psy D. CPsychol

Debrief sheet: V1

WARWICK
THE UNIVERSITY OF WARWICK

Coventry University

Debrief sheet

Exploring the lived experience of therapeutic support staff who have experienced violence perpetrated by looked after children in residential care

I would like to take this opportunity to thank you for taking part in this study, your answers are very helpful to us. I hope that by carrying out this research more can be learnt about how residential support staff experience violence within their role. In addition, it is anticipated that the findings of the study may inform future practice, training and support for all residential support staff working with Looked After Children (LAC).

I hope that you have found taking part in the research a useful opportunity to talk about your personal experiences of violence within your role, the impact this may have, and how you cope with such experiences. However, I understand that answering questions about stressful situations may bring up difficult feelings for some people. If you have experienced any distress as a result of taking part in the study please consider seeking support through your GP. Alternatively, additional sources of support which you may find useful are listed towards the end of this document (please see "Additional Sources of Support" below).

In the meantime, should you have any further questions or concerns about any aspect of the research please do not hesitate to contact a member of the research team (details below), and we will get back to you as soon as possible.

Kind regards

Claire Sweeney
Lead Researcher and Trainee Clinical Psychologist

The research team (contact details):

Claire Sweeney, Trainee Clinical Psychologist, Clinical Psychology Doctorate, Health and Life Sciences, James Starley Building, Coventry University, Priory Street, Coventry, CV1 5FB
Email: Sweene21@uni.coventry.ac.uk

Dr Anthony Colombo, Clinical Psychology Doctorate, Health and Life Sciences, James Starley Building, Coventry University, Priory Street, Coventry, CV1 5FB
Email: hsx412@coventry.ac.uk

Debrief sheet- V1

Dr Tom Patterson, Academic Director, Clinical Psychology Doctorate, Health and Life Sciences, James Starley Building, Coventry University, Priory Street, Coventry, CV1 5FB

Email: aa5654@coventry.ac.uk

Contact number: 02477 658 328

Additional sources of support:

MIND- Provide confidential support, Monday- Friday 9.00am-6.00pm

Tel: 0300 123 3393 Text: 86463

Website: http://www.mind.org.uk/ for more information

Samaritans- Free phone service, 24 hours a day

Email: jo@samaritans.org

Phone: 116 123 (free from mobile and landline)

Website: http://www.samaritans.org/ for more information

Appendix H: Gatekeeper Permission Letter

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7765 7688

Programme Director
Doctorate Course in Clinical Psychology
Dr Eva Knight
BSc Clin Psy,D. CPsychol

WARWICK
THE UNIVERSITY OF WARWICK

Coventry University

Dear Sir/ Madam,

I am a Trainee Clinical Psychologist currently studying on the Coventry and Warwick University Doctorate in Clinical Psychology. As part of this course I will be submitting a doctoral level research thesis to the University in order to qualify as a Clinical Psychologist. I am writing to you to request formal permission to contact staff within your service to inform them about my research project in the hope that they might consider participating in the project.

My research aims to explore therapeutic support staff experiences of violence from looked after children in residential care. Previous research highlights concerns around the impact of violence against staff working with children in care, however, despite this concern, very little research has been carried out in this area. My research would involve one to one interviews with support staff which would last up to approximately one hour each. During this time I would hope to gain an in depth understanding of their experience of a violent incident (or incidents) within their support worker role. It is hoped that the findings of this study will contribute to increasing our understanding of the experiences of support staff in residential care homes with looked after children. This understanding may in turn contribute towards future improvements in education, training and practice for staff working with looked after children in contexts where violence towards staff may occur.

This research project is supervised by Dr Anthony Colombo (Senior Lecturer in Clinical Psychology) and Dr Tom Patterson (Academic Director for Clinical Psychology Doctorate). Ethical approval has been sought from Coventry University Ethics Board.

