VOLUME I: RESEARCH COMPONENT

DOMESTIC VIOLENCE – CHILDREN, FAMILIES AND PROFESSIONALS

BY

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Thesis Overview

Volume I is divided into two papers. The first is a literature review that explored the emotional experience of professionals who work with victims of domestic violence. Twelve papers are evaluated and the evidence of negative and positive effects is presented. The second is a qualitative study with young people, their mothers and their grandmothers which explored resilience after domestic violence. Data was analysed using Interpretative Phenomenological Analysis. Four themes regarding the memories of domestic violence, newfound stability, acceptance and strength and continued and re-scripted attachments were found.

Volume II consists of five reports. The first describes the assessment of a 13-year-old boy with low self-esteem. His needs and strengths are formulated from two approaches: cognitive-behavioural and systemic. The next discusses a behavioural intervention and single case experimental design for a 15-year-old male presenting with challenging behaviours. The third paper outlines a Person Centred Care training program for staff working with older adults. The fourth is a case study of two siblings in local authority care. To consider care-plans, a formulation is informed by the complex trauma literature. The final report was an oral presentation of an admission assessment of a young woman in a high secure hospital.

Acknowledgments

I would like to thank all the young people, their parents and their grandmothers, who took part in my research. Their time, interest and enthusiasm in the project were incredible and without them, this thesis would not have been possible. I found their stories heart-wrenching, yet up-lifting, but most of all, inspirational. I would also like to thank the staff at the Domestic Violence Support Service and the Child and Adolescent Mental Health Service. They took the time to discuss and understand the study and worked extremely hard in recruiting families. Again, their passion for the study was fantastic. I also appreciate the time and support of my research supervisors over the course of the project, Dr Louise Dixon and Dr Helen Rostill, whose knowledge was invaluable – particularly Louise for helping me know how important it is to tell a story and Helen for her inspiration and passion. My thanks also go to Dr Jan Oyebode, who gave her time to this qualitative exploration without hesitation. She was committed and enthusiastic and gave me a space to nurture and develop this work.

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Literature Review

Investigating the Experience of Professionals who Work with Female Domestic Violence Victims: A Review

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Abstract

This literature review aims to explore the negative and positive emotional effects of professionals who work with victims of domestic violence, and the factors which intensify or buffer these effects. A systematic search of electronic databases identified quantitative and qualitative studies that reported on the emotional experience of working with domestic violence victims. Twelve papers met the inclusion criteria. Papers were assessed for their quality according to the methodological framework proposed by Sale and Brazil (2004). The quality assessment illustrated six studies were of good quality, five were of moderate quality and one was of poor quality. The review found no indication for clinical levels of burnout; however findings supporting the presence of secondary traumatic stress and vicarious trauma in this population were evident. Positive effects, some conceptualised within vicarious posttraumatic growth were also found. Several factors were shown to intensify and buffer negative effects and are presented in detail. Clinical and research implications of the findings are discussed.

Keywords: 'domestic violence'; 'staff'; 'burnout'; 'secondary trauma', vicarious posttraumatic growth'

Investigating the Experience of Professionals who Work with Female Domestic Violence Victims: A Review

The government is committed to healthier workplaces, aiming to ensure that people are protected from potential harm in their job roles (Department of Health, 1998). Recent consultation (Department of Health, 1999) acknowledged that good-quality working lives of National Health Service (NHS) staff are necessary to provide good-quality care for patients. A subsequent white paper (Department of Health, 2005) documented the NHS as a model employer in supporting and promoting health, including the mental health of its work-force (Borrill et al., 1998). Those working in caring professions are identified as being more at risk of experiencing high levels of work stress in comparison to any other occupational groups in the UK (Smith, Brice, Collins, Matthews & McNamara, 2000). It is important that research explores the effects of work stress on staff to ensure procedures can be put in place to protect staff and clients.

Emotional Experience of Staff Working With Trauma Victims

Work with traumatised clients has been shown to impact negatively on staff stress levels, although findings on this issue are mixed. Sabin-Farrell and Turpin (2003) completed an influential review on the extent of vicarious trauma in mental health workers. Their review of the broad literature showed the evidence supporting the negative impact of trauma on staff stress is inconsistent and insufficient. The exception is literature reporting on intrusive trauma responses (i.e., imagery; dreams; thoughts relating to DV trauma). For instance, higher posttraumatic stress symptoms in staff were associated with cumulative exposure to client trauma (Brady, Guy, Poelstra & Brokaw, 1999), a higher caseload of trauma clients (Schauben & Frazier, 1995) and less experience of trauma work (Pearlman & MacIan, 1995). In addition, the review highlighted the difficultly of distinguishing whether the negative experiences observed in staff working with traumatised clients was as a result of their therapeutic work, or as a result of other characteristics. For example, little examination of workplace variables which may interact with other variables, such as client caseload/

exposure, experience and education, or peer support was described in the literature. There is also a lack of understanding about variables that may either intensify or buffer these negative reactions, such as a history of personal trauma or positive coping strategies. Finally, Sabin-Farrell and Turpin's (2003) review also acknowledged the positive effects of working with this population and questioned whether this helped staff to manage the negative impact upon their role.

Theoretical Explanations

Several mechanisms have been proposed to explain the process by which professionals may experience positive or negative emotions from work with client groups exuding trauma. These most commonly include burnout (BO), secondary traumatic stress (STS), vicarious traumatisation (VT) and vicarious posttraumatic growth (VPTG).

Maslach (1982) defined BO as a "syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do people-work of some kind" (p. 98). Symptoms include low morale and self-esteem and high absenteeism, interpersonal difficulties and physical health complaints. The Maslach Burnout Inventory (Maslach & Jackson, 1986) measures total BO and levels of emotional exhaustion, depersonalisation and personal accomplishment.

STS has been defined as "the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other" (Figley, 1995 p. 7). Compassion for others is thought to become exhausting, which results in limited empathy and an inability to find resolve through helping others. Symptoms include re-experiencing the client's traumatic events through thoughts, feelings and imagery, physical complaints (Figley, 1995), interpersonal problems, a heightened awareness of victimisation and extreme identification with, or detachment from, clients (Dutton & Rubenstein, 1995). There is no widely accepted measure of STS.

VT involves a clinician experiencing traumatic reactions as a result of their work with victims of trauma. It is believed to effect how one experiences and relates to themselves, others and the world and symptoms are manifested through disrupted cognitive schemas (e.g., identity; world-view; self-capacities and abilities; psychological needs and beliefs, Saakvitne & Pearlman, 1996) or intrusive trauma imagery (e.g., client's traumatic memories incorporated into the therapist's memory system in the form of flashbacks or painful emotional reactions, Pearlman and MacIan 1995). VT is empirically examined with the Trauma Symptom Inventory Belief Scale (Pearlman, MacIan, Johnson & Mas, 1992).

VPTG (Arnold et al., 2005) relates to positive emotional experiences and is theorised to include increased recognition of personal strength and self-confidence, improved personal relationships, enhanced appreciation of what is important in life, and spiritual growth. The Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996) has been developed to evaluate this phenomenon, however little explorations have been afforded to date.

Emotional Experience of Staff Working With Victims of Domestic Violence Trauma

Women who have experienced violence in their relationship/s are one client group that frequently present with trauma and/or mental health issues. There is now an accumulation of convincing research that highlights the detrimental effects of domestic violence (DV) for women (Bonomi et al., 2009) and their children (Carpenter and Stacks 2009). Many organisations are dedicated to the prevention of DV and treatment of its victims; however, DV services continue to be chronically underfunded (Coy, Kelly & Foord, 2009), despite the grave risk of harm to women in violent relationships (Smith et al., 2010). Working with this client group may also pose risks of direct violence toward staff from perpetrators, due to only 24% of DV incidents being reported to the Police (Walby & Allen, 2004). However, the Crown Prosecution Service (CPS) has stated all DV incidents resulting in deaths will be subjected to a multi-agency review (CPS, 2011), demonstrating that DV remains a priority in the national agenda. As suggested previously (Sabin-Farrell & Turpin,

2003; Sexton, 1999), understanding the direct relationship, if any, between work with traumatised clients and subsequent negative experiences for staff is essential if organisations wish to uphold their duty of care to staff (i.e., assessing and reducing potential areas of risk). If this area remains misunderstood, it could potentially lead to future litigations and claims for psychological injury at work by staff who have not been clearly informed of the risks posed from work with traumatised clients. Despite this and extensive research into the phenomenon of DV itself, little research has examined the emotional impact experienced by professionals working with victims of DV. The experience of being repeatedly exposed to violent narratives is commonplace for DV workers, as is exposure to victims and their families recovering from the violence they were subjected to.

Objectives of the Review

This review of existing literature aims to explore the emotional experience of professional staff working with female victims of DV. This review only includes studies of male to female violence, as this is the most commonly studied area to date allowing for sufficient studies for review. The following research questions are investigated:

1a: Does working with adult female victims of DV result in a negative emotional experience for staff and if so, how is this conceptualised?

1b: Does working with adult female victims of DV result in a positive emotional experience for staff and if so, how is this conceptualised?

2a: What factors intensify negative emotional experiences for staff?

2b: What factors buffer negative emotional experiences and/or intensify positive emotional experiences for staff?

Method

Search Strategy

A systematic search of two electronic databases ISI Web of Knowledge and PsycINFO was conducted between 1st October 2010 and 31st January 2011 to identify peer

reviewed articles for this review (see Appendix 1). The titles and abstracts of studies were examined against criteria in Table 1. The search was augmented by a manual review of the references of key articles. Emails to established authors in the area were sent. Of the total number of hits and additional papers found from reference sections of the papers found in the search, twelve met the inclusion and exclusion criteria outlined in Table 1. Figure 1 illustrates this process.

Table 1.

Details of inclusion and exclusion criteria for papers considered for review

Inclusion Criteria	Exclusion Criteria
• Report on some staff effect, explored either quantitatively or qualitatively, of the negative or positive experience of working with female survivors of DV • Report on the factors that impact (intensify or buffer) the negative and/or positive effects of working with female DV victims for staff • Include a sample of individuals working with adult female victims of DV • Published and peer reviewed research papers	• Not published in English • Reported only on the attitudes of professionals (e.g. prevalence, myths, barriers, opportunities) towards DV • Reported only on the training of professionals working with DV victims

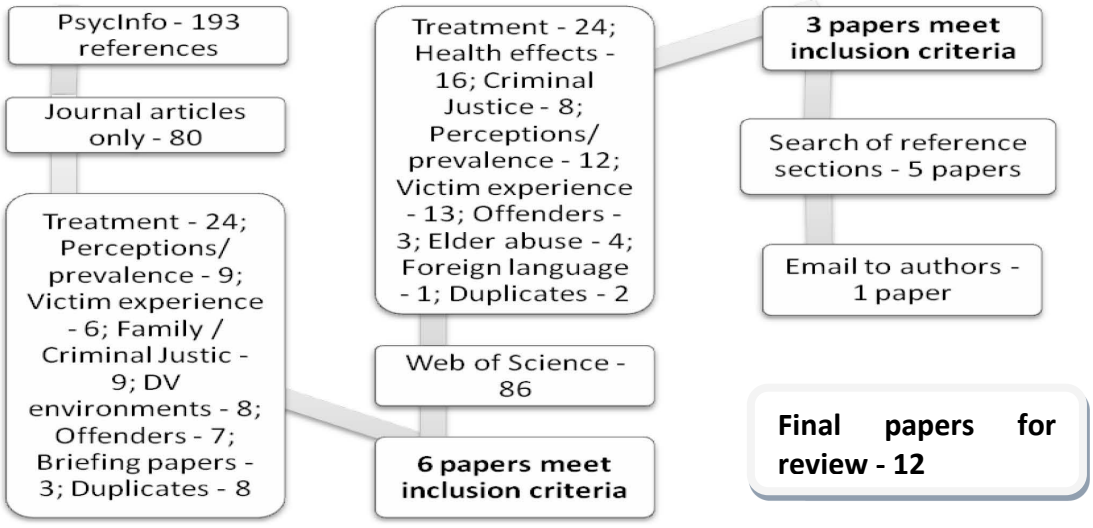

Figure 1. Process of retrieving final 12 papers

Data Synthesis

The author designed a data extraction form (Appendix 2) to facilitate the review of the 12 resultant papers with regards to the research questions

Quality Appraisal Criteria

This review includes studies of quantitative, qualitative and mixed-method research designs. The critical appraisal framework described by Sale and Brazil (2004) was deemed most appropriate to review the quality of studies in this review, as it provides a framework to critique studies using either one, or both, of these methodologies. Sale and Brazil (2004) suggested the framework would encourage researchers to present more complete and relevant information in peer-reviewed articles and therefore, the framework includes a variety of methodological appraisal criteria.

The appraisal criteria were developed under the assumption that quantitative methods are linked with positivist paradigms whilst qualitative methods are linked with paradigms of constructivism and interpretivism. Through maintaining method-specific criteria, this approach (i.e., Sale & Brazil) does not blend methodological assumptions and instead, offers equal value to each method, allowing fair comparison of studies, despite methodology.

Sale and Brazil (2004) chose Lincoln and Guba's (1985) theoretical approach to devise their criteria, as it has the capacity to dovetail both quantitative and qualitative paradigms and organise the criteria needed for critical appraisal in a simple manner. Specifically, criteria are organised into four goals of truth value, applicability, consistency, and neutrality (see Table 2). Each goal contains appraisal criteria that can be used to assess the quality of qualitative, quantitative and mixed-design studies (see Appendix 3 for the criteria specific to each goal).

Table 2
Methodological categories pertinent to Sale and Brazil's (2004) appraisal criteria

Main goal	Definition
Truth Value	Internal validity for quantitative methods versus Credibility for qualitative

	methods
Applicability	External validity for quantitative methods versus Transferability or fittingness for qualitative methods
Consistency	Reliability for quantitative methods versus Dependability for qualitative methods
Neutrality	Objectivity for quantitative methods versus Confirmability for qualitative methods

Each paper in the review is subject to this appraisal and rated on the series of criteria described by Sale and Brazil (2004). The mixed method papers are subject to criteria set out in both the quantitative and qualitative paradigms, whilst the remaining papers are appraised by their appropriate paradigm. Each variable is scored from 0-2 (0: denotes no available evidence; 1: indicates partial evidence; and 2: indicates definite evidence). This is laid out in the quality assessment proforma, which details the scoring process for each of the 12 studies included in the review (see Appendix 4).

To date, no published reviews have applied this framework when considering and synthesising different research methods and paradigms. Whilst completing the review, several dilemmas regarding this became apparent. Firstly, it is not clear how to best categorise and manage the 'weaker' studies in the review. One option would be to exclude such studies from the review. However, it is recognised that final quality scores may be influenced by the information accepted or required by journal editors, rather than primarily the quality of the paper itself. Therefore, in this review, all papers, despite their quality score, are included. Secondly, the reader is reminded that this review attempts to synthesise the results of research studies which make different claims (i.e., the quantitative results describe the relationships between variables and in some cases, map out causal relationships, whilst the qualitative results are describing people's experiences of, or explanations for, those relationships).

Results

Summary of Studies

Of the 12 studies identified from the search, four used a semi-structured interview and qualitative analysis (Bell, 2003; Goldblatt, 2009; Goldblatt, Buchbinder, Eisikovits & Arizon-Mesinger 2009; Iliffe & Steed, 2000). Two studies adopted a mixed-methodology (Ben-Porat & Itzhaky, 2009; Jenkins, Baird, Whitfield & Meyer, 2010). The remaining six employed quantitative analysis (Baird & Jenkins, 2003; Baker, O' Brien & Salahuddin, 2007; Brown & O' Brien, 1998; Bemiller & Williams, 2011; Dekel & Peled, 2000; Slattery & Goodman, 2009). The quantitative data in two studies (Baird & Jenkins, 2003; Jenkins, Baird, Whitfield & Meyer, 2010) is drawn from the same population and therefore, the original quantitative data is described once with regards to Baird and Jenkins (2003). Table 3 provides a summary of the papers' authors, origin, participant demographics and measures used.

Quality Assessment

The 12 papers were assessed for methodological quality using Sale and Brazil's (2004) framework (see Quality Appraisal Criteria above and Appendices 3 and 4). This quality review is taken into account when interpreting findings with regards to the research questions guiding the review.

Table 4 depicts how total quality assessment ratings were produced for each paper and is outlined in more detail in Appendix 4. Total percentage scores were assigned to each quantitative paper based on the summation of percentage scores assigned to three main goals. Total percentage scores were also assigned to qualitative papers, based on summation of percentage scores assigned to four main goals (see Table 4). The total percentage scores assigned to each study correspond to one of three resulting categories; good (≥80% or above), moderate (60-80%) or poor (≤60% or below). Total percentage scores for the 12 papers ranged between 44-97%. Papers in the top 20% of ranked scores were deemed to be good, the

next 20% of moderate quality, and next 20% of poor quality. According to this framework six studies were rated as good, five as moderate and one as poor quality.

It is clear to see the majority of studies were deemed to be of good quality in this review. In comparison to moderate quality studies, good quality studies tended to incorporate regression analyses to support results obtained in the correlation analyses, and therefore, examined the best predictors of the emotional experiences of DV staff. The poor quality study lacked appropriate and detailed description of the data analysis.

Table 3.
Summary of participant demographics and measures used in the 12 studies reviewed

Study	Participant demographics					Measures used (see Appendix 4 for detailed description)	
Origin	Sample Size / Age / Gender	Role	Years in Job	Education	Past trauma	RQ1 – Effects	RQ2 – Factors
Quantitative studies							
Brown and O'Brien (1998) North America	91/ M= 32.8 (SD= 9.59)/ 89=Female 1=Male	Shelter worker	0-144 months M= 29.62 (SD= 28.43)	Not assessed	Not assessed	• Maslach Burnout Inventory (MBI) • Shelter stress Inventory (SSI) • Adapted version of Job Stress Index (JSI)	• Perceived Social Support Scale (PSSS) • COPE • Motivation for employment scale
Baker, O'Brien and Salahuddin (2007) North America	128 (74%)/ M= 37 (SD= 9.48)/ 94%= Female, 2%= Male, 2%= No info	Shelter worker	71 months (SD= 56.5) (Full-time and part-time staff)	Not assessed	Not assessed	• MBI • (D scale only used for descriptive purposes due to low reliability estimate in sample)	• Adapted version - Job Stress Index (JSI) • Adapted version- Social Provisions Scale (SPS) • Adapted version - General Self-efficacy Scale (GSS) • Adapted - Brief COPE • Generalised Self-efficacy Scale (GdSS) • Level of exposure
Dekel and Peled (2000) Israel	55/ M= 42 (SD= 10.49)/ Female	Shelter worker	M= 52 months (SD= 64)	10-20 yrs formal education (M= 14.9; SD= 3.05)	Not assessed	• MBI • "After hours" Burnout	• Adapted measure of social support – House Questionnaire (H) • Level of exposure

Slattery and Goodman (2009) America	148 (79 online, 71 paper)/ 19-65 (M= 36; SD= 12)/ Female	DV staff	1-25 (M= 6 years)	High school diploma – doctorate; (78% college graduates)	Yes = 55.4%, No= 44.5%	• PTSD Checklist-Stressor Specific Version (STS)	• Relational Health Index-Mentor • Shared Power Scale (SP) • Work Environment Scale (WSS) (measuring social support) • Survivor of trauma (S) • Level of exposure
Baird and Jenkins (2003) North America	101/ 21-65 years/ 96 = Female, 5 = Male	Counsellors; Manger/ Supervisor; Crisis worker; Other	Paid – M = 51 months; volunteers – M = 9.3 months	Degree- 36.6%; Masters- 46.5% (in mental health – 62.4%); High school diploma- 13.9%	Yes = 55%, No = 45%	• Compassion Fatigue Self-Test for Psychotherapists (CFST, measuring STS) • TSI-Belief Scale (TSI-BS, measuring VT) • MBI (measuring BO) • SCL-90-R (measuring distress)	• Level of Exposure to clients • TSI Life Events Checklist (past trauma history)
Bemiller and Williams (2011) North America	194/ 21-60+/ 99.5% = Female; 0.5% = Male	DV / SA advocates	<1 year= 25.3%, 1-5 years= 4.6%, 6-10 years= 41.2%, 10+= 18.6%	High school/ college= 33.5%, Degree= 56.5%	Yes = 51.5%, No= 48.5%	• MBI	• Questions measuring – Job demands (hours per week, after hours, outside agencies) and resources (tools and autonomy); Work environment (safety, support, fair process, co-worker stress) • Level of exposure