I would be really keen to hear whether you agree to my contacting your support staff to see if they would be interested in taking part in this research. This would involve me sending them a participant information sheet and consent form in the first instance (documents enclosed/attached here for your information). For staff who then choose to opt in to the study, I would then arrange a suitable time to visit your service to conduct the actual interview. Please note that this would involve up to an hour of each staff member's time and I would be grateful if you could consider allowing those staff who choose to participate to take a one-hour break from their work responsibilities in order to be interviewed. I would endeavour to arrange this at a time that is convenient both for your service and for the member of staff. Please do not hesitate to contact me if you wish to have further discussion or require more information.

I look forward to hearing from you soon

Kind Regards

Claire Sweeney
Trainee Clinical Psychologist
Clinical Psychology Doctorate
Coventry University and University of Warwick

Dean of Faculty of Health and Life Sciences
Professor Guy Daly | Coventry University | Priory Street | Coventry CV1 5FB | Tel 024 7679 5805

Head of Department of Psychology
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Appendix I: IPA step by step process

(Smith, Flowers & Larkin, 2009. Pages 79-80)

Step	Process
1	The close, line-by-line analysis of the experiential claims, concerns and understandings of each participant
2	The identification of emergent patterns (i.e. themes) within this experiential material, emphasising both convergence and divergence, commonality and nuance, usually first for single cases, and then subsequently across multiple cases
3	The development of a 'dialogue' between the researchers, the coded data, and their psychological knowledge, about what it might mean for participants to have these concerns, in this context, leading in turn to the development of a more interpretative account
4	The development of a structure, frame or gestalt which illustrates the relationships between themes
5	The organisation of all this material in a format which allows for analysed data to be traced right through the process, from initial comments on the transcript, through initial clustering and thematic development, into the final structure of themes
6	The use of supervision, collaboration, or audit to help test and develop the coherence and plausibility of the interpretation
7	The development of a full narrative, evidenced by a detailed commentary on data extracts, which takes the reader through this interpretation, usually theme-by-theme, and is often supported by some form of visual guide (a simple structure, diagram or table)
8	Reflection on one's own perceptions, conceptions and processes

Appendix J: Coded section of interview transcript

Interview 7 (04/01/2018)

Pseudonym: Ian **Gender:** Male **Age:** 48 **Length of service in LAC:** 27 years **Ethnicity:** White British

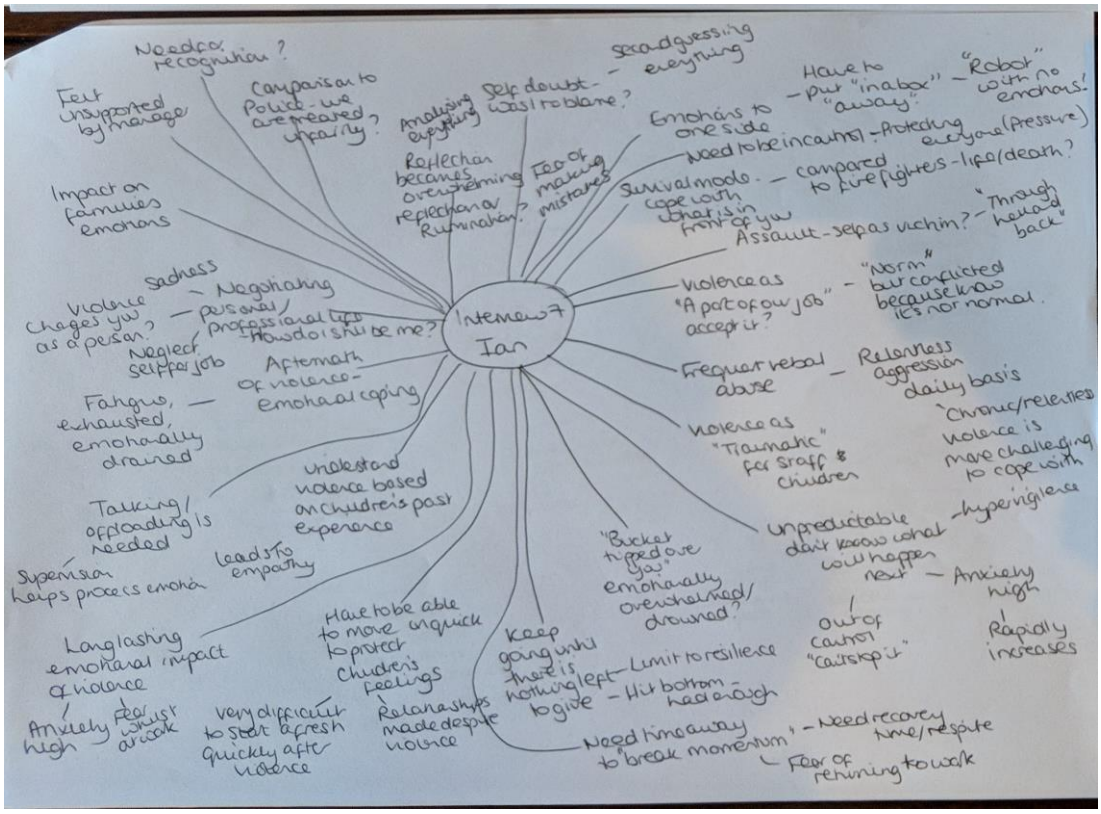
Job Title: Residential support worker **Based at:** Home 4

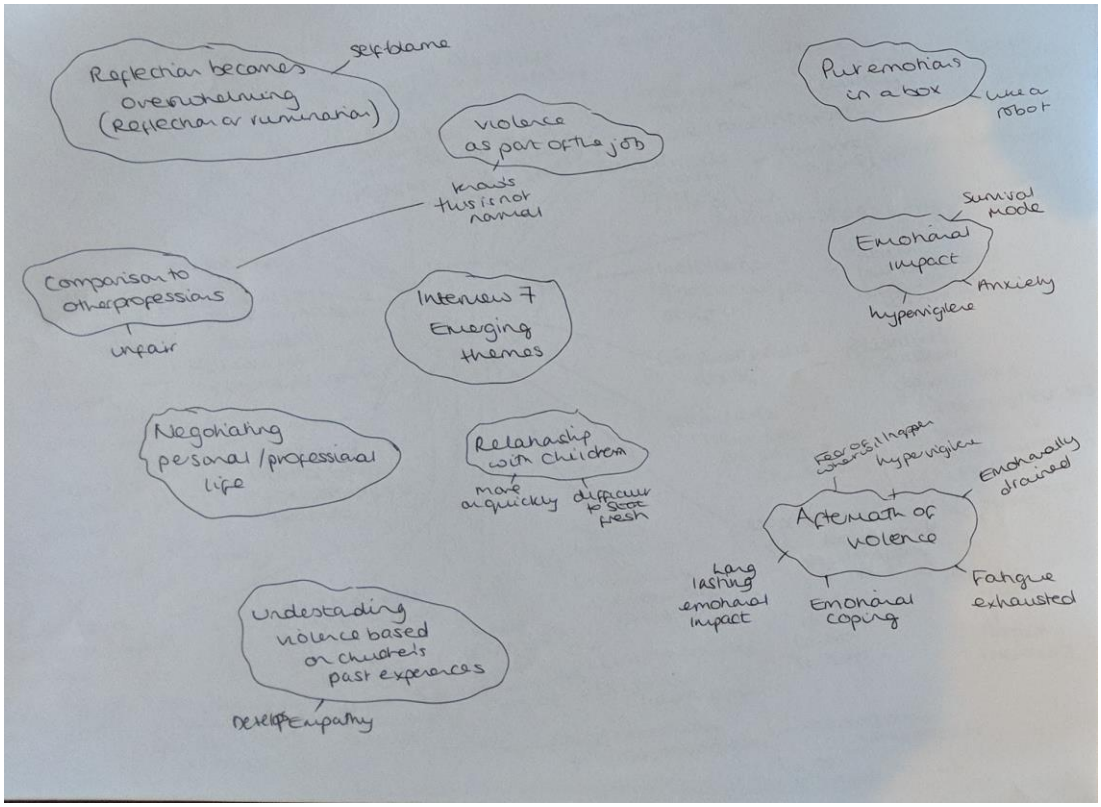
			Descriptive codes	Conceptual and linguistic codes
1.	R	So, generally this should last about an hour, some have been a bit shorter and others a bit longer		
2.		and as I said there are some general questions but if we go off then that is absolutely fine umm so		
3.		as I said this is more about the work with the EBD (emotional, behavioural difficulties) children that		
4.		you work with. I am going to start off with a broad question but then we will go more specific into a		
5.		particular incident you have experienced.		
6.	P	Sure..		
7.	R	So, can you tell me to what extent violence and aggression plays a role in your work if any?		
8.	P	I think part of our job is about that...one of the things that has got them into probably this setting	Violence and aggression as part of the job role	"part of our job" - have to accept it?
9.		is due to some sort of aggression whether it's verbal, emotional or physical...onto them or them	By the nature of the setting children are	
10.		onto others. So...they've experienced all these things and probably because they have experienced	likely to be aggressive.	Understand violence based on child's past experience
11.		all these things that has got them into the situation where they kind of like... can't function anymore	Children have experienced violence ≠ aggression	
12.		in society and they have kind of like had to be brought in by the state...so yeah. A lot.	violence ≠ aggression happens a lot	
13.	R	So how does it play out, what kind of sort of situations do you find when you are at work that		
14.		involve?		
15.	P	So...(sigh) a lot of the time, now, more often than not it's more verbal abuse. So there is a lot of,	verbal abuse is often.	Frequent verbal abuse
16.		you know, umm name calling or you know judgement calls or you know a lot of they don't like		
17.		you...not giving you specific reasons why umm but that's what it is now but if you'd have gone back	changes between verbal and physical	
18.		six months ago it was more physical...	violence/aggression	
19.	R	Ahh okay....so it changes....		
20.	P	Yeah, it was a lot more physical six months ago, it was ummm...yeah I would have probably said		
21.		now it's more like 95% verbal, if there is a challenge....if you want to look at aggression across the		
22.		board I would say now, where we are now and the children that are here if any kind of aggression	Depends on the children as to what	
23.		that would be coming it would probably be 95% verbal and 5% physical where as if I was to go back	aggression is displayed	
24.		6 months ago it would be 70% physical and 30% verbal...		
25.	R	and you mentioned about the kids...is that to do with changing children?		
26.	P	Yeah that was to do with the children that were here, there experiences in life...umm so their		
27.		experiences in life were...well all the children that come here are trauma'd, they're all trauma'd	Children experience trauma which impacts	
28.		children umm but what experience of trauma they have had probably effects how they are going to	how they feel and their behaviour	
29.		feel. So when we had children that were really really violent, and they were really violent it was very	violence is very	Violence is traumatic for staff and children
30.		traumatic...	traumatic for the children and	
31.	R	Traumatic for who?	the staff involved	
32.	P	Both of us, so I'm sure it was traumatic for the children because they were...well...they must have		
33.		gone through shit and back but it's extremely traumatic for the staff because every shift you came	Extremely traumatic for staff due to the	
34.		in you went through the same kind of aggression, day in day out...	Relentless aggression on a daily basis	
35.	R	mmmm...and what sort of aggression did you experience?		
36.	P	Well everything from...you go from verbal...you go from verbal to aggression on the environment		
37.		or the property and then you would have aggression onto staff, umm which would probably be	Realisation that the violence would	Assault - attack on a victim, self as victim?
38.		assault and then you would have aggression onto staffs property....so it's right across the board.	class as assault.	
39.		That's what we were experiencing this March.		
40.	R	Yeah...		
	P	Yeah....it was pretty bad.		