Mixed method studies

Ben-Porat and Itzhaky (2009) Israel	214 (143 in DV field; 71 not in DV field)/ M= 39.11; SD= 12.48/ 84% = Female, 15.4% = Male	Social worker (31.5% had admin or therapist; 68.5% practising SW)	Not assessed	50% had BSc; 49% has MSc or higher	Not assessed	• Secondary Traumatic Stress Scale (STSS) • Post-traumatic Growth Inventory	• Open-ended questions about negative and positive changes in themselves, their lives, and families as a result of their work. Theory on which qualitative data analysis was unclear
Jenkins, Mitchell, Baird, Whitfield and Meyer (2010) North America	101/ 21-65 years/ 96 = Female, 5 = Male	Volunteer or paid staff working with DV or sexual assault victim	Paid – M = 51 months; volunteers – M = 9.3 months	Degree-36.6%; Masters-46.5% (in mental health – 62.4%); High school diploma-13.9%	Yes = 55%, No = 45%	• CFST (STS) • TSI-BS (VT) • MBI (BO) • Symptom Checklist-90 Revised (general distress)	• TSI (previous trauma) • Motivations of why they chose to work in DV or SA. • General changes in themselves or seeing those in clients Content analysis for qualitative data

Qualitative studies

Study Origin	Sample Size / Age / Gender	Profession	Demographics Years in Job	Education	Past trauma	Measure / Analysis
Goldblatt (2009) Israel	22 / no information / Female	Hospitals and community healthcare clinics	1-25 years	Not assessed	Not assessed	• Semi-structured interview • Thematic content analysis
Iliffe and Steed (2000)	18 / 45yrs (mean) /	Counsellors	5.5 years (1-17)	Not assessed	Not assessed	• Semi-structured interview

Australia	13 = Female; 5 = Male					• Interpretative phenomenological analysis
Bell, H. (2003)	30 / 20-29=9; 30-39=9; 40-49=7; 50+= 5 / 97% = Female; 3% = Male	Counsellors	No information	No degree=27%; BSc= 17%; MSc= 49%; ClinPsy=7%.	Yes = 29, No = 1	• Semi-structured interview • HyperRESEARCH – a qualitative data analysis program
Goldblatt, Buchbinder, Eisikovits and Arizon-Mesinger (2009) Israel	14 / 29-52 / Female	Senior social workers	5-23 years	11 – MSc; 3 - BSc	Not assessed	• Semi-structured interview • Qualitative content analysis

Table 4
Summary of quality criteria standards and quality assessment ratings for each paper in the review

	Study											
Quality Criteria	Bemiller & Williams (2011)	Slattery & Goodman (2009)	Goldblatt et al. (2009)	Baird & Jenkins (2003)	Jenkins et al. (2010)	Ben-Porat & Itzhaky (2009)	Goldblatt (2009)	Baker, O' Brien & Salahuddin (2007)	Dekel & Peled (2000)	Iliffe & Steed (2000)	Brown & O' Brien (1998)	Bell (2003)
Truth Value	14 / 14 – 100%	12 / 14 – 85%	17 / 24 – 71%	13 / 14 – 92%	19 / 24 – 79%	10 / 24 – 42% ; 10 / 14 – 71%	16 / 24 – 66%	8/14 – 57%	8/14 – 57%	15/ 24 – 63%	8 / 14 – 57%	8 / 24 – 33%
Applic-ability	46 / 50 – 92%	44 / 50 – 88%	34 / 36 – 94%	43 / 50 – 86%	26 / 36 – 72%	18 / 36 – 50% ; 35 / 50 – 70%	28 / 36 – 72%	48 / 50 – 96%	46 / 50 – 92%	23 / 36 – 64%	39 / 50 – 78%	27 /36 – 75%

Consis-tency	2 / 2 – 100%	2 / 2 – 100%	2 / 2 – 100%	2 / 2 – 100%	2 / 2 – 100%	2 / 2 – 100% ; 2 / 2 – 100 %	2 / 2 – 100%	2 / 2 – 100%	2/2 – 100%	2 / 2 – 100%	2 / 2 – 100%	1 / 2 – 50%
Neutra-lity			6 / 6 – 100%		2 / 6 – 33%	2 / 6 – 33%	4 / 6 – 66%			2/6 – 33%		1 / 6 – 17%
Total Quality	97%	91%	91%	93%	71%	63%	76%	84%	83%	65%	78%	44%

Review of Findings

A detailed illustration of findings is available in Appendix 6 and key findings are synthesised in Table 5.

Research Question 1a: Does working with adult female victims of DV result in a negative emotional experience for staff and if so, how is this conceptualised?

Good quality studies. All six studies of good quality tested for negative emotional experiences of working with DV victims. Four tested for BO and all concluded average levels were present in DV staff (Baird & Jenkins, 2003; Baker, O' Brien & Salahuddin, 2007; Bemiller & Williams, 2011; Dekel & Peled, 2000). Based on Maslach and Jackson's (1986) definition of BO, this is not clinically significant. One study (Dekel & Peled, 2000) examined the impact that DV work may have on staff outside work (i.e., 'after-hours-BO'). Clinical levels of this experience were reported.

Some conflicting evidence regarding the presence of STS was revealed in two good quality studies. Baird and Jenkins (2003) found no evidence of clinical levels of STS; however Slattery and Goodman (2007) reported clinical levels of this experience in nearly half of their participants (47.3%) who completed the PTSD Checklist-Stressor Specific Version (PCL-S; Weathers, Litz, Herman, Huska & Keane, 1993). Past trauma was also evident within this sample and it is possible this result is indicative of latent symptoms from participants' past personal trauma, rather than evidence of STS as a result of their DV work.

No evidence of VT was found in the one study which directly tested for this experience (Baird & Jenkins, 2003), however a theme within Goldblatt and colleagues' (2009) results was 'violence as source of emerging worldview', highlighting violence as a metaphor against which intimate relationships are measured. As discussed earlier, VT is believed to affect the way one experiences and relates to themselves, others and the world. One married participant expressed "…I am the only one... still married… The fact that

everyone here eventually gets divorced because of what work has done to us is becoming the subject of black humour... You can't tell for sure it's because of the work, but it's work related" (p. 374). The authors also described an increasing awareness of gender inequality whereby DV workers began to re-enact gender conflicts and power struggles within their intimate relationships.

Detachment / depersonalisation is a factor, or symptom believed to occur in both BO and STS. Goldblatt et al.'s (2009) qualitative study reported emotional detachment from DV clients and that staff put boundaries in place between their personal and professional lives. Discussing this attempt, one worker expressed "... sort of closing a door, or pulling down a screen, something artificial which I place between myself and work..." (p. 371).

Finally, symptoms common to VT and STS are an increased awareness of psychological needs and beliefs. This was also evident in Goldblatt and colleagues (2009) work. Participants reflected on the sense of threat they felt for their family because of their awareness of gender inequality, and the need for the security of an intimate relationship against the search for freedom and independence.

Moderate quality studies. Studies of moderate quality found similar effects to those described in the good quality studies, such as average levels of BO, detachment, and symptoms consistent with the definitions of VT and STS.

All five moderate quality studies explored the potential negative emotional effects of DV work in some manner. One tested directly for BO (Brown & O' Brien, 1998). Average levels were found, consistent with results discussed above. Qualitative findings of two other papers (Iliffe & Steed, 2000; Jenkins et al., 2010) were deemed to be in line with BO symptoms.

One study directly tested for STS and no evidence of clinical levels was found (Ben-Porat & Itzhaky, 2009). Again, a different measure to that adopted by the two good quality

studies was used, the Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis & Figley, 2004).

As explained, VT is believed to have an impact on the way one experiences and relates to themselves, others and the world. The results from Ben-Porat and Itzhaky's (2009) qualitative exploration seem to reflect this. Exploring potential negative effects, they found DV staff reported significantly more negative changes in their spousal relations due to an awareness of power and control ($\chi^2 = 9.07$, df = 1, $p < .01$) and their views of humanity ($\chi^2 = 11.60$, df = 1, $p < .001$) than generic health staff. No other moderate quality study explored VT.

Jenkins and colleagues' (2010) results did not refer directly to depersonalisation or detachment (i.e., symptoms common to BO and STS). However, three studies in the moderate category did report evidence of depersonalisation and detachment (Brown & O' Brien, 1998; Goldbatt 2009; Iliffe & Steed, 2000). Iliffe and Steed (2000) found some participants strived for a balance between themselves and their clients' experiences. Goldblatt's (2009) thematic content analysis supports this. "Incurable" overwhelming emotions, particularly if "drawn into abused women's distress" (p. 1648) were expressed. Participants described that, although the feelings pass, it can leave them wanting to relinquish the emotionally involved and draining aspects of their role, in favour for more physical aspects. Goldblatt considers this strategy may be an attempt to rid feelings evoked through re-experiencing the women's trauma.

Symptoms common to VT and STS include the heightened awareness of psychological needs and beliefs and the re-experiencing of a client's trauma. This was evident in two qualitative studies (Goldblatt, 2009; Iliffe & Steed, 2000). A participant from Goldblatt's (2009) study described an experience where she appeared to embody the experience of the victim - "I will never forget it… It looked awful… I swear that for two

whole days I couldn't look at my face in the mirror. It kept turning into the abused woman's face, full of blood…" (p. 1650). Such experiences were consistent with earlier explorations (Iliffe & Steed, 2000), which concluded the personal impact of hearing women's stories resulted in intense and frequent negative emotional (e.g., horror, anger, emotionally drained), cognitive (e.g., visual imagery of abuse) and physiological experiences (e.g., nausea, exhaustion).

Poor quality study. Consistent with the good and moderate quality studies, Bell's (2003) study described symptoms similar to that in VT and STS.

Bell's (2003) study was a qualitative approach which interviewed participants twice in a year. The author highlighted that the majority of participants identified negative aspects of their role and analysis of the interviews enabled the author to divide the participants by their experience of distress, namely low, high or medium stress. One quote "I think I have just got used to it. After doing it for so long... I don't let it get to me to the extreme where it makes me nervous... You know, once it's over with, I'm just cool, calm and collected" (p. 517) from an individual in the medium stress group may be indicative of some detachment. However, the authors' vague description of participants' experiences means such a conclusion is unsafe. The description of participants' experiences in the high stress group was in line with definitions of STS and VT, particularly re-experiencing trauma. For instance, participants reported overwhelming emotions and questioned "when will the nightmares go away" (p. 517). Consistent with how VT refers to the change to a person's view of themselves and the world, another participant felt her personal beliefs were challenged as a result of the work and stated "I think you see the worst of people, working here... it just leaves you feeling a little baffled about.... the way things work in the world, your role in it, and all that" (p. 520).

Research Question 1b: Does working with adult female victims of DV result in a positive emotional experience for staff and if so, how is this conceptualised?

Good quality studies. Two good quality studies explored positive effects of working with DV victims. The most recent concluded that the positive experiences of working with this population outweigh any negative experiences (Bemiller & Williams, 2011), whilst previous results (Goldblatt et al., 2009) appear to map neatly onto the conceptualisation of VPTG. Participants described experiencing a sense of renewal, discovery and innovation, which transferred across to a softened family environment. Some felt DV work enabled them to discover their own emotional capabilities as client exposure helped them to move from a discourse of power and restraint to one where they experienced more resilience against external threat and were more able to perceive personal relationships in a balanced manner. One participant expressed – "My work in this area provided me with many things that I hadn't experienced previously… It's as if I've collected a sea of battered wives' tears in my imagination, which has melted my reserve, control, and denial… I built up many defences to survive in this world. But this job broke them all down." (p. 372). Finally, there were a group of participants who questioned how to ease a woman's distress, alongside attempts to manage personal emotions and perform their jobs effectively, possibly suggesting increased confidence in personal and professional capabilities.

Moderate quality studies. Moderate quality studies demonstrated a similar result to that outlined in the good quality studies, namely experiences synonymous with VPTG, however, no evidence of VPTG was found when empirically measured.

Of the five moderate quality studies, one directly tested for VPTG (Ben-Porat & Itzhaky, 2009). Two other studies (Goldblatt, 2009; Jenkins et al., 2010) adopted a qualitative approach to explore this possibility. Firstly, Ben-Porat and Itzhaky (2009) found no evidence of VPTG using the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996). The

authors also developed an instrument containing two open-ended questions asking participants to list the negative and positive changes that occurred in themselves, in their lives, and in their families as a result of their work. The authors then discussed and agreed on the themes which were drawn from these responses. This information was then subjected to chi-square tests to examine whether there were differences between the participants in the two groups (i.e., DV staff and non-DV staff). This analysis illustrated DV staff perceived significantly more positive personal (i.e., personal growth; development of assertiveness and communication skills; $\chi^2 = 17.25$, df = 1, $p < .001$) and familial changes (i.e., awareness of relations; $\chi^2 = 4.54$, df = 1, $p < .05$; and parenting; $\chi^2 = 4.24$, df = 1, $p < .05$) as a result of their work, than non-DV staff. Jenkins and colleagues (2010) also highlighted positive personal and occupational changes (e.g., professional and personal growth; learning to appreciate life). Taken together, such experiences seem to reflect Arnold and colleagues' (2005) original definition of VTPG.

Poor quality study. As with the good and moderate quality studies, again, VPTG experiences were described. However, Bell's study (2003) also highlighted a factor not described previously, namely that DV helped individuals resolve their personal trauma.

Bell's (2003) analysis revealed a picture of strength under stress. The majority of her sample was able to identify positive effects as a result of their work with DV victims. Thinking about the experience of following up clients, a supporting quote read "I'm reminded that the whole world is not in crisis... I truly feel like it's watching a rebirth of a human being... And that's the reward" (p. 516). Participants also highlighted finding strength through spiritual experiences and one of the main themes related to having a sense of competence about their roles, further representing VPTG.

Table 5.
Synthesis of key findings across the studies reviewed

Study Quality	Research Question 1		Research Question 2	
	Negative	Positive	Intensifying	Buffering
Good Quality (n = 6) (1) Bemiller & Williams (2011) (2) Slattery & Goodman (2009) (3) Goldblatt et al. (2009) (4) Baird & Jenkins (2003) (5) Baker, O' Brien & Salahuddin (2007) (6) Dekel & Peled (2000) *Moderate Quality (n = 5)* (7) Brown & O' Brien (1998) (8) Goldblatt (2009) (9) Jenkins et al. (2010) (10) Iliffe & Steed (2000) (11) Ben-Porat & Itzhaky (2009) *Poor Quality (n = 1)* (12) Bell (2003)	• Average levels of overall BO (1, 4, 5, 6, 7) • After hours BO (6) • No evidence of STS (4, 11) • Evidence of STS (2) • No evidence of VT (4) • VT-type symptoms (3, 8, 10, 11, 12) • High levels extreme detachment (3, 7, 8, 10) • STS-type symptoms (3, 8, 10, 12) • BO-type symptoms (9, 10)	• Positive effects noted to outweigh negative (1) • VPTG-type symptoms (3, 8, 9, 11, 12) • No evidence of VPTG (11) • Resolving personal trauma (12)	• Job stressors (1*, 5*, 7, 10) • Lower sense of PA (i.e. BO) (6) • More hours worked (1*, 4, 6, 10) ○ Not supported (2*, 5) • Personal trauma (2*, 9, 12) • Less therapeutic experience and high level of education (4*) ○ Not supported (1, 6) • Client exposure (10) • Mental disengagement (7) • Altruistic and personal motivations (9)	• Job stressor-time (5*) • Client exposure (1, 4*) • High level of education and experience (1*, 4*, 6) • Tools (1*) • Clinical supervision (2) ○ Not supported (1) • Social support (2, 6, 7, 10) • Shared power (2*) • Confidence (5*, 12) • Resolved personal trauma (9, 12) • Detachment (8, 10) • Using detachment and identification as strategies (8) General coping strategies (7, 9, 10)

**Finding supported by regression analysis*

Research Question 2a: What factors intensify negative emotional experiences for staff?

For the purposes of this review, the terms 'intensify' and 'buffer' are used when a relationship between two or more factors was found. Limitations of correlational analyses are acknowledged (i.e., unable to conclude causal relationship); however, regression analyses support some findings (see Table 5).

Good quality studies. Taken together, these studies found that job stressors, hours worked, a history of personal trauma and having less clinical experience intensified the negative effects for staff working with DV victims.

Two good quality studies (Baker, O' Brien & Salahuddin, 2007; Bemiller & Williams, 2011) examined whether job stressors (i.e., time pressures, organisational barriers; co-worker stress; lack of achievement) intensified or buffered the negative effects of DV work. Results suggested job stressors intensified BO, particularly emotional exhaustion. Bemiller and Williams (2011) also found that a perception of co-worker stress intensified negative emotional experiences.

Five of the six good quality studies examined the number of hours worked to understand if this was a factor which could either intensify or buffer negative effects. Three studies (Baird & Jenkins, 2003; Dekel & Peled, 2000; Bemiller & Williams, 2011) found that the more hours worked with DV victims tended to intensify higher levels of depersonalisation and emotional exhaustion (i.e., BO) and intensify 'after-hours-BO'. However, the remaining two studies found no significant effect with regard to STS (Slattery & Goodman, 2009) and BO (Baker, O' Brien & Salahuddin, 2007).

A history of personal trauma was measured in three good quality studies (Baird & Jenkins, 2003; Bemiller & Williams, 2011; Slattery & Goodman, 2007). Similar prevalence

rates were found, suggesting that approximately half of DV staff have previously experienced trauma. This is consistent with estimates of the general population (Yule, Williams & Joseph, 1999). However, only one study (Slattery & Goodman, 2007) examined this factor in relation to the negative effects of DV working, concluding a history of personal trauma was the only significant factor found to intensify STS ($\beta = .254$, $p < .01$, $R^2 = .08$).

Two studies examined education and experience with regards to negative emotional experiences (Baird & Jenkins, 2003; Dekel & Peled, 2000). Baird and Jenkins' study (2003) suggested that having less clinical experience with DV victims (i.e., making the assumption younger staff have less experience) and having a higher level of education can intensify negative experiences (i.e., BO), specifically emotional exhaustion. Dekel and Peled (2000) also found that individuals with more senior roles (i.e., making the assumption these individuals have higher levels of education and/or experience) experience more negative emotional effects. However, additional results indicate these factors can also have a buffering effect on negative experiences and are discussed below. Perhaps linked, Bemiller and Williams' (2011) study found that length of stay in the role had neither an intensifying nor buffering effect against negative emotional experiences.

Moderate quality studies. The moderate quality studies found job stressors, a history of past personal trauma, detachment from clients, and having altruistic or personal motivations for DV work intensified the negative effects of working with this population.

Two studies (Brown & O' Brien, 1998; Iliffe & Steed, 2000) examined job stressors, concluding that job stressors, particularly time pressures and organisational barriers (e.g., lack of training and isolation from other professionals) intensified negative emotional experiences, namely BO.

One study (Iliffe & Steed, 2000) concluded BO was intensified by long hours and more client exposure. Another questioned whether a history of personal trauma had an impact on the negative emotional experiences of DV workers (Jenkins et al., 2010) and concluded that a history of past personal trauma could intensify experiences of STS ($r = .40$, $p < .001$), VT ($r = .18$, $p < .10$), and general distress ($r = .23$, $p < .001$).

One study specifically examined coping styles in relation to negative emotional experiences (Brown & O' Brien, 1998) and found that mental disengagement could intensify experiences of BO.

Two moderate quality studies (Brown & O' Brien, 1998; Jenkins et al., 2010) explored motivations for DV work. Early results included wanting to contribute to a project, help others and stop the abuse of women (Brown & O' Brien, 1998). Jenkins and colleagues (2010) developed this concept and found the most common motivations related to altruism (i.e., an intrinsic motivation to help others and make a difference, present in 24% of the sample), personal meaning (i.e., desire to help others through counselling because it gave more to one's own life, present in 38% of the sample) and self-focus (i.e. getting intrinsic personal satisfaction from work, present in 37% of the sample). The authors concluded that individuals motivated by altruism were more likely to have experienced a personal trauma in the past and to perceive themselves as having more general distress ($\Phi = .20$, $p < .05$) and VT symptoms ($\Phi = .22$, $p < .05$). Being motivated by a personal meaning was also associated with reporting more negative changes ($\Phi = .21$, $p < .05$) and hypervigilance ($\Phi = .30$, $p < .01$).

Poor quality study. The poor quality study concluded a history of personal trauma may intensify the negative effects of DV work.

In contrast with prevalence rates outlined above, Bell's (2003) study stated that all but one of her sample (n= 30) experienced a personal trauma in the past. She also reported

individuals who experienced more than one personal trauma were more likely to report high levels of stress and concluded past personal traumas may intensify negative effects.

Research Question 2b: What factors buffer negative emotional experiences and/or intensify positive emotional experiences for staff?

Good quality studies. Collectively, studies demonstrated that time pressure, more client exposure, a higher level of education and experience, resources, social support, shared power, clinical supervision and confidence contributed to buffering the negative effects of DV work.

Of the three good quality studies examining job stressors, one (Baker, O' Brien & Salahuddin, 2007) indicated that job stressors, namely, time pressures, predicted 9.8% of the variance ($\beta = .12$, $p < .01$) in the regression analysis predicting personal accomplishment. This suggests that time pressures can also buffer negative emotional experiences for staff, by enhancing feelings of personal accomplishment in the workplace.

Of the five studies which investigated the amount of hours worked, one (Baird & Jenkins, 2003) concluded that more client exposure intensified experiences of personal accomplishment (i.e., BO) and buffered against experiences of VT. Another (Bemiller & Williams, 2011) suggested negative emotional experiences were buffered by a perception held by staff that the positive aspects and rewards of DV work outweigh stress and negative aspects. Education and experience was queried by two good quality studies (Baird & Jenkins, 2003; Dekel & Peled, 2000) and experience alone by another (Bemiller & Williams, 2011). Early findings suggested a higher level of education and experience buffered negative emotional experiences including depersonalisation and negative functioning outside of work respectively. Baird and Jenkins (2003) also found that a higher level of education can be a buffer against VT and intensify feelings of personal accomplishment. Bemiller and Williams

(2011) partially support this theory. Their regression analysis suggested personal adjustment to work (i.e., rewards of the role being perceived to decrease stress and experiencing the positive aspects of the role as outweighing the negative) had a significant buffering effect on BO.

Bemiller and Williams (2011) was the only study to directly examine whether tools (i.e., job resources) had any impact on negative experiences and concluded that having the resources to do one's job effectively is a critical factor in buffering the experience of BO.

Two good quality studies (Bemiller & Williams, 2011; Slattery & Goodman, 2009) observed whether clinical supervision and support had a buffering effect on negative emotional experiences. Slattery and Goodman's (2009) study found that among those who did access supervision, good quality supervision was found to buffer negative experiences, specifically STS ($r = -.226$, $p < .01$). Bemiller and Williams' (2011) regression analyses failed to find any significant effect for supervisor support on the experience of BO.

Two good quality studies examined the impact of social support (Dekel & Peled, 2000; Slattery & Goodman, 2009), concluding adequate levels are necessary to buffer staff against 'after-hours-BO' ($r = 0.30$; $p < 0.05$) and STS ($r = -.229$, $p < .01$).

One study examined the phenomenon of shared power (Slattery & Goodman, 2009) and another, the level of autonomy experienced in the workplace (Bemiller & Williams, 2011). Shared power relates to an individuals' perception of how much influence they have in their organisation and was measured using a questionnaire. Results confirmed this to be a critical buffering factor against the experience of STS (correlations $r = -.303$, $p < .01$; regression analysis $\beta = -.294$, $p < .01$, $R^2 = .19$). Level of autonomy in the workplace was not found to have either an intensifying or buffering effect on the experiences of DV staff (Bemiller & Williams, 2011).

Baker, O' Brien and Salahuddin (2007) was the sole study which empirically measured self-efficacy (i.e., one's belief in their ability to be successful at work). Regression analyses suggested a positive sense of self-efficacy acted as a buffer against negative emotional experiences of BO ($\beta = -.40$, $p < .01$, $R^2 = -.27$) and intensified feelings of personal accomplishment ($\beta = .60$, $p < .01$, $R^2 = .38$).

Moderate quality studies. The moderate quality studies found that resolved past personal trauma, social support, detachment from clients, a combination of detachment and identification with clients and generic coping skills acted as buffering factors against the negative effects of working with DV victims.

One study (Jenkins et al., 2010) which examined past personal trauma, found individuals with a history of trauma were more likely than others to report more positive changes ($\Phi = .26$, $p < .01$), and that DV working helped resolve their personal trauma in some manner ($\Phi = .46$, $p < .001$). A similar, but not statistically significant, pattern was noted for individuals who chose DV work because of a close connection with someone who had a personal trauma. This suggests that past personal trauma, in cases where individuals felt this was resolved, may encourage DV staff to be more aware of the positive changes resulting from this work.

Two studies (Brown & O' Brien, 1998; Iliffe & Steed, 2000) of moderate quality looked at support in the workplace with regards to negative emotional experiences and concluded it acted as a buffering factor against BO.

Two studies (Goldblatt, 2009; Iliffe & Steed, 2000) suggested that distancing or detachment from DV trauma clients can act as a buffering factor against negative emotional experiences. The earlier study highlighted that staff believed this act protected them from negative and overwhelming feelings caused by exposure to the trauma of DV victims' lives.

Goldblatt's (2009) more recent study supports this. Participants described putting clear boundaries between themselves and their work (i.e., attending to the emotional lives of DV victims is not part of the professional role) to avoid "being totally drawn into abused women's distress" (p. 1648). The author concluded this strategy buffered feelings of anxiety, helplessness and particularly a fear that one's personal life would be threatened. Such a fear is reminiscent of the experience of STS and VT, whereby a common symptom is an increased awareness of psychological needs and beliefs. Finally, strategies which prevented over-identification with DV victims were deemed necessary for some staff in preserving a sense of self and control over personal life domains, as well as shedding light on the positive aspects of one's personal life, therefore, intensifying positive experiences and perhaps, VPTG.

Following on from acts of detachment, one study (Goldblatt, 2009) commented on whether a combination of detachment and identification with DV victims can have a buffering effect on negative emotional experiences. It appeared that movement between detachment and identification could intensify feelings of empathy for DV victims, and buffer against judgemental attitudes. Furthermore, it seemed to intensify positive personal experiences, such as parental and intimate partner roles, perhaps similar to experiences related to VPTG. Together, this seemed to nurture reflective practitioners, who were both aware of, and attempting to manage, the emotional needs of DV victims and their own.

Three studies (Brown & O' Brien, 1998; Iliffe & Steed, 2000; Jenkins et al., 2010) of moderate quality highlighted general coping strategies perceived to buffer against the negative experiences or intensify positive emotional experiences. For instance, the earliest study concluded that active coping, planning and positive reinterpretation intensified feelings of personal accomplishment. Following on from this, Iliffe and Steed's exploration revealed regular de-briefing, physical activity and self-care, monitoring DV caseload, identifying and

nurturing victims' strengths and becoming involved in socio-political events in the community buffered against negative emotional experiences. Finally, Jenkins and colleagues found negative emotional experiences to be buffered by staff maintaining a community focus (BO, $\Phi = -.21$, $p < .05$), being aware of the personal impact of client effects (STS, $\Phi = -.25$, $p < .05$; general distress, $\Phi = -.23$, $p < .05$) and being aware of changes in personal relationships (VT, $\Phi = -.22$, $p < .05$).

Poor quality study. The one study (Bell 2003) of poor quality suggested negative emotional experiences were primarily intensified or buffered by the confidence felt by staff members. To maintain optimism and a sense of efficacy in the often cyclical environment of DV, one counsellor explained "… Maybe if I'm lucky, maybe they'll actually hear something that I'm saying that will make them get out at the time. But, if they don't, I'm believing that what I'm doing is planting seed" (p. 518).

With regards to personal trauma, Bell (2003) suggested that participant's experience of resolving their personal trauma enhanced their belief in the human capacity to heal and therefore, buffered their work stress. Finally, Bell explored motivations to working with DV victims. She suggested individuals holding an objective motivation for their DV work may buffer them from negative experiences. However, other motivations that may be in contrast to this were not explored.

Discussion

This review aimed to explore the current understanding of the emotional experiences of staff who work with DV victims. Twelve papers met inclusion criteria which, for the majority, deemed of moderate –good methodological quality and examined mainly negative emotional effects on staff working with DV victims. Positive emotional effects were examined in qualitative studies.

In terms of how emotional experiences for staff were conceptualised in the quantitative literature, no study found evidence of clinical levels of BO when adopting Maslach and Jackson's (1986) measure and definition. This is most likely due to elevated feelings of personal accomplishment as a result of work with DV victims which is consistent with Bemiller and Williams' (2011) hypothesis of 'good soldiering' whereby the positive effects of DV work outweigh any negative. No evidence of VT was found and conflicting evidence concerning the presence of STS was described, complicated further by the use of several different measures. Where STS was evident, conclusions are unreliable due to potential historical effects. Concerning positive effects noted in the quantitative literature, no evidence for VPTG was found. With regard to factors that intensify staff emotional experiences, job stressors, less therapeutic experience, mental disengagement and altruistic or personal motivations for this area of work intensified negative effects. In contrast, buffering factors were found to include a higher level of education and experience, work resources, social support, shared power in the organisation, supervision and personal adjustment to the work and lastly, confidence. Finally, in terms of clinical implications, this review highlighted the importance of supervision, education, shared power and improved resources.

The Utility of Qualitative Studies

This review illustrates the importance of considering both qualitative and quantitative methodology as few conclusions from the quantitative results alone can be reliably proposed.

In summary qualitative studies described symptoms common to BO, STS and VT in staff. With regards to BO, physiological symptoms in line with this concept were reported (Iliffe & Steed, 2000; Jenkins et al., 2010). Of relevance to STS and VT, posttraumatic effects such as frequent negative emotional and cognitive experiences were described (Bell 2003; Goldblatt 2009; Iliffe and Steed 2000). However, much of the qualitative results were perhaps

most in line with the definition of VT. Goldblatt and colleagues (2009) detailed 'violence as an emerging worldview', whereby DV workers often interpreted their partner's behaviour as reminiscent of DV. Re-enactments of power struggles were common, leaving some fearful for the continuation of their intimate relationship. Such an effect on personal relationships was supported by further qualitative results (Ben-Porat & Itzhaky, 2009; Goldblatt, 2009; Jenkins et al., 2010) and as individuals were repeatedly exposed to aggressive and violent narratives, views of the world and others were negatively affected (Bell, 2003; Goldblatt, 2009; Goldblatt et al., 2009; Jenkins et al., 2009).

In contrast to this, positive effects of DV work were apparent. Experiences with most resemblance of VPTG included a sense of renewal and personal discovery, strengthened emotional capacities and learning to appreciate life, all of which were deemed to have a positive impact on personal lives. Furthermore, the qualitative aspect of Ben-Porat and Itzhaky's (2009) study demonstrated DV staff reported significantly more positive experiences as a result of their work than non-DV staff. Finally, exposure to women who had experienced trauma in intimate relationships seemed to encourage staff to reflect on their intimate, parental (Ben-Porat & Itzhaky, 2009; Goldblatt, 2009; Goldblatt et al., 2009; Jenkins et al., 2010) and professional roles (Bell, 2003; Ben-Porat & Itzhaky, 2009; Goldblatt et al., 2009; Jenkins et al., 2010).

The Complexity of the Process

It is clear from this review that the processes by which factors affect the emotional experience of staff are not straight forward. The first of these relate to time pressures which were found to intensify negative (Baker O' Brien & Salahuddin, 2007; Bemiller & Williams, 2011; Brown & O' Brien, 1998), and positive emotional experiences and buffer negative effects (Baker O' Brien & Salahuddin, 2007). Similarly, client exposure was found to be both

an intensifying (Baird & Jenkins, 2003; Dekel & Peled, 2000; Bemiller & Williams, 2011) and buffering factor (Baird & Jenkins 2003). To further complicate the relationship, some studies (Baker O' Brien & Salahuddin, 2007; Slattery & Goodman, 2009) reported no effects relating to client exposure. This highlights a more complex interaction of factors. It suggests that it is not possible to reliably conclude that time pressures and exposure to the trauma of DV victims, in isolation, intensify negative effects. However, it is possible that the process of seeing many clients and time restraints can lead staff to feel they are fulfilling a worthwhile and complex role.

Past personal trauma also complicates the process. Some studies concluded this had the potential to intensify negative emotional experiences (Bell, 2003; Jenkins et al., 2010; Slattery & Goodman, 2009). Others found individuals were more likely to report positive personal changes (Jenkins et al., 2010) and believed in the human capacity to heal (Bell, 2003), particularly if the personal trauma was resolved (Bell, 2003).

Finally, the experience of depersonalisation / detachment found in DV professionals is captured in a quote from Iliffe and Steed's (2000) study -"There's a dilemma in this isn't there? If you don't let it touch you, you can't empathise, you're hard and cold. But if you allow it to touch you in some way and really be there for the client, it's very hard for it not to leave at least some residue" (p. 401). Initially hypothesised by Wallace and Brinkerhoff (1991), depersonalisation seems to act as negative emotional effect, as well as a mode of coping with negative effects. Iliffe and Steed's (2000) finding illustrated staff found that detachment negatively impacted on their counselling skills, yet it protected them from overwhelming emotions. Goldblatt's (Goldblatt, 2009; Goldblatt et al., 2009) findings also concluded that staff who used depersonalisation enabled them to avoid being attuned to the emotional lives of DV victims. However, ignoring this aspect of the role will not only impact

on the therapeutic care provided to the women, but will also reduce potential feelings of personal accomplishment and achievement in the staff member. Perhaps staff would benefit from Goldblatt's (2009) finding, whereby movement between detachment and identification with DV clients enable staff to manage the emotional needs and reactions of their clients as well within themselves.

Limitations

Considerable overlap exists between the conceptual definitions of BO, STS and VT, as was evident in the description of the results. The next limitation is in terms of measurement. Firstly, several of the psychometric tools (described in Appendix 6 for the interested reader) were adapted or created by authors without sufficient examination of their reliability or validity. With the exception of BO; different tools were repeatedly used to measure the same phenomenon. Secondly, in terms of severity or type, the measurement of personal trauma hindered any overall conclusion. It is likely a DV worker, who was a DV victim in the past, would respond differently to trauma narratives they are exposed to when compared to an individual whose personal trauma was unrelated to DV. Of final reference to measurement, the tools which measured job stressors were generic and therefore, discounted the complexity of working with traumatised women.

The profession of participants and their country of origin varied across the studies making generalisation of results difficult. For example, social workers face a significant amount of stressors in their roles (Lloyd, Kind & Chenoweth, 2002) and therefore, it is possible the negative effects measured are not a result of their work with DV victims compared to professionals who work predominantly with this type of victim.

Implications for Clinical Practice

It is clear that the theoretical understanding of the personal emotional effects of this work remains complex and insufficient. Although a result of the limited research to date, our limited understanding is also likely to be hampered by staff not having a space to adequately reflect on their experiences. Therefore, the provision of reflective supervision for staff would enhance clinical practice and therapeutic care. This would in turn, enable researchers to gain further understanding of the emotional experience of this work. Supervision should also monitor caseloads, particularly whilst research continues to explore the impact of time pressures and client exposure.

This review illustrates some positive effects of working with DV victims, as well as characteristics which seemed to nurture resilience. These factors could be incorporated into training packages for new and existing professionals working in this area and may include peer supervision for isolated clinicians, sign-posting to relevant agencies to encourage staff to address their experiences, 'group coping' such as joint fun-runs for charity or a mentoring scheme for new and experienced staff. Furthermore, the review suggested staff would benefit from increased involvement in policy, decision-making and shared power, as well as the provision of tools and resources.

Implications for Future Research

Only 12 papers met the inclusion criteria of this review, indicating the research base of this topic remains in its' infancy. Nonetheless, this review indicated several implications for future exploration. Firstly, it seems a conceptual review of the existing theories, relating to the emotional impact of DV work, would refine future measurement. Such a review might support the proposal that our understanding would be most enhanced by future phenomenological explorations, particularly the experience of VT and positive effects such as

VPTG, whilst continued measurement of BO (as conceptualised within the Maslach Burnout Inventory, 1986) is futile. In turn, this would enable organisations to refine their support services for staff.

The review highlighted the complexity of the process by which client work impacts on staff emotions and future investigations may shed light on these relationships. One potential avenue of research relates to the experience of depersonalisation and detachment; a factor conceptualised as a negative effect, yet also found to have an intensifying and buffering impact on negative emotional experiences.

The final implication for future research is borne from the limits of the review itself, which focussed primarily on staff who work with victims of DV. However, female victims of DV are likely to have experienced more than one type of abuse (Coleman et al., 2007) and therefore, future reviews could potentially amalgamate the literature base and comment on any commonalities and differences.

Conclusion

"You can't tell for sure it is because of the work, but it is work related" (p. 374, Goldblatt, 2009) is perhaps an ample summary for the current understanding of this literature. Significant experiences affecting the professional and personal lives of DV workers are described across the studies. These effects infiltrate their professional and personal lives and therefore it is necessary that organisations uphold the duty of care to their staff through the provision of supervision, shared decision-making, training and resources. Further exploration of this phenomenon is required before any reliable conclusions can be made to fully understand the direct and indirect relationships between the effects which were found and the therapeutic engagement with trauma narratives that DV professionals are exposed to on a daily basis.

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Empirical Paper

‘Growing Together – How do families experience resilience after domestic violence?’

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Abstract

There are significant adverse effects for young people and their families in the aftermath of domestic violence (DV), but we also know that resilience is a common phenomenon. What we know little about however, are the dynamic processes between the children and their families which may contribute to the development of resilience.

Adopting Interpretative Phenomenological Analysis (IPA), this study explored the experiences of three families in the aftermath of DV. Interviews were conducted with nine participants – two grandmothers, two mothers and five young people. Four themes emerged: Adversity in the backdrop – DV leftovers; The slow journey to stability and togetherness; Getting on with life and Feelings and relationships. Although the trauma of DV ceased to be a reality for these participants, memories were left behind. Yet, it seems that the provision of stability, particularly through the role of the grandmother, facilitated and nurtured growth. Within this dynamic, it seemed alliances could be formed and strengthened and attachment narratives could be re-scripted.

Clinically, the findings primarily emphasise the importance of stability as a foundation and springboard for resilience, engagement at all levels of the child's ecology and where necessary, the vital role of multi-systemic working. The importance of future research to gain further insight into multiple generations and the concept of re-scripting attachment narratives is highlighted.

Keywords: 'domestic violence'; resilience; family; intergenerational; attachment

‘Growing Together – How do families experience resilience after domestic violence?’

Domestic violence (DV) is defined by government agencies as “any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or ethnicity” (Mullender, 2004, p. 1). DV is recognised as a social problem of significant magnitude across the globe (Garcia-Moreno et al., 2005; World Health Organisation, 1997; United Nations, 1993). Britain proves no exception – with incidents of DV accounting for a quarter of all reported crime (Home Office, 2004). In addition to negative consequences for adult victims, the effects of DV are also adverse for children (Herrenkohl, Sousa, Tajima, Herrenkohl & Moylan, 2008).

Effects of Domestic Violence

In comparison to children who are not exposed to DV, children who live with this adversity experience more emotional and behavioural difficulties (Bogat, DeJonghe, Levendosky, Davidson & von Eye, 2006; Edleson, 1999; Moylan et al., 2010; Wolfe, Crooks, Lee, McIntyre-Smith & Jaffe, 2003). Furthermore, the ‘cycle of violence’ theory suggested that young people who are consistently exposed to DV during their childhood and adolescent years are more likely to be victims or perpetrators of DV during their adult lives (Canon, Bonomi, Anderson & Rivara, 2009; Ehrensaft, Cohen & Brown, 2003; Renner & Shook Slack, 2006; Stith, Rosen, Middleton, Busch, Lundeburg & Carlton, 2000). The resulting financial cost of DV is estimated at 1.45bn each year (Walby, 2004).