42.	R	So what is that like from your perspective?		
43.	P	How do you mean?		
44.	R	What's it like for you to have to deal with that I suppose?		
45.	P	Well, I suppose you come in here and the first thing you do...your anxiety kicks in...you, you want	Anxiety starts as soon as you walk in because of the unpredictable nature of the environment	unpredictable, don't know what will happen. Anxiety is high
46.		to be in a position where you're working in any kind of children's or social care setting where there's		
47.		a, a predictable way around things....and that's what we've got at the moment. It's quite		
48.		predictable, which is lovely, that's the way it should be, it should be kind of like...okay fine you		
49.		accept the fact that four people might not get on, they will have their little spats, you know, they've		
50.		got their own issues but they seem to kind of like get on as a group....to a degree. You know they're		
51.		not going to be all saints umm but where we were 6 months ago...none of them could get on at all.		
52.		And it was two young people that were literally taking the place apart... in every way. So young	Two children took the house apart. Impact on the other children feeling unsafe	
53.		people were making complaints, other people were complaining that they weren't very safe and		
54.		these two young people were taking the place apart and when we walked in ummm (pause) your		
55.		anxiety goes up, three or four gears and you've not even got to anything yet....but you know you're	Anxiety increases because you know you are going to get violence and you can't do anything to stop it.	Three or four gears - anxiety increase quickly, rapidly? Before anything has happened - anticipatory? out of control - can't stop it
56.		going to get there and as much as you try not to, you know you're going to get there and it's going		
57.		to happen whether you like it or whether you don't and no matter what happens it's going to get		
58.		there...		
59.	R	is that every day when you come in?		
60.	P	at that time it was....		
61.	R	So how do you cope with that when that anxiety is there and it kicks in how do you cope with		
62.		that?		
63.	P	I don't think you do...I think for me, personally, is umm....you kind of like have to, you have to	Don't cope with the anxiety	