Domestic Violence and Resilience Research

In stark contrast to this is the concept of resilience. Research is beginning to demonstrate prevalence rates of resilience amongst children living with DV of between 31% and 65% (Grych et al., 2000). Resilience is believed to be a dynamic process (Rutter, 2006),

defined as the maintenance of successful functioning or adaptation within a context of significant adversity or threat (Masten & Obradovic, 2006). Most likely related to the chronic nature of DV, it is thought that children exposed to DV are subjected to stressors beyond their capacities to cope and therefore, experience long-term negative effects (Maker, Kemmelmeier & Peterson, 1998). However, general psychological formulations over the past two decades have seen an evolution from a deficit-based model to that of a strengths and resilience-based model (Masten, 2001). Definitions have moved from conceptualisations that see resilience as a remarkable intrapersonal attribute to those which view resilience as a more common phenomenon and consequence of basic human systems including attachment, cognitive and emotional development and extended families (Masten, 2001). Finally, resilience can be seen as the result of developmental process, whereby successfully overcoming adversity nurtures an internal sense of well-being (Masten & Obradovic, 2006) as well as self-efficacy and confidence that one can influence one's own environment (Kitano & Lewis, 2005).

A summary of the research illustrates a range of factors believed to foster resilience in the face of DV, namely secure attachment (Graham-Bermann, DeVoe, Mattis, Lynch & Thomas, 2006; Mullender, Hague, Iman, Kelly, Malos & Regan, 2002), the maternal parenting role (Levendosky & Graham-Bermann, 1998; 2001), the availability of emotional support from the wider system, including grandparents (Cox, Kotch & Everson, 2003), positive peer and sibling relationships (Guille, 2004; Mullender et al., 2002) and self-esteem (Kashani & Allan, 1998). Osofsky (1999) and Mullender et al.'s (2002) studies also concluded a child's relationship with their mother or another care-giver is the greatest protective resource within DV contexts.

A decade ago, Edleson (1999) called for services to enhance their ability to foster and nurture resilience. He highlighted:

> "the current literature offers only a glimpse of children's resilience and the factors in their environments that lessens or heightens the impact of the violent events swirling around them. It is these protective factors - about which we know little – that may lead us to design more effective interventions to minimise the impact of violence on children" (p. 865).

Nonetheless, MartinezTorteya, Bogat, von Eye and Levondosky (2009) continue to reflect upon our inadequate understanding of the characteristics and processes which cultivate resilience after DV. Others (Anderson, 2010) have challenged current resilience research for its attempts to classify individuals as either successes or failures and advocated that resiliency is not extraordinary, but rather:

> "there can be many roads to surviving, persevering, and thriving if we are prepared to listen and learn from individuals' experiences with suffering and healing" (p. xiv).

Again, this is consonant with Masten's (2001) much earlier conclusion that resilience is a culmination of ordinary processes.

Researchers are considering how best to explore these ordinary processes. Holt, Buckley and Whelan (2008) emphasised that young people are active participants in creating their social worlds, thus it would be misplaced to ignore their context. Others have advocated for a focus on individual differences and normative processes (Masten, 2001) as well as interfamilial features and coping mechanisms (Rutter, 2007).

For women, DV consequences include emotional difficulties such as depression (Khan, Welch & Zillmer, 1993) and posttraumatic stress disorder (Kemp, Green Hovanitz & Rawlings, 1995), a negative influence on their parenting capacity (Stephens, 1999) including emotional availability (Holden, 2003) and the warmth and quality of attachment with their children (Levendosky &Graham-Bermann, 2000; Levendosky, Huth-Bocks, Shapiro &

Semel, 2003). Yet, holding in mind Osofsky (1999) and Mullender et al.'s (2002) conclusion – the mother as the greatest protective resource - it seems necessary to also consider her experiences when exploring resilience after DV. That is, if she is able to maintain the capacity to emotionally hold her children, where in her environment might her experiences of resilience be coming from? Other theorists also advocate such an approach. For instance, ecological models (Benzies & Mychasiuk, 2008) suggest resilience is built on complex interactions between risk and protective factors, each operating at individual, family and community levels. Consequently, resilience research is shifting its focus to try and understand the dynamic processes (Rutter, 2006) or interactions (Simon, Murphy & Smith, 2005) of risk and protective factors that may serve to nurture and facilitate resilience within families.

Aim

In summary, the process of resilience in children and families after DV experiences is a developing, yet currently under-researched phenomenon and more focus should be placed on the child *and* their environment. Subsequently, a qualitative approach was chosen to allow for a detailed exploration (Krahn & Puhnam, 2003; Rutter, 2006) and to facilitate young people *and* their families divulge what the most important factors are for them are in relation to resilience after DV (Reid, Flowers & Larkin, 2005). Therefore, the aim of this study is to gain an understanding of the experience of resiliency and coping after DV in families *across three generations*.

Method

Design

Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) was chosen for this research paper to facilitate the exploration of a phenomenon (resiliency after DV) from multiple perspectives (grandparent, parent, child). It allows a detailed multi-faceted

account which is thought to be particularly useful when developing "ways of looking at new areas of study" (p. 87, Smith, Flowers & Osborn, 1997). Other approaches were considered (Appendix 7), but IPA was found to be preferable.

The philosophical position of IPA holds no objective reality; rather it understands individual experience as influenced by personal perspectives, which are ultimately constrained by social constructions. Also central to IPA are interpretative processes. Theoretical orientations can be accommodated, yet in a provisional and reflective manner as the researcher aims to remain open to multiple positions and interpretations, whilst making their personal interpretative processes as transparent as possible (Smith, Flowers & Larkin, 2009). With this in mind, the study aimed to ensure the families and their expert position remained at the heart of the exploration. Taken together, this process represents a "double hermeneutic" where "participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p. 51, as cited in Smith, Flowers & Larkin, 2009).

Procedure

Ethical approval for the study was gained (Appendix 8). A purposive sampling strategy was used whereby participants for whom DV and subsequent coping and resilience were pertinent were recruited. Participants were recruited from a local post-DV therapeutic group provided by the National Health Service and through a DV shelters (charitable organisation) based on the inclusion criteria outlined in Table 6. The researcher discussed the study with lead clinicians working across the organisations, who then approached families suitable for the study. If an interest was voiced, further information was provided (Appendix 9) and they returned a 'consent to be contacted' form to the researcher (Appendix 10). The researcher then made an appointment with the families to discuss the study in more detail and

if they agreed to participate, informed consent and assent was gained from the mother, grandmother and young person in the family (Appendix 11).

All interviews took place in the participants' homes. Separate interviews with each participant were digitally recorded and ranged between 35 and 100 minutes. Some young people chose to have their mother or grandparent remain with them during the interview.

De-briefing information (Appendix 12) was discussed at the end of each interview and families were reminded of the opportunity to discuss the initial results and quotes used by the researcher to ensure their truth value. A small gift was given to participants in order to thank them for their time and effort.

Interview schedules

Semi-structured interviews are deemed most appropriate for IPA (Smith, Flowers & Larkin, 2009). Relevant literature and clinicians working in the area of DV were consulted and a draft interview schedule was reviewed by three young people. Their comments were incorporated into the schedules (e.g. 'Looking back, when mum and dad were not getting along...', rather than 'what were your relationships with your mum and grandparent like during the DV?'). The final interview schedules (see Appendix 13) allowed the researcher to explore the topic and gave participants the flexibility to talk freely. The study procedure is also illustrated in figure 2.

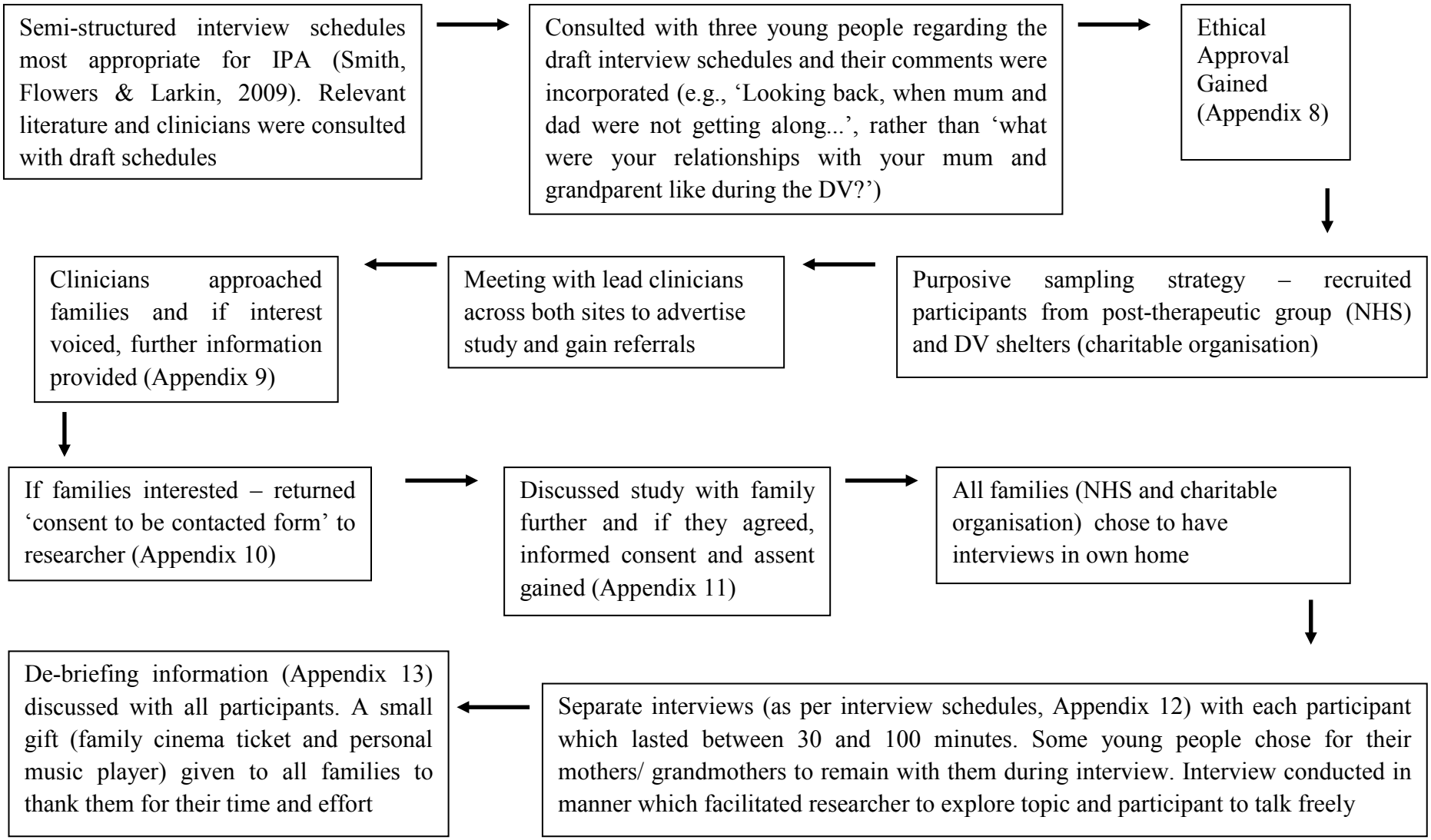


Figure 2: Illustration of study procedure

Participants

In line with the inclusion criteria in Table 6, a total of nine participants took part in the study, which is deemed appropriate for IPA (Smith, Flowers & Larkin, 2009). Although the study aimed to recruit triads (i.e., grandparent-mother-young person), this was not possible. However, it is the opinion of the researcher that the resulting family groups are representative of families, both in terms of the impact of DV and today's society and therefore, appropriate to the context under investigation and the lived experiences for people after DV.

Table 6
Description of inclusion criteria

1	Mothers and children who have experienced domestic violence in the past and who are now living in a safe environment and a grandparent related to this dyad.
2	Young people aged between 7 and 20 years old. This age range is in line with other qualitative research examining the topic of domestic violence (e.g. Mullender et al., 2002) and it was felt the young people would be sufficiently developed to be able to cognitively and linguistically engage in the process.
3	Participants needed to be perceived by staff as 'doing well'. Staff used their clinical and subjective opinion of 'doing well'.
4	Participants were of any ethnicity, race or religion and individuals with disabilities or mental health difficulties were invited.
6	Participants were proficient in English.

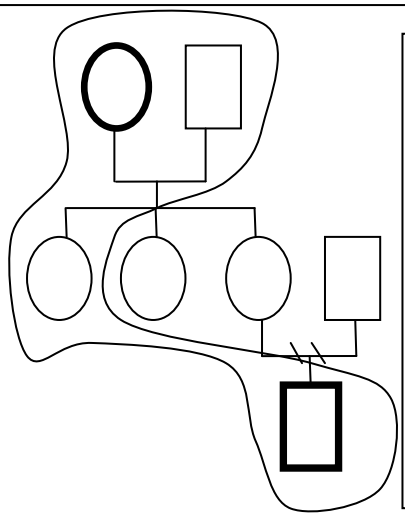
Demographic information and interview composition is provided in Table 7. Further contextual information is illustrated in Figure 3.

Table 7
Participant Demographics

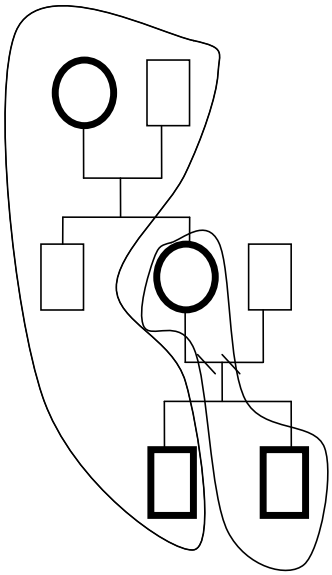
Family Group	Child (name* / age)	Mother	Grand-parent	Ethnicity	Interview compositions*
Grayson Family	Jack / 12	*Not included*	Patricia	White British	Interview 1 – **Patricia** Interview 2 – **Jack** and Patricia

Smith Family	Connor / 13 Daniel / 16	Sonia	Emma	White British	Interview 1 – **Connor,** Sonia and Emma (who joined approx ½ way) Interview 2 – **Emma** Interview 3 – **Daniel** and Sonia Interview 4 - **Sonia**
Kahlon Family	Aadi / 16 Sobhia / 20	Sandeep	*Not included*	Asian British	Interview 1 – **Aadi** Interview 2 – **Sobhia** Interview 3 - **Sandeep**

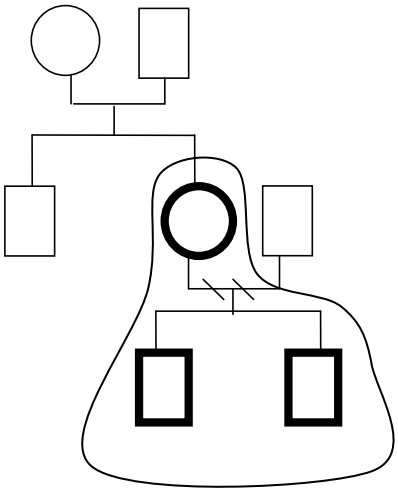
*Note. *All names have been changed to protect confidentiality.* ***Bold*** *typeface indicates primary interviewee*



The **Grayson Family** experienced violence directed towards Jack's mother, perpetrated by her partner. Jack and his mother often stayed with his grandmother, Patricia for short periods. However, following continuous violence; Jack is now permanently living with Patricia. Jack's mother remains in a violent relationship and has no regular contact with either Jack or Patricia. The family members included in the interviews were **Patricia** and **Jack**.



The Smith Family experienced violence directed towards Sonia, perpetrated by her husband at the time. This was witnessed by Sonia's children, Daniel and Connor, who later became victims of his violence during contact visits after the separation of their parents. Connor disclosed this violence and contact has been suspended. Following a period of unsettled and violent behaviour exhibited by Connor, he went to live with his grandmother. The family members included in the interviews were **Emma** (Sonia's mother), **Sonia**, **Daniel** and **Connor**.



The **Kahlon Family** experienced violence directed towards Sandeep, by her husband. This was also directed towards their daughter Sobhia from a young age. This violence was witnessed by Aadi, Sandeep's son. The family have continued to live together and their grandmother lives within walking distance. The perpetrator has moved out of the family home, but remains living in the local area. The family members included in the interviews were **Sandeep**, **Sobhia** and **Aadi**.

Key: =female =male =separated =living together

Figure 3: Contextual information regarding participants

Data analysis

Interviews were audio-taped and transcribed. Data analysis was guided by IPA conventions (Smith, Flowers & Larkin, 2009) and the steps taken are described in Table 8. In addition to 'bracketing off' (Ahern, 1999) the researcher's perspective, the data analysis was reviewed by two clinical supervisors to ensure neutrality (Smith, Flowers & Larkin, 2009). A detailed record was maintained, allowing an audit of the 'warrantability' of themes. Alternative positions and interpretations were discussed and the final interpretations were deemed 'warrantable'.

Table 8
Steps taken in data analysis

Step	Details of analysis (steps 1-4 completed for all separate transcripts)
1	Reading and re-reading: Reading transcript whilst listening to audio-tape – initial thoughts and observations noted and 'bracketed off'. Re-reading to get a real sense of the participants' stories and noticing shifts from generic to specific explanations.
2	Initial noting: Detailed analysis and exploration of semantic content and language using descriptive, linguistic and conceptual comments. Interpretative comments and attempts to find abstract concepts to complement these followed.
3	Developing emergent themes: Emergent themes were gathered by mapping out relationships and patterns between notes/comments. Create formulation of interpretative comments and participants' lived experiences.
4	Searching for connections across emergent themes: Emergent themes were ordered and 'mapped'. Techniques including abstraction, contextualisation, polarisation and function facilitated this.
5	Looking for patterns across cases: Identifying connections between cases and

	using themes to illuminate themes in other cases. Moved to a theoretical level by finding themes that represent higher-order concepts.
6	Taking it to deeper levels of interpretation: Further attempts to move from the 'P' to the 'I' (i.e., from descriptive phenomenology sense, to deeper interpretation). Super-ordinate themes were refined (Table 9).

Note: Worked example of analysis in Appendix 14

Self-reflexivity

IPA relies on the lived experience and meaning-making of the participant. However, the end result is a subjective account of how the researcher understands and conveys the message of the participants (Smith, Flowers & Larkin, 2009). Reflections on personal experiences are necessary to bracket off preconceptions and so, I briefly outline the positions I brought to the research (see also Appendix 15). I am a white Irish female, aged 28. I was brought up in a family who appreciated a stoic attitude and the need to contain, minimise or indeed hide family 'secrets' for fear of breakdown. However, I also brought experience of the security, protection and support that can be felt within a 'family' and how strong bonds can nurture adequate coping and resilience. My experience and values have led me to focus on nurturing strengths, which I feel is fundamental when working with families. Interviewing participants in their own homes gave me an appreciation of their context and the way this differed from my own. Finally, my empathy at hearing the participants' stories and subsequent desire to provide containment may have impacted on the full lived experience for me as researcher as I attempted to balance this with my more usual role of clinician.

Results

Four super-ordinate themes emerged from the analysis (Table 9): Adversity in the backdrop - DV Leftovers; Stability; Growth and Attachment processes. A narrative account

follows, presenting and exploring the sub-ordinate themes comprising each super-ordinate theme. Illustrative quotes[1] are provided.

Table 9
Contributions to super-ordinate themes

Super-ordinate theme	Sub-ordinate themes	Participants contributing to the sub-ordinate theme
Adversity in the backdrop – DV leftovers	a. Living with emotional memories	Patricia; Emma; Sonia; Sandeep; Connor; Daniel and Sobhia
	b. Coping with DV re-enactments	Patricia; Emma; Sonia; Sandeep; Jack; Connor; Daniel and Sobhia
The slow journey to stability and togetherness	a. Being taken care of by grandmother	All
	b. Taking pleasure in everyday togetherness	Patricia; Emma; Sonia; Sandeep; Jack; Connor; Aadi and Sobhia
Getting on with life	a. Working towards change over time	All
	b. Accepting the past and strengthening the self	All
Feelings and relationships	a. Learning about feelings and forming strong bonds	All

[1] In presenting verbatim extracts, minor hesitations, a repeated word or words such as "erm" have not been removed. Although this may have improved readability, it is felt these nuances facilitate descriptive and linguistic analysis. Where material has been added, it is enclosed with [square brackets]. All identifying information has been removed to ensure anonymity. Names used in verbatim extracts are aliases.

Adversity in the backdrop – DV Leftovers

Although this first theme does not focus on resilience, a discussion of the adversity in the background seems necessary to acknowledge that the DV had left a difficult and active legacy, as well as to fully appreciate the remarkable strength of the participants, despite these continuing adverse experiences. Two sub-ordinate themes were present: 'living with emotional memories' and 'coping with DV re-enactments'.

Living with emotional memories. For the majority of participants, their experiences left painful memories behind. For some, recollections of hypervigilance were evident, including the children and young people:

> It was scary... you're always on guard, have your phone in your hand so you can ring the Police as soon as possible. So I think it just kind of stress after stress really, kind of always on the lookout, not really smiling because I'm thinking 'crap, someone's going to be behind me, shove me in a van', and so it did get quite, you know, just quite stressful (Sobhia, line 72-79)

This excerpt illustrates Sobhia Kahlon's memory of being on constant alert, even when away from home. Sleep, a basic need, seems something the memories have also intruded upon, whilst for others sleep perhaps acts as an escape from ongoing reminiscences. Sobhia explained:

> While sometimes, you know, I can wake up to nightmares and stuff (Sobhia, line 859-860)

In contrast, Daniel Smith recalled feeling so overwhelmed that he "never had to worry as much"; his main respite comes with sleep.

> Yeah 'coz when I'm asleep I don't think about it, but if I'm- if I'm still awake I'll think…I'll still think about sad things (Daniel, line 733-735)

These extracts represent disruptions in normal functioning common to young people who have experienced trauma. For Sobhia, engaging in normal functioning was limited as she explained often felt she needed retreat to her bedroom:

> Like because my dad used to always pick on little things about me because he's never really liked me or got on with me, so I used to always be sat in my room doing whatever, listening to music or stuff (Sobhia, line 96-99)

Although attempting to find a place of safety, it is possible Sobhia's "nightmares and stuff" were a result of her bedroom being repeatedly associated with the systemic effects of DV. Referring to her father, mother and brother, Aadi:

> Them lot used to be downstairs watching their own programmes, so we were very split (Sobhia, line 99-100)

Sobhia recognised the "split" in her family. Perhaps her use of "them lot" represents a sense that she felt positioned as the estranged and isolated family member, whilst the others remained intact. Such splits were common (Figure 3). Jack was estranged from his mother, whilst Connor was separated from Sonia and Daniel. Although some splits were beyond the families' control, others seemed the result of the feelings and memories left behind.

As well as traumatic memories, underlying tensions were described. Patricia Grayson's feelings of resentment towards her daughter continued to infiltrate their relationship.

> No, I haven't... I don't know how to put this without sounding callous, but I have no feeling for her. I don't know if that's because of all she's put us through. I mean, it's not just me, it's the whole family she's put us through... Now I don't know if that's anger or what... what she's done, she's messed it up (Patricia, line 717-726).

It is apparent in this quotation that Patricia is blaming her daughter for the ordeal that the whole family has experienced and she is finding that her feelings have destroyed any affection for her. In contrast, grandmother Emma's resentment towards her daughter Sonia (Smith family) for the pain caused within the family has not led to estrangement, instead it was referred to by Emma as "underlying" and something they both "tolerate".

The underlying tensions felt by the grandparents also seemed to be something experienced by the young people who had some ambivalent feelings towards their mothers. Jack recalled his mother trying to keep him safe, albeit in a way which he felt did not actually protect him, Connor reminded his mother that she needed to continue thinking about their relationship, whilst Sobhia questioned why it took so long for her mother to recognise what herself and her brother needed from her as their mother.

> Well, my mum used to take care of me a lot, but she didn't do the right things 'cos she didn't take me to school, at all. Um, well, she…mm…gave me whatever I wanted, and, um, she really took care of me, but not the right way. (Jack, line 48-53)
>
> [talking to Sonia] Yeah. Or just think more about it. No offence (Connor, line 804)
>
> …because it obviously took Mum, like, 20 years to know what kind of made us happy, but at least now we can say we can move on (Sobhia, line 708-711)

Referring to his new experience of "boundaries" with Patricia, Jack explained:

> Boundaries is okay, but I don't really like them (Jack, line 61-62)

He explained that Patricia set boundaries:

> Because that's how you're supposed to bring your, your children or your grandchildren up (Jack, line 72-74)

This extract perhaps represents Jack's awareness of his need for containment and structure. Although he, Connor and Sobhia seemed to acknowledge their mother's efforts in caring for

them, their narratives offer a sense that their mother's attempts were not enough to adequately meet their needs and that their relationships and experiences of normal family life have been sacrificed to DV. Daniel alludes to this when referring to Connor's new school and environment:

> ...but I mean now he's moved school and, you know, he's…because I mean my school is not a very good school, but I mean the school he's at now I think he's really improved, you know, managing to cope with our Mam's situation. I think it's just because he isn't- he isn't here everyday like if he used to be because if he…I'm not saying anything about our Mam that's bad, but if he was still here now I'd have to say he'd probably still have a bit of that temper on…with him. I think having seen our Mam a couple of times every week 'coz he's not very routine…like we might not have dinners at set times (Daniel, line 346-358)

Coping with DV re-enactments. The legacy of DV seems to be enacted in various ways in the current system. In the Kahlon family this was described by Sandeep and her children as affecting Sandeep's behaviour.

> Well, I think because we were sort of always scared of him because he used to get quite sort of nasty, whether it's for... And just not to make an evening, every evening into an argument and a fight. And I think sometimes he used to sort of, sort of have a go at the kids, but then he comes if you know it's food time, just... He'd mean to make an argument even if, you know, if we were having a curry he'd expect the sauces out, more so aimed at Sobhia he'd just make it into an argument. And then I'd start having, getting snappy and sort of shout, if you know, just to save an argument sort of take it out on the kids, just knowing that it's not their fault, it's just him, because if it wouldn't be for the sauces, he'll find something else to argue over. And it'll be more,

> then it's like... It's just I didn't want to put the kids each time, each evening into an argument if he was like happy and pleased hopefully he wouldn't sort of say anything (Sandeep, line 288-304)

Sandeep was fearful she would "snap" over "something really silly", something noted by her children who commented that she takes out her upset on them:

> So then she gets upset about that. She tries not to take it out on us but then we kind of see that she's upset so it's kind of hard to, like, pass it by (Sobhia, line 592-595)

By contrast, in the Grayson family, it was Jack whose behaviour was seen as being influenced and inextricably linked to his earlier exposure to violence:

> And he knows more about it than I've ever dreamed of knowing about it myself. I mean, I haven't got a clue. But he's seen a lot in his young life. And he's come out with little comments and that. And… if he sees someone getting hit on the telly, he'll say, "Go on!" you know, "Hit 'em!" And "Kill 'em!" or stuff like that. And I think that's not normal behaviour (Patricia, line 38-44)

Whilst Jack was seen as viewing physical violence as almost desirable, in the Smith family one of the boys had become prone to losing his temper. Connor's aggression was most likely a result of his own victimisation and perhaps exacerbated by his disclosure of the violence, something many young people find difficult. However, his violent expressions led him to be placed in the role of the abuser by his older brother and mother.

> I cannot- I cannot cope Connor with you kicking off because it's when he kicks off I can't cope and…I just can't cope with it anymore. I don't know how you feel about that, how you cope with it?' [questioning mother] (Daniel, line 646-649)

Sonia described how DV services helped her understand perpetrators, but then seemed to use Connor as an example of someone showing behaviour typical of a perpetrator. Initially

referring to a disagreement she had with Connor's teacher, who felt Connor should be allowed on a school-trip:

> ...he will choose to kick off... And then summat went in my head and I thought, oh hang on a minute, yeah that's right..."He's got you where he wants you... we all pussyfoot round him, so of course he's going to do it if he can get away with it." So they helped me understand all of this and lights just started going on and it was like oh, and they taught me like with men if they pretend to be nice at first um it's obviously worked before um, they know what they're doing (Sonia, line 309-343)

Although Sonia did not explicitly describe her awareness of this dynamic, Emma also held this perspective and often commented how the "time apart" helped them as a "unit".

> But Connor you know, but there's just something there, his mannerisms or his actions, I think when she [Sonia], she looks at Connor she sees his dad and I think like when he was being violent and pushing her around and stuff like that I think that all came, came up. You know she could just see that he was his dad (Emma, line 566-570)

The two sub-themes considered seem to illustrate the negative effect of DV on individuals and its rippling effect on families. The trauma has ceased to be an ever-present reality, but has been transformed into a memory with lasting effects on fundamental (sleep) and multi-faceted (love and belonging through family connections) survival mechanisms.

The slow journey to stability and togetherness

In contrast, it seems the families are now going through a more transformative and affirming experience, whereby stability is serving to restore basic and multi-faceted needs. There were two sub-ordinate themes – 'taking pleasure in everyday togetherness' and 'being taken care of by grandmother'.

Taking pleasure in everyday togetherness. Another theme evident for this group of participants was the way they gained a sense of normality from doing everyday things together. In questioning the participants about their celebrations of happy times, the majority identified everyday activities where they were together with their family, rather than more outstanding major events. Patricia highlighted the importance of this, but explained

> I can't describe it. It's just having all my family there. That means a lot (Patricia, line 616-617).

Referring to what another person might see in their family she commented:

> That we always have a laugh and a joke. Always taking the Mickey out of something... You know? Don't matter which one it is. It's always have a laugh and a joke. And playing silly games and stuff like that (Patricia, line 646-650)

Aadi, Connor and Daniel also talked about getting together.

> Um, well my family we generally get together a lot. So, so a lot of the time we're always like always talking where there's like other people friends and that come down, um, so a lot of the time we are like talking ha--, happy and stuff (Aadi, 168-171)
>
> [referring to what would be seen if an alien came into the living room in the evening] I'd say to him that, "We're watching a film and sitting down together." So we're together. Yeah, so we spend some time together and stuff. Because they're my family and I like to be around them (Connor, line 518-524)
>
> ... as long as I spend time with her [referring to Sonia] I'm not really like fussed. If you get what I mean (Connor, line 224-225)
>
> I just come and spend time with you [talking to Sonia] (Daniel, line 652)

These quotes seem to illustrate the sense of safety that is gained through being together - in what many might consider simply routine everyday experiences. Perhaps what normality is

serving to provide is a (re-)discovery of the joy that can be found through social connectedness, rather than their previous experiences whereby social connections were dominated by fear and violence.

Were one to remove the word 'snow' from the following extract and the fact that Jack was laughing whilst telling his story, it could be mistaken for a DV incident.

> Um, and then, er, I rolled some, er, snow and it was so cold and then Granddad looked at me and he had his gloves on so he grabbed some snow and chucked it at Monica [Jack's aunt]. And then it landed right at the back because she was turning around. And then, um, and then she got one and chucked it at me, and I got one and then I keep on missing Granddad. Then I got close up and I got him in the ear. But then he got me on the nose and the head on the ear and on me eyeballs ((laughs)) (Jack, line 507-515)

Yet, this extract seems to give an impression of childlike fun and convey a sense of innocence. It seems his new-found stability has enabled him to integrate social connections as positive and warm experiences.

This was also evident in the Kahlon and Smith families. In the extracts below, Aadi is talking about new role models he has found, whilst Patricia reflects on the excitement Jack appeared to gain from everyday experiences.

> Whether it's just to talk to about things or maybe take you out. Whether it's just downtown, park, walk whatever I think that's quite, um, good. Um, changes I think obviously I said we got closer, close as a family. I think that's a, a good thing to do as well (Aadi, line 185-189)

> It's just like going on the bus. It was only a small... he says, "Cor, look Granddad, we're going! Look!" And all this and that, he was on and on and he was, it was just

the bewilderment of it all and you know, his face was full of, full of wonder (Patricia, line 986-990)

Within this theme, something common to the young people was the focus on a reciprocal interaction and relationship, where rather than materialistic or verbal offerings being a requisite, just being together provided warmth, safety and memories.

Jack: Er, in her [Patricia] bed, 'coz it's comfy, more comfy. And then she tapes it because we've got a TV what can tape stuff can't we Nan?

Patricia: Hm. DVD we call it.

Jack: Yeah. And then we do that. And we watch it on that. And we, er, then me and Nan cuddle up to each other 'coz I was... 'coz I was cold and she was roasting hot. So we cuddled up to each other. And then we just watched a film. And then once when the doctor [television series - Doctor Who] fell over onto the floor and we saw nothing there we laughed our heads off (Jack, line 534-545)

What is interesting in the extract below is the juxtaposition of 'celebration' and 'Coronation St.' – the families seemed to gain a sense of joy and closeness when just making their way through mundane everyday experiences.

... they'll go [referring to Connor and Daniel], "Oh, we're going to have a celebration now, Mam" and we'll all sit down and watch Coronation Street together and [Connor and Daniel will say] "I'll make you a cup of tea..." (Sonia, line 986-989)

In contrast to the "bewilderment" felt by Jack and the celebration experienced by Connor and Daniel, Sobhia referred to being together as "annoying".

> Yeah. It can get quite annoying because we're always in the same house, ((laughingly)) so kind of in each other's ways. But then we didn't really do that before (Sobhia, 92-94)

Maybe Sobhia is searching for independence. Still, deeper interpretation of this extract and her lived experience as a whole could suggest something more. Perhaps every now and then, being together is experienced as uniquely different from the feeling of isolation she felt within her family for so long. Yet, she seems aware of such a narrative and her sense of warmth and humour from this extract suggests her annoyed feelings do not overwhelm her ability to reintegrate herself and perhaps restructure the ideas she has developed about herself in relation to others.

Describing how their lived experiences were so long dominated by DV, Sandeep says:

> Whereas now we've sort of... we all feel comfortable. Within days when he moved out we sort of all, ((laughingly)) well the following night we all slept fine. Whereas even at night 'cos at half two he'd get up and he'd be walking around, putting the TV on, meaning to slam doors... yeah, he's not, you know, they [Aadi and Sobhia] do feel like that close, comfortable and that now, you know, the kids are always down whereas [before] if he was there they'd sort of scatter (Sandeep, line 373-383)

Sandeep seems to put these perspectives into context, allowing an appreciation that everyday experiences are something to be nurtured and treasured, as before, a sense of safety and normality had no space. Sobhia seemed to mirror this idea:

> Whereas now we just kind of sit as a family and just eat; whether it's in, like, the front room or in this room, really doesn't matter (Sobhia, line 625-628)

Being taken care of containing grandmother. Something which appeared to instil stability into the everyday lives of these families was that of a containing grandmother. She

seemed to provide a stable and secure base at times of unpredictability, meeting physical and emotional needs and aligning the family towards strength and hope.

In the Grayson family, it seemed that the experience of stability was very pertinent for Jack. Here, he explains how Patricia provides him with a stable and predictable presence, something his own mother was unable to do.

> Erm, me and Nan really get along with each other. We, um, we keep together most of the time, and we…I know that I can talk to her whenever I, er, have bad feelings (Jack, line 3-7)

Jack's comment seems to represent his experience of a 'secure base', deriving from his grandmother's capacity to be attuned to his emotional needs and expressions, without becoming overwhelmed. Patricia also holds some awareness of this - here she talks of making sure that a photo of his sister is kept for Jack even though he does not want to see her at the present time.

> Yeah, I had that put in a nice frame for him. I won't, I won't push it away or hide it or anything. I mean he will get a shoebox diary now for so many years (Patricia, line 1254-1256)

> So I know, I know here [pointing to heart] that he will get there (Patricia, line 1084)

In addition to a real sense of hopefulness, these extracts give a sense of Patricia's capacity to physically and emotionally contain Jack's feelings, with the implication being that he learns that difficult emotions can be contained, and that at some point he will be able to process and integrate his experiences into his identity.

Similarly to Jack, it appears that Sobhia and Aadi also found a secure and safe base through their grandmothers at times of threat.

> ... the kids feel safer now at home as well, 'cos they'd sort of say 'I'll stop at mammies' [referring to their grandmother]... but now as soon as he [DV perpetrator] was out the kids obviously feel comfortable, you know, they're not feeling, well threatened... that oh there's going to be another argument or there's going to be fighting at home... (Sandeep, line 650-664)

Sobhia, Aadi, Connor and Daniel also described how many of their basic needs were met via their grandmother when their mothers were unable to do so for other reasons.

> *Aadi:* ... and, um, ever since then she basically brought me up so I'm really close with her as well, I've always close with her.
>
> *Interviewer*: Do you want to say a little more about that?
>
> *Aadi:* Um, well it's basically I'll go over there when my mum's at work, she'll make me food and all of that and then, um, I don't know it's just being close she'll like talk to me, I talk to her and it's just been like more of a, a friend more ...than a grandma (Aadi, line 33-42)
>
> Um, it's been very close from day one and my, my Nan has brought me up from when I was little I used to always stay there. My mum was at work... so yeah it's been a very close relationship (Sobhia, line 13-17)
>
> So even from day one like my mum used to be at work and my Nan looked after me, it's still like that now, like I'll go and stop at my Nan's (Sobhia, line 432-433)

In these extracts, the young people are describing how their grandmothers are not only associated with safety at times of threat, but have been somewhat of a stable base throughout their lives.

> *Connor:* Yeah. She ... when like I didn't live with her and my mum was working she was like always offering to look after us if we was ill...

Interviewer: Okay.

Connor: And she really liked seeing us, like me and my brother and my mum.

Interviewer: How do you know that?

Connor: She told me.... Um, um, she said it a lot of times (Connor, 324-336)

A further point alluded to in these extracts is the importance of communication, whereby perhaps repeated positive interactions provide a foundation from which new stories can be developed. Here, Connor was talking about how Emma looks after him when he is unwell:

Interviewer: Yeah, okay. Does she ever look after you if you have ... if you're sick or if your tummy's not ...?

Connor: Yeah.

Interviewer: Yeah? What kind of things did she do then?

Connor: Well I sprained my ankle twice and she sort of like helps in that way. And she helps like me move around and stuff (Connor, line 311-318)

This extract represents Connor's basic needs being met; however a distinct change in Connor's tone of voice was remarkable. He seemed to connect with Emma at this point and there was a sense of warmth and attunement between them both.

Patricia and Emma's roles as grandmothers embrace stabilisation. Their provision of a 'stable place of safety' for Jack, Connor, Daniel and Sonia seems to be enabling the young people to integrate their own difficult experiences. For instance, Jack has found new ways of expressing feelings, which are recognised, named and accepted by his grandmother:

Jack: Well I go upstairs and, um, I grab my pillow, hold it, er, like a snake would do, um, squeeze their prey, I would turn that like [squirming], no offence Nan, but I pretend it's the person who I don't, er, who's just told me off ...it's not that I hate the person who I, who I just didn't like

for that second, and I dislike them for a couple of seconds while I hit the pillow. Then I start liking them again. If you understand, you understand... [looking to Patricia] ...that?

Patricia: Yes it's called frustration (Jack, line 1010-1021)

This extract also demonstrates that Jack is becoming aware that feelings can be contained, something perhaps facilitated by Patricia's attunement with him. Emma also seemed to describe her role as 'containing'. Yet, rather than containing purely feelings, she seems to act as a 'container' for relationships, until a time comes when they could be together again. In the extracts below, Emma is referring to Connor now living with her and the "pressure being lifted" from Daniel and Sonia.

But I think him [Daniel] and Connor just do need that time apart. They're fine for short bits, and Sonia's fine with short periods of time, but, um, she doesn't seem to manage both boys for more than, you know, perhaps a week or so. And then that's it, she's, she's had enough; she's had enough (Emma, line 76-82)

So, I think the relationship between them is better than it was. (Emma, line 58-59)

Er from that, from that point of view. So I think that you know as far as that they're a stronger unit… within themselves when they are together. And if there are any fall, fall outs Sonia can cope with it better (Emma, line 920-924)

The young people, and perhaps the mothers, also acknowledged the efforts and support provided by the grandmothers. Evident from Connor and Sonia's dialogue below is Emma's role of 'container' for both their feelings and their relationship. It seems she is somehow managing to co-regulate them, which over time perhaps, will enable them to regulate themselves.

Sonia: If we're sitting there and going what's gone wrong, it's all it is; if I start getting grumpy and then you start getting grumpy, and then we end up getting grumpy together. If you start getting grumpy what do we say?

Connor: Talk to grandma (Connor, line 788-792)

A similar experience of her grandmother is felt by Sobhia. The extract below hints at Sobhia's fear of being overwhelmed should she acknowledge her feelings. However, through being emotionally attuned with her family, it seems Sobhia's grandmother safely makes attempts to explore underlying, or even hidden, feelings. In contrast to being overwhelmed, Sobhia seems to find this experience 'containing', serving to instil an idea that difficult emotions can be experienced as something other than overwhelming.