64.		deal with the situation there and then....you can't (sigh)....you know your emotions are up there	Just cope with what is in front of you. Put your own emotions to one side	survival mode - cope with what is in front of you, emotions to one side
65.		(points high) but to a certain degree you try and put yourself to one side and deal with the situation		
66.		in front of you...it's a bit like the police and the fire service, I'm sure...you know...they go into a		
67.		fire....they know full well fire turns around and says don't go in but they go in anyway but they go in	Comparison to other professions where the anxiety is high.	Compare to life / death situations e.g fire - fear is high, life threatened?
68.		all tooled up knowing what to do with the job but it doesn't stop them from feeling scared and it		
69.		doesn't stop them from feeling frightened and it certainly doesn't stop them from feeling		
70.		anxious...the downside for that is when they come out the other side they have to deal with how	Dealing with the aftermath of violence is the difficult part - having to cope with the emotions you are left with	Aftermath of violence - emotional coping is difficult
71.		they felt and how they off load that....that's the difficult part... that's the part I think has the biggest		
72.		impact. Because you're dealing with a situation there which can be really really intense and you		
73.		know...you could have a brick thrown at you, you could have you know...someone throwing a fist at		
74.		you or barge at you or somebody breaking somebody else's bike or throwing somebody else's bike		
75.		at you or kicking windows and god knows what and you know you have to stop them but we've been		
76.		given all the, you know, the physical techniques of how to stop them and everything...but it doesn't		
77.		stop you from getting hurt...it just means it minimises you from being hurt...		
78.	R	Physically?		
79.	P	Physically yeah....but you still get a knock in. I've still got...I had bruises and everything...there was	Physical impact of violence.	
80.		one situation where one kid just launched a shoe at me...I mean...it was smarted and four days later I		
81.		looked down and there was a dirty great big bruise...you know, so while that was one part of a		
82.		situation that probably lasted 4 hours, that was just one act. The ramifications of it was days	The impact it has on you afterwards. Feeling tired and mentally drained - Need to be able to put it in a box and put it away	Fatigue - exhausted psychologically drained
83.		after...so I don't believe it's...yes you're dealing with the stress of it then but I still think it's not the		
84.		thing that's the problem...it's afterwards and the fatigue afterwards and the mental umm ability to		
		kind of like put it in the box and put it away...		Have to put emotion in a box "away"?

Appendix K: Example of emergent themes





Appendix L: Certificate of ethical approval for empirical study

Certificate of Ethical Approval

Applicant:

Claire Sweeney

Project Title:

Exploring the lived experience of therapeutic support staff who have experienced violence perpetrated by looked after children in residential care

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

19 January 2017

Project Reference Number:

P49056

Appendix M: Journal of Family Violence- author guidelines

Journal of Family Violence

General

Manuscripts, in American English, should be submitted to the Editor's Office via the journal's web-based online manuscript submission and peer-review system:

https://www.editorialmanager.com/jofv/

Manuscript Submission

Inquiries regarding journal policy, manuscript preparation, and other such general topics can be sent to the Editor's editorial assistants:

Dr. Robert Geffner, Ph.D., ABN, ABPP

Institute on Violence, Abuse and Trauma

Alliant International University

10065 Old Grove Road

San Diego, CA 92131

Editorial Assistants: Amber K. Ulrich and Sarah Nicholson: journals@alliant.edu

The online system offers easy straightforward log-in and submission; supports a wide range of submission file formats [such as Word, WordPerfect, RTF, TXT, and LaTeX for manuscripts; TIFF, GIF, JPEG, EPS, PPT, and Postscript for figures (artwork)]; eliminates the need to submit manuscripts as hard-copy printouts, disks, and/or e-mail attachments; enables real-time tracking of manuscript status by author; and provides help should authors experience any submission difficulties.

Manuscripts should be checked for content and style before submitting (must follow latest version of the American Psychological Association Publication Manual; correct spelling, punctuation, and grammar; accuracy and consistency in the citation of figures, tables, and references; stylistic uniformity of entries in the References section; etc.), or the editorial assistants will return the manuscripts before outside reviews. Page proofs are sent to the designated author for proofreading and checking. Typographical errors are corrected; authors' alterations are not allowed.

Publication Policies

Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to Springer Science+Business Media, LLC will be required before the manuscript can be accepted for publication.

The necessary forms for this transfer can be found on the journal website and on the journal's Editorial Manager log-in page.

Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

Manuscript Style

The entire manuscript should adhere to APA 6th edition standards including: Times New Roman 12 pt. font, 1” all around page margins, with a page header at ½" and entire manuscript should be double spaced, left aligned with .5” first line indents. Quotations, references, figure-caption list, and tables must also adhere to APA 6th edition guidelines. With quotations of 40 or more words, DO NOT use quotation marks. Set off the quotation in Block style format indented ½". Number all pages consecutively with Arabic numerals, with the title page being page 1 and include a running head on all pages. The suggested running head should be less than 40 characters (including spaces) and should comprise the article title or an abbreviated version thereof

A title page should be uploaded as the first page of the manuscript and should include only the title of the article. Do not include author's name or author's affiliation or other identifying names since the manuscripts undergo anonymous reviews. An abstract is to be provided, and should be no more than 150 words. Abstract should be flush left and left-aligned. A list of 4−8 key words is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. Where there are six or more authors, only the first author’s name is given in the text, followed by et al., unless there are more than two references with the same author surname and same year. In this case, list as many others as needed (usually no more than two or three) to indicate which reference you are referring to followed by et al.

References

Journal Article - Elements Needed: Author's surname and initials of first and middle name (if given). (Year of publication). Title of article. Publication information which includes: Journal title and volume number (italicized), the inclusive page numbers, and the digital object identifier (DOI) if one is assigned.

Periodicals with Three to Seven Authors

Georgesen, J. C., Harris, M. J., Milich, R., & Young, J. (1999). “Just teasing…”: Personality effects on perceptions and life narratives of childhood teasing. Personality and Social Psychology Bulletin, 25(10), 1254-1267.

• Periodical with More than Seven Authors (cite first six authors, three ellipsis points, and final author. If seven authors, list all seven).

Kaukiainen, A., Bjorkqvist, K., Lagerspetz, K., Osterman, K., Salmivalli, D, Rothberg, S., ... Jones, K. (1999). The relationships between social intelligence, empathy, and three types of aggression. Aggressive Behavior, 25(2), 81-89.

Book - Elements needed: Book authors or editors, date of publication, book title, city and state in which publisher is located, and name of publishing company.

Elkind, D. (1978). The child's reality: Three developmental themes. Hoboken, NJ: Lawrence Erlbaum Associates.

Contribution to a Book – Elements needed: Author's surname and initials of first and middle name (if given), date of publication. Title of article or chapter. “In” book author or editors “(Eds.)”, book title (“pp.” page numbers), city and state in which publisher is located, and name of publishing company.