> …like if something is going on she'll [referring to grandmother] kind of – if not ask us – she'll kind of try and find out what's going on. So, um, like I say, if a thing is going on at home with Mum she'll kind of just ask us, you know, "Is, like, everything okay?" Whereas sometimes I find that quite awkward if I ask, because I find it kind of…kind of brings up things you don't want to talk about – if that makes sense – but sometimes it can help if you do ask (Sobhia, line 719-726)

An interpretation of Sobhia's final words might be that such experiences can enable opportunities for co-constructed and integrated emotions and narratives to be taken up.

Both Sandeep and Sonia also seemed to recognise their mother's commitment and efforts.

> And I think it's like what my mum's doing with us now is putting up and really looking after us, popping round (Sandeep, line 607-609)

Referring to Emma letting Connor live with her:

> [referring to Emma letting Connor live with her]...so I just... So that, that was a big stepping stone um... you know, this, this I'm sort of it's a very big important thing for me, other people get help, but that my mum would agree to do it (Sonia, line 839-844)

Finally, the containing role of a grandmother as well as the ripple effect that this has on the subsequent generations was described by Aadi and Daniel.

> I think, um, I, I went like to her because obviously she brought me up and that, and it, um, I, I, I don't think we got closer but I think it was more... she was more of a support because she supported my mum and then that, um, also helped me as well. Um, she was probably more of a support. Because I've, I've always been close with her so yeah she was more of a support really. Because I, I think that took a bit of pressure off me because then it, it ultimately meant that I, I didn't have to do as much because I knew there were other people, like her... (Aadi, line 124-137)

The knowledge that his grandmother has supported his mother has helped Aadi, by taking away some pressure. Daniel also reflected on how his grandmother's actions helped himself and his mother, Sonia. Knowing that his grandmother is supporting his mother

> *Daniel*: but now he's [Connor] at grandma's he's managing to- managing to ((sighs)) I can't kind of get it out. …okay he's managing to be more calmer... Which I think is good and he's more- he's more happier, he's more, you know, more nicer, more happier, more friendlier with you now isn't he? [questioning Sonia]
>
> *Sonia*: Yeah.
>
> *Daniel*: He's not like so rah, rah, rah, "I'm gonna do this, I'm gonna do that" kind of he's more chilled and relaxed. So yeah he is a more chilled and relaxed person now. Sonia - And he used to have it quite a bit

when you'd see Connor with me wouldn't you? You'd argue then like you'd stick up for me against my brother and…

Sonia: …hard work wasn't it?

Daniel: Yeah it was hard work ((laughing)) ((sighs)) (Daniel, line 369-381)

For Daniel, it seems that Patricia's support to Connor has enabled Connor to be "friendlier" with Sonia, relieving Daniel's feeling that he needs to "stick up" for his mother. Thus these extracts seem to illustrate how the role of the grandmother can act as a containing experience for subsequent generations.

Both sub-themes seem to illustrate stability. This sense of stability brought about through the role of the grandmother as a 'container' and the humdrum of everyday life seems to help families re-establish the world as a safe place and assure them they will not be overwhelmed.

Getting on with life

Following on from the experience of DV and the (re-)experience of stability, the idea of growth seems to be another phenomenon. It appears that, in collaboration with stability, growth is facilitated by the process of positive change over time and accepting difficult past experiences.

Working towards change over time. Across the majority of the participants, the experience of time seemed pertinent:

Because you box everything up don't you? Time, time for forgiveness, time for loving, time for learning, time. Time and healing. You box up all of time (Patricia, line 1212-1214)

Patricia's choice of words is interesting. She talks about time facilitating forgiveness, love learning and healing. Yet her opening statement alludes to the idea of a reorganisation of sorts

– perhaps, a period of reprocessing and retelling a narrative – something, which in her mind, can only be achieved through time. A perspective on time for forgiveness was also sensed by Emma. Again, she was aware that change could not be instant or instructed, but that her family, perhaps with the provision of stability, could come together again.

> Really I think it's with all of them as much as I'd like to go in and say "you've got to do this" and "you've got to do that" you, you just have to take a step back. And then just over time hopefully like with Connor and his mum, hopefully that it'll get back in one, in one piece, rather than being scattered all over (Emma, line 945-949)

It seems that Emma is trying to guide the family together again. In trying to find some meaning to Emma's comment, perhaps one interpretation may be that she does not feel truly part of the family unit herself. Thought about further, this could be a result of the "underlying" tensions between herself and Sonia and an unconscious message to Sonia attempting to say that she is not facilitating the break-up of their family, but rather she is trying to get it back "in one piece". It may also be indicative of the societal expectations of 'family-ness' in the modern world which often disregards the older generation. However, her perspective is slightly different from Patricia's, who described their growth as

> ...a slow journey but it's a journey that we're all taking together (Patricia, line 1087)

The potential for roles to change and adapt over time was also experienced by the participants. Both grandmothers, Emma and Patricia, acknowledged the new responsibilities they have taken on board as a result of caring for Connor and Jack (their grandsons). However, as Patricia commented, "But that's fine", implying that although it was hard work and possibly disruptive, it was all worthwhile.

Sobhia and Aadi's mother, Sandeep, also recognised the change in her own role over time.

> So I think now it's making me think that... It's making me stand on my feet and, you know, I am sort of kind of thinking of doing things. It's still a slow process and what I should have done years ago and sort of making the decisions myself and that's, that was a big change as well. Mm, it's slow (Sandeep, line 71-77)

For Sonia, time offered her a chance to develop her role and how she sees herself in the world.

> And I went away and thought about it and I thought they're talking a load of bleeding rubbish, riddle talking, psychobabble, rubbish. And then I was watching summat and it clicked and I went, oops, I'm being a bit of a victim here ain't I, because if I'm saying that he can control my feelings then I'm in victim mode ain't I? Oh yeah, and that clicked. And just by her saying that is very powerful (Sonia, line 781-788)

This echoes Patricia's perspective, whereby time offers an opportunity for learning and reflection. Daniel and Aadi also experienced a change in their roles as a result of DV and its consequences. As mentioned for Daniel, he felt the need to "stick up" for his mother and it appears Aadi had a similar perspective:

> And I just like started to help out more. It started like that really. So yeah it did, it did make me get closer with my mum (Aadi, line 91-92)

Aadi describes his change brought him closer to Sandeep. This is something mirrored by Sobhia, his sister, who explained that Sandeep's new-found strength in her mothering role brought them closer as a family.

> You can tell that it's helped her a lot to become stronger and look after us the way she wants us to be looked after. So that's brought us closer as well. Because she's stronger ((laughs)) (Sobhia, line 657-661)

The changes evident for Connor and Jack seemed to enable them to build a more coherent perception of themselves, both within the new family and the world. Connor spoke about building relationships with his grandparents over time. He explained his relationship was "better" with Emma and his grandfather as:

> I've got to know them more better, not I just see them every so often, I see them all the time now (Connor, line 232-233)

In the extract below, Connor is describing a trolley he built with his grandfather.

> *Connor*: Yeah. Because of the plants. He'd got some plants in these big heavy tubs, so I bought this ... we made this trolley out of some ... he had some wheels ... And he had some, um, like leftover wood, so we built the wood and then we put the wood together, I measured it and then stuck the wheels on. But on Friday the trolley actually broke.
>
> *Interviewer:* Oh! So what did that mean?
>
> *Connor*: We had it a long time though.
>
> *Interviewer*: Do you think you might try and fix it?
>
> *Connor:* Yeah, he said he would, yeah (Connor, line 263-275)

Connor's description of the flowers and trolley appear to represent the growth he has experienced in his time with his grandparents and show how he has gained a sense of control and self efficacy by building something together with his grandfather. Daniel's descriptions of Connor before his move to Emma's seem to describe Connor overwhelmed by his feelings:

> ...shouting at me and he used to be quite violent, he used to say really hurtful things sometimes, bash his head up against walls and doors he'd kick his…and kick his foot up against bricks and all that, brick walls um and bash his head up against them and

just punch stuff like walls and all that um he used to- he used to do all stuff like that (Daniel, line 332-329)

Yet, it seems the experience of stability and time has enabled Connor to have some confidence the broken trolley could be repaired. When asked if he would fix it, he directed this task to his grandfather and although some hesitance seems apparent, it does not imply that the rupture is catastrophic or irreversible.

Like Connor, the consequences of Jack's experience of trauma on his core assumptions about himself in the world were also evident. When asked about something difficult that he and Patricia had coped with, Jack recalled being given a present.

Jack: Er, yeah when I... Well the last time I basically seen Nan cry is today. But, um, the one before today the last time I remember was at Christmas beca--, because, er, there was, um, Nan and Granddad before they didn't get me a pr--... a Christmas present. I said, "I understand" because, um, for all they'd been through for looking after me and that. And actually they've got a massive box and it's a BMX. I was like, "Oh my god." So my auntie and Granddad they were in the kitchen building it all up and the dog had to go in the living room. Because the dog didn't want to

Interviewer: So it kind of sounds like what you're saying is that even though you weren't expecting a big present because...

Jack: Or a present at all (Jack, line 431-444)

Illustrated in this extract is the idea that Jack holds a perception of himself as a young boy in the world who is not loved or wanted - he seems to believe it is an ordeal for his grandparents taking care of him. His portrayal that he could be given "a present at all" emphasises this, as

perhaps, does his sense of guilt that the dog should need to leave the room as a result of what is being done for him. However, his astonishment and joy when describing this story was blatant - perhaps a poignant example of the new experiences he is gaining, which can only serve to modify his narrative over time.

Accepting the past and strengthening the self.

> He's [Jack] had a lot to cope with... and it's amazing how he's coped with it all. I mean for a young lad that age... (Patricia, line 850-852)

Patricia's description of Jack recognises the adversity Jack has been faced with – a general perspective held by the adults about the young people. Yet, she also seems truly amazed that Jack has achieved this. Similarly, Sandeep mentioned "it amazes me how I just sometimes carry on", perhaps something that is reinforced by the recognition from others.

> I think she was shocked because I've sort of spoken out, I used to just think, oh, let it happen (Sandeep, line 1474-1475)

Connor faced the "horror" of disclosing abuse (something recognised by Emma, Sonia and Daniel). Connor explained the consequences as the "hardest" thing he and his family faced:

> When I stopped seeing my dad. That would be the hardest, because as I said early on, he like wouldn't stop harassing us, would he, because he stuck like notes on the door and he come to the school, didn't he, and stuff like that. So it's not really ... it were quite tough because my brother was really worried... Was really worried because he [father] were coming down to the school and stuff (Connor, line 343-345)

Yet, he also used other examples to portray his strength:

Connor: Yeah. They [grandparents], they sometimes help me with my homework, but I just sort of like to do it myself, if you get what I mean.

Interviewer: Mmmm. So why do you like to do it yourself?

Connor: Because then I feel like I've achieved something (Connor, line 246-249)

This extract illustrates the sense of pride and confidence Connor feels from doing his homework alone and achieving small, yet essential goals. However, he also seems aware that his grandparents are there, should he need help from them. This is mirrored by Patricia.

> Love him. I think. To reassure him that he's loved and… And then just get on with everyday things. You have to be strong (Patricia, line 314-316)

Alongside the achievement of everyday things, what also seems evident from Patricia's comment is a sense of determination. Aadi also spoke of this:

> I've, I've just... obviously I go out with my friends, I go to school, work hard and that. Um, and whatever happens you, you're just... I, I've always felt just get on with it. Some things make you angry, and I do feel angry for a couple of days maybe, but, um, I always just feel you have to get on with life. You can't let anyone or, er, anything stop you (Aadi, line 383-388)

Acceptance was another commonality for many of the participants, including accepting the past, accepting help and self-acceptance of one's personality and emotions.

> Oh I think he's er, since he's been started back at school and that I think you know he's, he's got over, he's not over it completely I don't think because obviously he's still… talks about his you know being, he said he'll never forget. And that's what I've said to him, I said "you'll never forget but you can move on". So he said he won't

> forget that his mum said these things about him and whatever but he's, can move on and sort of put it to the back of his mind (Emma, line 677-685)

Emma seems to express some hope that Connor is "over it", yet his reminders to her that he will "never forget" are acknowledged by Emma, perhaps enabling Connor to choose a valued direction and "move on".

> You just accept it and get on with it. You might not like it, you know, you don't like it what's happening but just get on with it (Patricia, line 876-879)

The idea of accepting help was also recognised. In the extract below, Sobhia explains how help has been crucial for her to avoid problems escalating. Her words may also give the impression that, for Sobhia, a fundamental incentive for receiving help is the assurance of the relational contact. However, something Sobhia is clear about is personal choice.

> ...a person can give you their advice, whether you take it or not, that's up to you but at least you know and feel that someone's there... at least there's that person [peers] to talk to... So that's kind of…that's how I do it anyway. So that's the best way really. So it's not building up and… and that's it, yeah (Sobhia, line 822-837)

Daniel emphasised the importance of self acceptance rather than being at the mercy of others. The extract below follows a description of an episode of bullying in school whereby Daniel was being teased and called a girl. He responded by cutting his hair, hoping his peers would "stop being dickheads to me".

> Yeah, just ... ((slight hesitation)) Yeah, be who you want to be, just don't let other people change your mind 'cos like at the, like at the end if you change your person ... just 'cos you change as a person doesn't mean they're going to stop being like they are to you. 'Cos at the end of the day that's who they are. No matter how you look or, or how much you change your personality they're just not going to stop bullying ya.

> They're going to keep saying, they're, they're never going to change. But if you manage to keep as yourself and not change 'cos you know if you've changed once then you finally realise what, what the ... if they're still going to carry on there's no point in changing again (Daniel, line 1077-1063)

As evident in this extract, Daniel's peers did not stop bullying him. However, rather than continuing his attempts to please others by changing, the experience seems to have facilitated Daniel in accepting his own identity and how he chooses to be. Perhaps Aadi feels something similar - talking about what he would say to another young person after DV:

> Um, I would say find a person you can actually trust e--, e--, even if they can't give like a good response, maybe a way to actually help you but maybe someone that you trust, someone, um, that will, er, take it in, in account maybe treat you differently, talk to you differently but, um, someone that you trust, someone that you've known for a while at least. Um, and then hopefully that can like help them really (Aadi, line 405-411)

In this extract Aadi talks about finding trust in another person. A further understanding of his dialogue may be that he is searching for something that he has little experience of so far. Earlier in his transcript, he explained his peers were facilitating and enabling him to change and develop – to find out who he is in the world. However, a deeper interpretation may be that he wants to find someone who can acknowledge and recognise his past experiences as part of him and relate with him accordingly.

> The idea of accepting and acknowledging emotions also came through.
>
> Um, I was just aware of getting it all out really, rather than just staying inside. (Aadi, line 236-237)

> I thought, I don't want to cry like this, I don't want to feel this sadness but I will because I know now that running away from things don't make it better, it just makes it worse (Sonia, line 400-403)

Here, Sonia talks about her feelings and expression of sadness. She seems to refer to this as a journey and gives the impression that a strategy for her in the past has been to avoid or hide from problems and difficult emotions, whereas now she acknowledges them. It seems her sense of determination has been a vehicle to facilitate this process:

> Um and they weren't nice feelings to have but if I didn't have them I wouldn't have moved on, I was just determined in me head this will get better one day (Sonia, line 560-563)

For some, a determination to ensure they are not overwhelmed by their emotions seemed crucial.

> but, um, with her [referring to Sandeep] she kind of doesn't show that she's upset in front of us. When she's angry or, like, pissed off or some'at you can tell – because, like, with anyone you can tell when they're kind of annoyed – but with everything going on she's never really cried in front of us or anything, which that, that to me is very good because it's something that I want to learn how to do. Because if anyone even tries to pick up the subject, things that are hurting…kind of just well up, when I don't want to because I want to be stronger than that. So I think that's one thing see in her and want to do more of (Sobhia, line 681-692)

Sobhia felt her emotional expression was overwhelming and is working towards being able to "cover" this up more. This was something also noted by Sandeep and Sonia.

> You know, it's like you cover it up, you have another face on you. Mm. (Sandeep, line 1224-1225)

> So I'd like to be able to use that when I'm feeling very scared inside, be able to put on that bravado that Connor does, you know, to get him out of trouble that way (Sonia, line 1139-1142)

Also illustrated in these quotes is how families negotiate and learn from each other. Sobhia indicates she is trying to be more like her mother, whilst Sonia indicates she would like to manage some emotions in a manner like her son.

Finally, both Sobhia and Daniel spoke of how they want their past experiences to act as a foundation for their futures.

> Erm, so I think it's just kind of building up on myself doing what I want to (Sobhia, line 699-700)

For Sobhia, the sense is that she wants to build herself up, something which for so long had been dominated by a need to be isolated and estranged. Daniel's experiences seem to have instilled a passion in him to help others.

> ... what's happened through me, brother and me mum like, my mum's had her injury and like me and Connor have sort of been faced with what's happened to our dad, um, I said to Sarah I either want to be a nurse or a counsellor. Counsellor to help people with the ... like the same problems as me, what I've been going through... (Daniel, 1010-1016)

The choices of Sobhia and Daniel could be perceived as indicative of their attachment narratives and ways of relating. Daniel's desire to please others through helping echoed in his choice of counselling, whilst for Sobhia, a future career in computing makes sense for her in a world she has so long experienced as emotionally overwhelming. However, for Sobhia, a desire to infiltrate herself into student life is viewed as crucial and something she wishes to build on.

> Yeah. I think it's being more confident, because I've always been a very shy person from a young age, like, people, like, just, say at a party, if they wanted to dance I used to be the one that used to always sit and not move. So I think it's just becoming more confident and kind of getting involved in group work and stuff at college, just kind of building myself up, whereas I'm not very ((laughingly)) that talkative, when it comes to things yet. So it's just kind of growing on that. Yeah (Sobhia, line 739-747)

The sub-themes discussed in this section illustrate the participants' experience of growth which seems to be partly facilitated by change over time and strength and acceptance. It appears that, rather than being stuck in a vulnerable position or continuing to repeatedly re-enact the traumas evident in the opening super-ordinate theme, the young people and their families were open to taking on new positions and identities. A sense of avoidance or disregard for the past did not come across from the lived experiences of the participants – instead, it seemed they were able to acknowledge and accept their realities and the realities of their family members.

Feelings and relationships

Finally, a theme of learning about feelings, attachment and forming strong bonds was evident. This seems to be an overarching and perhaps, mediating super-ordinate theme, interacting with what the families have endured and their responses to such adversity.

The development of attachment, particularly for Jack and Connor seems inextricably linked to their experiences of stability and growth. Referring to boundaries (something experienced as novel) Jack explained:

> mm-hm, erm, er, I don't really know how but it's just helped me know that I can talk to my Nan, and that's how I started to talk to my Nan. It's told me that I can talk to her, and she…I can rely…er, I can rely on her (Jack, line 193-201)

He struggled to verbalise how boundaries were helpful for him but is acutely aware of the consequences – that he is now closer to his grandmother. Perhaps through the stability and consistency provided by Patricia, Jack now knows he can confide in her and she will remain in his life. Patricia's behaviours "told" Jack so. It seems that as they both negotiated with each other, an attachment began to develop. Jack recalled the development of this over time and again emphasised that he can "rely on" Patricia – perhaps indicative of experiencing her as his secure base.

> I can talk to her. And, um, that she is someone who I can rely on. And, um, I can, I can hug her more than I used to. 'Coz when I lived with Mum we used to go, "Hi Nan". And also I was very small I went ((small wave to Patricia)) hello. Didn't I Nan? Yeah. Since I've got taller I've gone more... [indicates bear hug]. Nan likes the bear hugs now don't you? [questioning Patricia, who responds with a smile] (Jack, line 988-1004)

An interpretation of Jack's extract relates to his final statement. He looks for reassurance from Patricia, perhaps checking that his offerings of physical affection are desired. It seems that Sobhia also recognises the importance of physical closeness:

> Um ((pauses)) that's it really, just ... I think he was just kind of in the middle of us all getting close. We've always been close but because there was always that barrier there it was kind of stopping us seeing each other (Sobhia, line 115-119)

Her quote is a reminder of the context the family had endured. Yet, she goes on to describe that, facilitated by a more relaxed and stable environment, her attachments have become closer, perhaps strengthened as a result.

> Um, she has become a lot more relaxed and everything's kind of happy, she's able to come here, so we're a lot more closer than before as well (Sobhia, line 231-233)

Aadi emphasises this point:

> Um, but, um, I think that the way I feel with her is, is definitely changing because I feel like a lot closer, um, and so I think in that sort of way I'm like, I feel more for her th--, than before. (Aadi, line110-113)

Aadi holds a definite awareness of the growth of closeness in his attachment to his mother. He refers to "before", with his choice of words again being reminiscent of DV experiences. However, a further interpretation may be that his attachment is somehow being re-scripted.

The earlier extract from Jack's interview was also evidence of the growth in his attachment to Patricia, as he "got taller". Connor echoed this, whilst the following quotes also seem to demonstrate the importance of reciprocity.

> Um, by going to live with them and stuff like that. And I helped my granddad build a trolley, and I help my grandma out sometimes (Connor, line 238-240)

> Yeah. She ... when like I didn't live with her and my mum was working she was like always offering to look after us... (Connor, line 324-325)

Jack: Is there anything else? No. 'Cept from doing the sad face and then people come up to her.

Patricia: ((laughs)).

Interviewer: So what's that one?

Jack: Er, like me go up to her and give her a hug and cheer her up.

Interviewer: So when she's got a sad face on?

Jack: Yeah. She's not crying anymore, she's starting to laugh more. It's helped her (Jack, line 904-911)

On a similar manner, Patricia described how Jack is now re-scripting how he perceives and managing himself in the world. She felt this was:

> From us all I think, we've all been there. You know been there for him and when we're going through our own little things ourselves. I think he sees us coping with it and thinks, well if they can cope with it, I can (Patricia, line 856-860)

Patricia's extract seems to demonstrate the importance of family members learning from each other. Sonia has come to recognise this:

> ...kids are like sponges and the way you deal with things they will copy you. Um and so that's what I started doing, started leading by example (Sonia, line 430-433)

This is also experienced by Connor. Referring to what he has learned through his attachment with his grandmother:

> ((laughs)) Don't know really, just something you, like, learn just to ignore people if they be horrible to you and think about something before you do it. I think so, yeah. I think, like, telling me that it's best to think about stuff before you do it because sometimes it get you into more trouble if you don't think about it than… thinking about it first and then doing it that way (Connor, line 593-605)

Affective attunement was also apparent within this theme.

> Well I say to Nan, "Why are you crying? It's only me who's crying" and she laughs. And then 'coz her laugh's funny ((laughs)) you see, it makes me laugh and then I'll wipe the tears and it go... and then I stop crying and I'll laugh again (Jack, line 473-477)

What seems illustrated in this extract is Jack's confidence in his grandmother's ability to be attuned to and co-regulate his emotional expressions rather than being overwhelmed by her own or his emotions. It appears that Connor and Daniel are also now beginning to feel safer in expressing their emotions.

> In erm, er, at school... somebody had called him [Connor] something... I picked him up from er school and he got in the car and er and he, and he was in tears. And that's something Sonia said that he, he would never do, he would never cry in front of Sonia, which he has done, we don't seem to have that problem with us (Emma, line 805-811)
>
> *Sonia*: But we have worked out with Sarah [Daniel's counsellor] um is that it's okay for Daniel not to have to be happy and perfect all the time (Daniel, line 548-550)

Emma described Connor being "in tears" following an incident at school. Yet it appears she perceived this to be an achievement for Connor, overcoming a "problem" of lack of expression of sadness he had whilst living with Sonia. In the subsequent extract from Daniel's interview, Sonia describes being helped by Sarah (Daniel's counsellor) in facilitating this process for Daniel, with an extract from her interview places some further context on this by showing how she has realised she needs acceptance of her own feelings in order to accept her son's:

> ... because if I'm feeling guilty I can't look after myself, I can't look after my kids because I can only look after them as much as I can look after myself (Sonia, line 426-428)

Sonia reflected on often wanting more acknowledgment from Emma, however more recently it appears as though this dynamic is being re-scripted.

> Um that um, you know, I am gaining the confidence to phone her up which again then they see me doing that with my mum so my kids can then... And I can phone her up and speak to her and say to her, "You all right, Mum? How's the dogs?" or how's this or how's that, how's the other, without her turning round to me and saying, "what do you want?" Cos I'd stopped asking her if she had a nice day in case she said what do

> you want? And now I'm able to do that so because I can do that in hard times I will just get on the phone. And then she'll speak to me and she'll speak to Connor um speak to, you know, Daniel if he wants to, Daniel feels he can phone her. So we do work with it all together now (Sonia, line 844-857)

The idea of ruptures and repairs also came through the lived experiences of the participants.

> Um, just be okay to say, um, Nan's told me that I can say to her, um, "Nan, I feel a little bit angry with you" so... She just said "Jack, if you have any problems and you have a little bit of feeling about somebody you can just tell us." (Jack, line 1038-1043)
>
> Well he can be very helpful. When he is naughty he'll write me a little note and say, 'Nanny I'm sorry'. He does that with his Granddad as well. ((laughs)) And he goes, 'You know I love you, don't you?' And I, well we always tell him we love him. And I think he, him knowing when he's wrong, he will go away and think about it, come back and then say, "Look I'm sorry, I shouldn't have done that." Knowing that, knowing that accepting what he's doing and then just get on with it. Knowing the wrong and then accepting it and getting on with it (Patricia, line 1047-1056)

The extracts provided by Jack and Patricia illustrate the idea of Jack starting to internalise an awareness that he can approach Patricia and explain how he feels. Patricia's extract suggests this to be a safe option for Jack – that he will be loved, despite his behaviours or feelings. Patricia's "just get on with it" also seems to indicate that problems are part of daily life, aspects that are acknowledged, accepted and understood, rather than difficulties which remain underlying or dominating their relationship.

Referring to an argument with Emma, Daniel spoke of how Sarah (his counsellor) facilitated a repair in their relationship by helping him to reflect on his own feelings and to

think about his grandmother's. Below, Daniel is describing how he managed the incident. Rather than:

> simply just say, 'I'm sorry, didn't mean to say it, won't do it again' and then just walk off (Daniel, line 262-264)

Daniel explained:

> ...in this case I said it as in the difference like I kind of said, "Grandma, I think there's something come between us. I didn't want it to happen, it was a couple of- couple of months ago when I said something to Ellis that I didn't mean" and so on and then at the end I said, "I'm sorry I didn't mean to hurt your feelings if I did um I just wanna get along with you again" and we managed to again (Daniel, line 264-272)

Finally, just as splits are evident from the current constellation of the families, there is also a suggestion of new alliances developing. Some additional alliances, not visible in Figure 3 are described.

> Well 'cause my Nan and my mum obviously they have more of a like a mum's sort of effect with, um, like food, school all that kind of stuff. They [uncles], they mainly like take me out, buy me stuff and talk to me like in a different sort of way whether it's about sports or anything (Aadi, 73-77)

Here, Aadi illustrates how he has found new male role models in his life, in contrast to the nurturing care of his mother and grandmother. Jack is also described by his grandmother as having developed a bond with his grandfather:

> Yeah, very much so. He takes a lot of notice of his Granddad. And the fact that when ((coughs)) his Granddad also, when he was a child, he was taken from his Mum and Dad and placed into foster care. So ((coughs)) we've explained it to him and we'll say, oh well, because he says, "Actually you don't understand", when we first had him

> ...but then his Granddad turned round and says, "Well I do understand because I had exactly the same thing done to me." And it's, "Oh did you Granddad?" And they became like the best of buddies then, just in a ... because he wasn't, he felt like he wasn't the only one in the family that had been like it. I think yeah, they had the like bond there and the understanding as well (Patricia, line 821-837)

Patricia seems to be describing that the shared understanding between Jack and his grandfather has enabled Jack to make contact and have a shared connection with another, rather than feeling isolated by his experiences. A new alliance for Daniel and Connor also seems to be developing. In addition to the therapeutic intervention offered to Daniel, the stability and resulting "calm" Connor has experienced seems critical in repairing the brothers' relationship.

> he's a much more calmer person and much more…with me and Connor gotten more closer as brother and brother ((coughs))and part of that as well was thanks to Sarah and the counselling because managed…we had a session when me and him went in there and we just talked about what we liked and what we didn't like about each other and how we could've sorted that out so I think that kind of made us more closer as well because we managed to figure out what- what we really knew about each other and what we really felt about each other and all that. So…I mean now after that it's just like me and him are more happier and more closer as brothers than we used to be so…yeah (Daniel, line 306-320)

This extract also portrays a sense that Daniel and Connor came together in discussing their experiences, rather than being isolated from each other by the assumptions they had. Similarly to Jack and his grandfather, it seems Sarah's (Daniel's counsellor) attempt at providing an opportunity for a shared connection enabled a closer bond between the brothers.

In contrast, the alliance between Daniel and Sonia seems to hold a different tone. Following the previous extract, encouraged by Sonia, Daniel goes on to describe the difficulties in the home "caused" by Connor. Whether Daniel's lived experience continues to be dominated by that experience is unclear, however what did seem evident was his efforts to please his mother. Questioning Sonia:

Daniel: Also you like to see me when I'm happy, you feel happy as well

Sonia: I do yeah.

Interviewer: What's that like? Knowing that when you're happy, Mum's happy?

Daniel: Um I think it's just 'coz like I don't know... if I'm happy and nice and then she's like, "Yeah okay then" like it's nice to…[talking to Sonia] don't like to see me feeling sad do you?

Sonia: No. You do though, he's okay today.

Daniel: If I feel sad…yeah. If I feel sad you'll be like, "What's the matter?" If I'm in a happy mood then you'll be in a happy mood. Like if we are…like most of the time you're always happy (Daniel, line 533-547)

Daniel's quote leaves one wondering whether he is left with a sense of responsibility towards his mother, whom he is now left to care for, physically (Daniel is a recognised young carer) and emotionally. Later in his interview he expressed "I don't like to make other people feel sad... I just tend to...won't say anything about it", perhaps suggesting he has internalised an idea that he is responsible for the emotions of others, and in the context of his previous extract, is responsible for ensuring they are contained in some manner.

Daniel: Um sometimes I'd worry about her if she fell over or anything, you know? Or, you know, that…I kept thinking that um good worry... mmm… um oh well like sometimes she wouldn't be able to lift and

that, but I'd- I'd worry about her in a good way because it would be really…I'd worry about her lifting the kettle or something a bit, but I wouldn't- I wouldn't worry and I think that's really good, you know, I think it's good that she's managing to do stuff or managing to walk outside or…and walking back. I'd worry if she tripped over but I'd be really, really happy that she's managed to do that…

Interviewer: That's she's managed to kind of be doing things?

Daniel: Yeah managed to get more better as herself instead of being laid up on the bed like a piece of jelly. Wasn't it Mam? Okay? (Daniel, line 193-208)

His concern and worry about her fragility is perhaps emphasised by his use of words in the earlier above, whereby boiling water seems to represent a potential threat to his mother - that she could easily "dissolve". However, an adaptive alliance Daniel seems to have formed is the therapeutic relationship he has with his counsellor, Sarah. Perhaps this space allows him to be feel contained and safe enough to express his 'trapped feelings'.

'coz like Sarah's my counsellor, I talk to her about things like…I talk to Mam…my Mam about anything like, but sometimes some things…feelings that are trapped deep inside that I don't know about or anything that can't get sorted out with Mam I'll- I'll go talk to Sarah about it, you know, so…I mean Sarah helps me with things that I don't know, but I can talk to Mam about most things, but I don't think it's uh mother to son relationships or whatever (Daniel, line 94-103)

The ideas portrayed in this section illustrate experiences that tell us something about the (re-)forming of the participants' attachments, as they "grow taller", develop and perhaps re-script over time. The emotional connections between the family members illustrated by the

examples of attunement and reciprocity, and the bonds within the families, also seem to be evidence of this.

Discussion

The experiences of the participants were evident across four main themes: adversity in the backdrop – DV leftovers; the slow journey to stability and togetherness; getting on with life and feelings and relationships. In the aftermath of DV, participants experience aspects of hypervigilance, estranged or broken family connections and resentments. At times, violence was re-enacted, resulting in young people being mistaken for the 'abuser', or family members perceiving violence as normal and expected. However, amidst this backdrop of adversity there seemed to be a newfound experience of doing well. The participants who experienced stability seemed to derive it from the grandmother in the family who provided a safe, consistent and containing secure base. Stability also came in the form of everyday togetherness. Perhaps as emotional arousal decreased, everyday tasks and simply 'being together' were internalised as positive and helped the families to appreciate essential and beneficial facets of social connections. Getting on with life was another theme. It appeared that time provided opportunity for processing previous experiences, for reflection and for the development of new roles and identities. Strength was crucial, whereby participants acknowledged getting through complex situations and achieving everyday tasks. Acceptance played a large part in this theme – of the past, of help from others, and of emotions. The final theme was feelings and relationships, which seemed to embrace the previous themes. The development of new attachments, alliances, and narratives seemed apparent, as was the re-scripting of old. Intertwined with this were features of reciprocity, attunement and repairs, which all seemed to work together to negotiate with the past and move forward to the future.

A statement by Patricia introduces a summary of how the families have grown together:

> Life still goes on. Every… tomorrow's still going to come, in't it? It's not… so you have to get on with it. You have to make the best of what you've got (Patricia, line 308-312)

The past is fixed and unchangeable and for many of us, merely a hint of what is yet to come. However, for these families, the past did not appear to be a sole predictor of their future – instead, they appeared to take what they could from their circumstances and move forward. Rather than letting their experiences and attachments trap them in repeated adversity, they were adaptive and flexible in finding new stability and growth. It seemed this resulted in the re-scripting of their attachment narratives. They each facilitated this process for the other. Jack may have equated his worth to that of a dog, yet alongside Patricia, seemed to write a new narrative. Sonia may have remained overwhelmed by guilt and subsequently, not been able to care for Daniel or Connor, had some pressure not been relieved by Emma. For Connor, without the support of Emma, his chances of finding constructive and effective strategies (such as building a trolley or showing his tears) for managing his mental health would have been limited and he may have internalised the 'abuser' role he somehow found himself placed in. Alongside the support from Sarah, it appeared Daniel's strength was nurtured by Sonia and Emma. Opportunities to get to know his brother again were found and he realised his potential and motivation for future careers. For the Kahlon family, each became closer to the other, despite the barrier that had been prevalent for so many years. Sobhia and Aadi's grandmother helped this as they provided much needed respite throughout their lives. Like Daniel, Sobhia and Aadi were forging their identity and position in the world – perhaps their experiences of becoming closer helped them realise the potential positive aspects of human relatedness and

enabled them to use their experiences as a springboard for their futures. Sandeep also realised her potential and was amazed at her ability to keep going. Maybe this was facilitated by allowing her mother to 'contain' her snappiness, rather than it being projected onto her children.

The Containing Grandmother and Re-scripted Attachment Narratives

From the findings, several ideas warrant further discussion. Yet, for the purpose of this paper, two interesting ideas that have arisen will be explored, namely the containing role of the grandmother and the possibility of re-scripting attachments.

Firstly, some ideas from attachment theory which seem fundamental to this discussion are presented. Attachment theory is central when understanding human relatedness and child development (Cassidy & Shaver, 2008) and proposes that early relational experiences ensure that key developmental tasks are achieved (Levy & Orlans, 1998). Consistent and reliable relationships enable children to develop a sense of self (i.e., primary inter-subjectivity, Trevarthen, 2001), whilst attunement with their care-giver provides consistent emotional connection (Stern, 1985, as cited in Hughes, 2006). Such a consistent and attuned relationship enables a child to internalise the characteristics of the relationship and to develop a positive mental representation of themselves and others in the world around them. Through recognising, accepting and synchronising with a child's internal state, care-givers regulate and then co-regulate the child's internal arousal, which enables the child to learn that their emotional experience is manageable and can be shared and accepted by others. A child's capacity to think and understand their world is also developed through their care-givers' interpretations (i.e., secondary inter-subjectivity, Trevarthen, 2001). Subsequently, this encourages reflective functioning and the development of a theory of mind, enhancing emotional understanding and regulation.

Research has indicated that children who are exposed to DV are generally less attached to and receive less support from their care-givers (Levendosky, Huth-Bocks, & Semel, 2002; Rikhye et al., 2008; Styron & Janoff-Bulman, 1997). This study seemed to provide some support for these ideas. Sonia expressed that she was unable to care for her children when she was overwhelmed by the emotions evoked from DV; Sobhia felt her only respite was in her room, primarily from her father's DV but also from Sandeep's "snappiness" as she made attempts to please her husband. Similarly, Jack's mother could not support or care for him due to her continued involvement in a DV relationship. However, research has also demonstrated that the attachments young people have with adults outside the home can serve as buffering and protective factors against the difficulties in family relationships (Aisenberg & Herrenkohl, 2008). For the participants in this study, it seemed their grandmother played this role. Masten's (2001) comment seems pertinent here. She highlighted that the best predictors against risk are the "connections to competent and caring adults in the family and community, cognitive and self-regulation skills, positive views of self and motivation to be effective in the environment" (p. 234). Thus, it appears the grandmother was crucial as she facilitated and nurtured the resilience of the young people, and of their mothers, in this study. She provided a place of stability, safety and security, acted as a primary or secondary 'secure base', a contrast to the traumatic home environment. In doing so, this perhaps freed the young people from the physiological (i.e., a decrease in the release of stress hormones; van der Kolk, McFarlane & Weisaeth, 1996) and emotional constraints (Cairns, 1999) of trauma and provided sufficient space to internalise self-regulation and reflective skills as well as positive social connections.

Possibly through the lens of the individuals in this study, one common criticism of attachment theory - as something that is linear and, if experienced as insensitive or adverse,

will act as something that is set early in life and which is then immutable – seems somewhat misguided. With this in mind, the next area of discussion is that of re-scripting attachments, something which seemed evident from the findings. Sroufe and colleagues (1999) explained "early experience often plays a critical role... but this role is dependent on the surrounding context of sustained environmental supports" (p. 2). Primarily through advances in narrative assessments of mental representations and 'natural experiments' of children being adopted from care, researchers have begun to explore the idea of attachment narratives modifying and developing in the light of new environments and experiences (Hodges, Steel, Hillman, Henderson & Kanuik, 2003, 2004). Hodges and colleagues (2003) have studied children with histories of trauma, who mostly present with insecure or disorganised attachments. They have found that when such children are adopted they initially present with more avoidance and disorganisation, perceiving adults as unaware of their needs. However, over time (1 and 2 years), they found that attachment representations were slowly transforming. Some negative representations remained somewhat stable, yet there was a clear increase across many of the positive representations. The findings of their study seem to somewhat mirror the lived experience of the participants in this study. The negative representations remained – as described particularly in the DV leftovers, - yet new secure representations and experiences came to the forefront and were fostered. Furthermore, for these families, the experience of stability and growth nurtured positive narratives and working models of relationships, enabled the children, mothers and grandmothers to reflect on how they want their lives to be and instilled motivation in each other to achieve this. Together, the themes mirror some fundamental strategies advocated in therapeutic approaches when caring for children with trauma histories (e.g., Hughes, 2004).

This study aimed to explore the coping and resilience of individuals and families after DV. Simply, resilience is about overcoming stress and adversity (Cicchetti, Rogosch, Lynch & Holt, 1993; Masten, 2001). For the participants in this study, the initial theme was evidence of the adversity, whilst the remaining themes were surely indications of how the families were overcoming this adversity. However, in order to fully understand resilience, Rutter (2006) explained that we need to explore the dynamic processes within this. For the families in this study, what seemed most pertinent was their ability to be flexible and adaptive. Attachments and alliances were developed or strengthened, which enabled a shift in mental representations and thus, the meaning ascribed to life experiences. Within this dynamic process, the families were also able to find stability through the many generations of family and appreciate the experience of being together. Finally, the families were able to nurture growth as they embraced change and accepted the past and present. It seemed these encounters set the scene for their experience of resilience.

Limitations

With regards to limitations, it has not been possible to receive feedback from participants to date. This lack of triangulation significantly reduces validity. Many discussions with the research team, colleagues and peers had throughout the analysis, focused on both the individual transcripts and the development of super-ordinate themes. Still, this is not sufficient and the research team anticipate further engagement with the families over the following months.

Secondly, this project initially aimed to recruit three families, each containing a triad of participants (grandparent-mother-young person). This aim was not achieved. Yet, the interview schedules still explored and allowed consideration of trans-generational perspectives.