Duckworth, J. C., & Levitt, E. E. (1994). Minnesota Multiphasic Personality Inventory-2. In D. J. Keyser & R. C. Sweetland (Eds.), Test critiques: Vol. 10 (pp. 424- 428). Austin, TX: Pro-Ed.

Footnotes

Footnotes should be avoided. When their use is absolutely necessary, footnotes should be numbered consecutively using Arabic numerals and should be typed at the bottom of the page to which they refer. Place a line above the footnote, so that it is set off from the text. Use the appropriate superscript numeral for citation in the text.

APA Tips

Acronyms

Acronyms should always be spelled out the first time used. For example, Minnesota Multiphasic Personality Inventory (MMPI); posttraumatic stress disorder (PTSD); Diagnostic and Statistical Manual of Mental Disorders (DSM). Thereafter, use the acronym.

****

Spacing

In the text, double space after punctuation marks at the end of a sentence; however, single space the references, after colons, commas, semicolons, periods that separate sentences or parts of a reference citation, and after the periods of the initials of personal names (e.g., Zellner, J. A.). Do not space after internal periods in abbreviations (e.g., a.m., i.e., e.g.).

****

Numbers

Use the Arabic symbol with numbers 10 and above (12, 50, etc.); numbers in the abstract of the paper or in a graphical display within the paper, numbers that precede a unit of measurement (5-mg dose; 10.54 cm); numbers that represent statistical or mathematical functions, fractions or decimal quantities, percentages, and ratios; numbers that represent time, dates, ages, scores, exact sums of money. When beginning a sentence or when using a number below 10, spell it out. To make plurals out of numbers, add 's' with no apostrophe (e.g., the 1990s). Use combinations of written and Arabic numerals for back-to-back modifiers (six 4-point scales).

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Headings and Subheadings (pp. 111-115 in 5th Ed. of APA Manual)

Headings range from a Level 1 heading to a Level 5. They should not be preceded by numbers or letters. They are as follows:

Centered Title Case Heading (Level 1 Heading)

Flush Left, Boldface, Title Case Heading (Level 2 Heading)

• Indented (½"), boldface, lowercase paragraph heading ending with a period. (Level 3 Heading) The first sentence then begins immediately after the heading.

• Indented, boldface, italicized, lowercase paragraph heading ending with a period. (Level 4 Heading)

• Indented, italicized, lowercase paragraph heading ending with a period. (Level 5 Heading)

Indented (½"), boldface, lowercase paragraph heading ending with a period. (Level 3 Heading) The first sentence then begins immediately after the heading.

Indented, boldface, italicized, lowercase paragraph heading ending with a period. (Level 4 Heading)

Indented, italicized, lowercase paragraph heading ending with a period. (Level 5 Heading)

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• Illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals and cited in numerical order in the text. Photographs should be high-contrast and drawings should be dark, sharp, and clear. Artwork for each figure should be provided on a separate page. Each figure should have an accompanying caption. The captions for illustrations should be listed on a separate page.

• Tables should be numbered (with Roman numerals) and referred to by number in the text. Each table should be typed on a separate sheet of paper. Center the title above the table, and type explanatory footnotes (indicated by superscript lower−case letters) below the table.

• If there are tables and/or figures, they must be referred to in text (e.g., see Table 1). In addition, you should provide an indication of approximately where the table/figure should be placed within the manuscript. This indicator should be placed at a natural break in the text (e.g., between paragraphs or between sections) after the corresponding in-text citation of the table/figure.

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Appendix N: The British Journal of Social Work- author guidelines

Instructions and Notes for Authors and other Contributors

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2. **Footnotes** : Footnotes expanding content are not admitted.
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7. **Supplementary Material** Only directly relevant material should be included in the full text of manuscripts. Supporting materials which are not essential in the full text, but would nevertheless benefit the reader, can be considered for publishing as online-only supplementary data. Supplementary data should be submitted for review, in a separate file from the manuscript. Authors should ensure that supplementary data is labelled appropriately and is referred to in the main manuscript at an appropriate point in the text.

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