Potential sample biases may have influenced the results as referring professionals may have been very selective in the families they approached. However, a diverse population in terms of experiences, time since DV exposure and culture was achieved. Recruitment within this population is often tricky and so, achieving a sample of nine individuals across three families is noteworthy. It is felt that the focus on families working together evoked a sense of calm in committees and clinicians.

Qualitative results provide an in-depth analysis of the lived experience of participants and in this case, families and it is widely accepted results of this kind do not generalise across populations or to all families who have been exposed to DV. Instead, IPA studies provide opportunities to gradually develop the knowledge base (Smith, Flowers & Larkin, 2009). The findings in this study did resonate with existing literature, perhaps increasing their credibility. However, were other researchers to complete the same analysis, additional salient findings would surely have been proposed.

Research Implications

In consideration of the findings, several avenues of research seem important. As advocated by Rutter (2006), future investment in qualitative studies to explore the processes of resilience is warranted. IPA advocates the use of case studies for research. Maintaining a generational perspective, researchers could explore the themes produced by the grandparents, the mothers and the young people before generating super-ordinate themes for each generation. This IPA analysis could then be combined with a detailed and elaborate 'case study' of sorts for one families, exploring the position taken by each family member with regards to the pertinent themes.

The findings illustrate the importance of transactional models of development (Sameroff & MacKenzie, 2003) and suggest that future studies explore how individual protective (and risk) factors interact with factors at different levels of the child's ecology.

Further exploration in this area of study would enable theorists to look 'from the inside out' (Brinich, 1990), to understand more about the process by which some attachment scripts remain as vulnerabilities, whilst others can be re-scripted and foster adaptive development.

A longitudinal approach to research in this area may prove fruitful, enabling a clarification of the interactive and multidimensional aspects of resilience after DV, as well as the potential for attachment narratives to modify and develop over time. Such a study would certainly benefit from a broad and dynamic definition of resilience and a more direct assessment of the child's attachment representations.

Clinical Implications

Some key clinical implications emerged. What seemed crucial after the experience of DV was the re-experience of stability. This theme highlighted the fundamental importance of everyday activities in ensuring these families regain a sense of safety and security where it is then possible for them to internalise and integrate new positive experiences into their narratives. Clinicians often feel compelled by the system to engage young people in post-trauma therapy. It seems more important that, for the young people who may benefit from therapeutic intervention, a stable and containing environment is given just as much, if not more, credence within their care-planning needs.

Another finding of this study was the containing role of the grandmother. This seems to highlight the importance of engaging grandparents in early intervention and family support, rather than just an archaic focus on the nuclear family or mother-child dyad.

This study also lends support to the importance of an integrated network (Sprice, 2000), of consultation as an intervention in itself and, where necessary, multi-systemic interventions which target multiple levels of the child's ecology.

Finally, encouraging consistent sources of support for these young people and their families seems vital. This could potentially be provided via the voluntary sector, yet a role for clinical psychologists could potentially be to provide training and consultation to help support and maintain these community projects.

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Public Dissemination Document

Investigating the Experience of Staff who Work with Female Domestic Violence Victims: A Review

And

'Growing Together – How do families experience resilience after domestic violence?'

Word Count – 1473

Public Dissemination Document

This paper summarises the two papers submitted as part of a thesis in fulfilment of the requirements for the degree of Doctor of Clinical Psychology, University of Birmingham. The paper comprises a summary of a literature review detailing the positive and negative emotional effects for professionals who work closely with adult victims of domestic violence. The paper also comprises a summary of an original piece of research that adopts qualitative methods to explore the experience of children, their mothers and their grandmothers in the aftermath of domestic violence.

The Government defines domestic violence as "Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality" (Home Office, 2004). Domestic violence is considered a significant social problem across the globe and across Britain, it accounts for a quarter of all reported crime (Home Office, 2004) and is estimated to cost health and social services 1.45bn each year (Walby, 2004).

Investigating the Experience of Staff who Work with Female Domestic Violence Victims: A Review

We know that working with victims of trauma in general is an emotionally difficult and challenging task (Sabin-Farrell & Turpin, 2003), yet we still know little about the experience of working with victims of domestic violence. Mechanisms including burnout (i.e., emotional exhaustion, depersonalisation and reduced personal accomplishment from one's role), secondary traumatic stress (i.e., re-experiencing the victim's trauma, heightened awareness of victimisation, interpersonal problems and extreme detachment or identification with victims), vicarious trauma (i.e., re-experiencing the victim's trauma and disrupted narratives regarding how one perceives themselves and their needs, how they relate to others

and how they experience the world) and vicarious posttraumatic growth (i.e., increased recognition and appreciation of personal strengths, positive relationships and life) have been proposed to help us understand the experience of general trauma work. These ideas were contribute to the need for the literature review, which aimed to explore the negative and positive effects of working with victims of violence and what the factors which may intensify or buffer these effects are.

Method. Electronic research databases were searched to find to seek the relevant papers for this review. In total, 12 papers were reviewed and these were all rated for their quality using a predetermined tool designed by authors Sale and Brazil's (2004). This tool provided a framework by which the quality of quantitative and qualitative studies could be assessed, and as this review contained both of these; it was deemed a useful framework.

Results. The quality assessment found six studies to be of good quality, five to be of moderate quality and one to be of poor quality. No evidence for clinical levels of burnout was found. This was most likely because staff experienced feelings of personal accomplishment which protected against this happening. There was no evidence of secondary traumatic stress in the quantitative studies either. However, there was conflicting evidence of whether professionals experienced vicarious trauma. The studies that adopted predetermined assessments did not conclude clinical levels. Yet, the qualitative studies, which allowed professionals to talk in depth about their experiences, proved more fruitful in helping us understand the lived experiences of professionals. Experiences seemed most akin vicarious trauma and a final theme by one set of authors (Goldblatt, Buchbinder, Eisikovits & Arizon-Mesinger, 2009) seems to sum this up – 'violence as an emerging worldview'. Re-experiencing the victim's trauma and disrupted cognitions were concluded to have a detrimental effect on the professional and personal lives of staff. It seemed that job stressors,

less therapeutic experience, emotionally distancing oneself from the work and having personal motivations intensified these negative effects. Similar for the negative effects, the quantitative studies found no evidence of vicarious posttraumatic growth, yet the qualitative explorations concluded working with domestic violence victims can be rewarding, both professionally and personally. Buffering factors to negative effects were found to include a high level of education, experience and supervision, support (i.e. socially and in the workplace) and a sense of shared power in the organisation. However, the evidence regarding whether client exposure, past personal trauma and the experience of emotionally distancing oneself from clients is contradictory.

Implications. Although firm conclusions could not be drawn from the literature review, an extract from one paper seems fitting to sum up the findings - "*You can't tell for sure it is because of the work, but it is work related*" (p. 374, Goldblatt 2009). The findings of this review suggest that reflective supervision and training for domestic violence staff are necessary to fully support these clinicians in meeting the needs of the victims to ensure they remain emotionally resilient. Future research in this area would benefit from employing qualitative approaches (hearing about people's experiences in detail) to expand on the limited knowledge base at present.

'Growing Together – How do families experience resilience after domestic violence?'

It is well documented that the effects of domestic violence for young people are adverse and negative (e.g. Herrenkohl, Sousa, Tajima, Herrenkohl & Moylan, 2008) and some children go on to be victims or perpetrators of violence later in their lives (Canon, Bonomi, Anderson & Rivara, 2009). Yet, in contrast to this, the field of research exploring the experience of resilience (i.e. doing well despite adversity) is growing. This is promising as a greater understanding of resilience seems vital to future service provision and early

intervention. Furthermore, it is now accepted that resilience is not some kind of magic, rather it is more likely a series of ordinary processes (Masten, 2001) that we have yet to fully appreciate. Theorists have advocated for research to appreciate the context of the child and subsequently, explore individual and familial processes. With this in mind, the aim of this study was to gain an understanding of the experience of resilience and coping after domestic violence across three generations (i.e., grandmother, mother, and child).

Method. Following appropriate ethical approval, three families, comprising of nine participants in total, were recruited from local services. They all took part in separate semi-structured interviews and they were encouraged to talk freely about their lived experiences. Analysis was carried out using Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009). This type of analysis ensures the participants remain at the heart of the exploration and as "participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p. 51, as cited in Smith, Flowers & Larkin, 2009).

Results. Four themes emerged from the data: adversity in the backdrop – domestic violence leftovers; the slow journey to stability and togetherness; getting on with life and feelings and relationships. In the aftermath of domestic violence, a negative and rippling effect on families was apparent. Although the trauma had ceased, the results suggested it left lasting memories and negative effects on how the participants got through each day. The theme of the slow journey to stability and togetherness highlighted the importance in the role of the grandmother in families, where she provided security, safety and nurturance. The idea of simply being together also contributed to this theme and it seemed the participants were able to internalise normality and close social connections as positive and beneficial. Getting on with life was another theme, which found that time was essential for the participants to

allow them to process previous experiences, reflect and learn and develop new roles and identities. The participants' experiences also emphasised how important the process of acceptance has been for them. The final theme was that of feelings and relationships. For the participants, it seemed this theme bridged the gap between the others and features of reciprocity, attunement and repair were evident, giving rise to the development of new attachments, alliances and narratives, as well as the re-scripting of old.

Implications. To fully understand resilience Rutter (2006) explained we need to explore the dynamic family processes. For the families in this study, it was found that attachments and alliances were developed or strengthened, which enabled a shift in mental representations and attachment narratives and thus, the meaning ascribed to life experiences. Within this dynamic process the families found stability across generations and found time to appreciate the experience of being together. Subsequently, the participants were able to nurture growth as they embraced change and accepted the past and present – they all worked together to set the scene for their experience of resilience. Future research is crucial in this area, particularly embracing the focus on multiple generations and transactional models of development (Sameroff & MacKenzie, 2003). Clinically, this research emphasises the need to be creative when engaging families in therapeutic work and to hold in mind who else might be able to provide stability and growth and the importance of clinicians working closely with each other.

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Appendix 1

Search process and criteria

A systematic search of two electronic databases, ISI Web of Knowledge (comprising Social Science Citation Index Expanded – 1899-present; Social Sciences Citation Index – 1989-present; Arts and Humanities Citation Index – 1975-present; Conference Proceedings Citation Index – Science – 1990-present and Conference Proceedings Citation Index – Social Science and Humanities – 1990-present) and PsycINFO - 1948-2011 (comprising the OVID resources of OVID MEDLINE -1947-2011 and PsycINFO 1987-2011)) was conducted between 1st October 2010 and 31st January 2011 to identify appropriate peer reviewed articles for this review. Searches included text words terms, using combinations of Boolean markers 'AND' 'OR' (see Box 1).

Box 1: Hits from search terms

Search Terms	PsycINFO #hits	WoS #hits	Search terms (contd.)	PsycINFO #hits	WoS #hits
1. Domestic violen*	9004386	7776 4299	12. 7 OR 8 OR 9 OR 10 OR 11	151615	>100000 >100000
2. Domestic abus*	2827	3656	13. Experience	173651	200
3. Intimate partner violen*	483 1749	754 3781	14. Vicarious trauma*	365	951 7850
4. Spouse abus*	12109	12339	15. Secondary trauma* stress	236	1018
5. Battered women	34450	68741	16. Burnout	5577	78
6. 1 OR 2 OR 3 OR 4 OR 5	99067 1124	>100000	17. Posttrauma* growth	562 150	4 0
7. Staff	27811	3749	18. 13 AND 6 AND 12	19	3
8. Professional	865	10700	19. 14 AND 6 AND 12	7 16	1
9. Mental health professional		565	20. 15 AND 6 AND 12	1	
10. Therapist			21. 16 AND 6 AND 12		
11. Counsellor			22. 17 AND 6 AND 12		

Appendix 2

Data Extraction Tool

- Study title, authors and origin

- Participant demographics
    - Sample size
    - Age and gender
    - Profession
    - Years in job role
    - Education
    - Past personal trauma
- Measures used
- Method of analysis
- Results - Research question one
    - Negative effects
    - Positive effects
- Results - Research question two
    - Factors influencing negative effects
    - Factors influencing positive effects

Appendix 3

Quality Assessment Proforma – Sale and Brazil's (2004) framework

Goals of Criteria	Qualitative Methods	Quantitative Methods
Truth Value (Credibility vs. Internal Validity)	1. Triangulation of sources 2. Triangulation of methods 3. Triangulation of investigators 4. Triangulation of theory / perspective 5. Peer debriefing 6. Negative case analysis or searching for disconfirming evidence 7. Member checks 8. Use of quotations 9. Informed consent stated 10. Ethical review or human subject review undertaken 11. Statement that confidentiality protected 12. Consent procedure described	1. Extraneous or confounding variables identified 2. Extraneous or confounding variables or baseline differences controlled for in the analysis 3. Statement about comparibility of control group to intervention group at baseline 4. Statement that comparison group treated equally to aside from intervention 5. Informed consent stated 6. Ethical Review undertaken 7. Statement that confidentiality protected
Applicability (Transferability / Fittingness vs. Validity / Generalisability)	1. Statement of purpose 2. Statement of research questions 3. Phenomenon of study stated 4. Rational for the use of qualitative methods 5. Rationale for the tradition	1. Statement of purpose 2. Objective of study explicitly stated or described 3. Description of intervention if appropriate 4. Outcome measures defined

within qualitative methods

6. Description of study context or setting
7. Statement of how setting was selected
8. Sampling procedure described
9. Justification or rationale for sampling strategy
10. Description of participants or informants
11. Data gathering procedures described
12. Audiotaping procedures described
13. Transcription procedures described
14. Field note procedures described
15. Data analysis described
16. Coding techniques described
17. Data collection to saturation specified
18. Statement that reflexive journals were kept

5. Assessment of outcome blinded
6. Description of setting or conditions under which data was collected
7. Design stated explicitly (i.e. case study, cross-sectional)
8. Subject recruitment or sampling selection described
9. Sample randomly selected
10. Inclusion and exclusion criteria for subject selection stated explicitly
11. Study population defined or described
12. Source of subjects stated (i.e. sampling frame identified)
13. Source of controls stated
14. Selection of controls described
15. Control or comparison group described
16. Statement about non-respondents or dropouts or deaths
17. Missing data addressed
18. Power calculation to assess adequacy of sample size or sample size calculated for adequate power
19. Statistical procedures referenced or described

	19. Description of raw data	20. *P* values stated 21. Confidence intervals given for main results 22. Data gathering procedures described 23. Data collection instruments or source of data described 24. At least one hypothesis stated 25. Both statistical and clinical significance acknowledged
Consistency (Dependability vs. Reliability)	1. External audit of process	1. Standardisation of observers described
Neutrality (Confirmability vs. Objectivity)	1. External audit of data and reconstructions of the dates 2. Bracketing 3. Statement of researcher's assumptions or statement of researcher's perspective	

Appendix 4

Detailed scoring of papers included within the review with regards to the quality criteria – Yes=2; Partial=1; No=0; N/A=2

Quantitative Research Studies

Study Title *Origin*	Truth Value		Applicability				Consistency	Total Score
Brown & O'Brien (1998) Understanding stress and burnout in shelter workers. *North America*	1. Yes 2. Yes 3. N/A 4. N/A 5. No 6. No 7. No	1. Yes 2. Yes 3. N/A 4. Yes 5. N/A 6. Yes	7. Yes 8. Yes 9. Yes 10. Partial 11. Yes 12. Yes	13. N/A 14. N/A 15. N/A 16. No 17. No 18. No	19. Yes 20. Yes 21. No 22. Yes 23. Yes 24. Yes	25. No *39 / 50 – 78%*	1. Yes *2 / 2 – 100%*	**78%**
	8 / 14 – 57%							
Baker, O'Brien & Salahuddin (2007) Are Shelter workers burned out? An examination of stress, social support and coping. *North America*	1. Yes 2. Yes 3. N/A 4. N/A 5. No 6. No 7. No	1. Yes 2. Yes 3. N/A 4. Yes 5. N/A 6. Yes	7. Yes 8. Yes 9. Yes 10.Yes 11.Yes	12.Yes 13.N/A 14.N/A 15.N/A 16.Yes	17.N/A 18.No 19.Yes 20.Yes 21.Yes	22.Yes 23.Yes 24.Yes 25.Yes *48 / 50 – 96%*	1. Yes *2 / 2 – 100%*	**84%**
	8/14 – 57%							
Dekel & Peled (2000) Staff burnout in	1. Yes 1. Yes 2. N/A	1. Yes 2. Yes 3. N/A	7. Yes 8. Yes 9. Yes	12. Yes 13. N/A 14. N/A	17. N/A 18. No 19. Yes	22. Yes 23. Yes 24. Yes	1. Yes	

battered women's shelters. *Israel*	3. N/A 4. No 5. No 6. No *8/14 – 57%*	4. Yes 5. N/A 6. Yes	10. Yes 11. Yes	15. N/A 16. Yes	20. Yes 21. Yes	25. No *46 / 50 – 92%*	*2/2 – 100%*	**83%**
Slattery & Goodman (2009) Secondary traumatic stress among domestic violence advocates: workplace risk and protective factors. *America*	1. Yes 2. Yes 3. N/A 4. N/A 5. Yes 6. No 7. Yes *12 / 14 – 85%*	1. Yes 2. Yes 3. N/A 4. Yes 5. N/A 6. Yes	7. Yes 8. Yes 9. Yes 10. Yes 11. Yes 12. Yes	13. N/A 14. N/A 15. N/A 16. No 17. Yes	18. No 19. Yes 20. Yes 21. Yes 22. Yes	23. Yes 24. Yes 25. No *44 / 50 – 88%*	1. Yes *2 / 2 – 100%*	**91%**
Baird & Jenkins (2003) Vicarious traumatisation, secondary traumatic stress and burnout in sexual assault and domestic violence agency staff and volunteers *America*	1. Yes 2. Yes 3. N/A 4. N/A 5. Yes 6. Partial 7. Yes *13 / 14 – 92%*	1. Yes 2. Yes 3. N/A 4. Yes 5. N/A	6. Yes 7. Partial 8. Yes 9. Yes 10.Partial 11.Yes	12.Yes 13.N/A 14.N/A 15.N/A 16.Yes 17.N/A	18.No 19.Yes 20.Yes 21.No 22.Yes	23.Yes 24.Yes 25.Partial *43 / 50 – 86%*	1. Yes *2 / 2 – 100%*	**93%**
Bemillier, M. &	1. Yes	1. Yes	7. Partial	13. N/A	18. Yes	23. Yes	1. Yes	

Williams, L.S. (2011) The role of adaptation in advocate burnout: A case of good soldiering.	2. Yes 3. N/A 4. N/A 5. Yes 6. Yes 7. Yes *14 / 14 – 100%*	2. Yes 3. N/A 4. Yes 5. N/A 6. Yes	8. Yes 9. Yes 10. Partial 11. Yes 12. Yes	14. N/A 15. N/A 16. Yes 17. Yes	19. No 20. Yes 21. Yes 22. Yes	24. Yes 25. Yes *46 / 50 – 92%*	*2 / 2 – 100*	**97%**

Qualitative Research Studies

Study Title *Origin*	Truth Value		Applicability			Consistency	Neutrality	Total Score
Goldblatt (2009) Caring for abused women: impact on nurse' professional and personal life experiences *Israel*	1. Yes 2. No 3. Yes 4. Partial 5. No 6. Partial 7. No	8. Yes 9. Yes 10.Yes 11.Yes 12.Yes *16 / 24 – 66%*	1. Yes 2. Yes 3. Yes 4. Yes 5. Yes 6. Yes 7. No	8. Yes 9. Yes 10.Yes 11.Yes 12.Yes 13.No	14.Yes 15.Yes 16.Yes 17.No 18.No *28 / 36 – 72%*	1. Yes *2 / 2 – 100%*	1. No 2. Yes 3. Yes *4 / 6 – 66%*	**76%**
Iliffe & Steed (2000) Exploring the counsellor's experience of working with perpetrators of and survivors of domestic violence *Perth, Australia*	1. No 2. No 3. Yes 4. No 5. Partial 6. Partial 7. Yes *15/ 24 – 63%*	8. Yes 9. Yes 10.Partial 11.Yes 12.Yes	1. Yes 2. Yes 3. Yes 4. Yes 5. Partial 6. Yes 7. No	8. Yes 9. Yes 10.Yes 11.Yes 12.Yes 13.No	14.Yes 15.No 16.No 17.No 18.No *23 / 36 – 64%*	1. Yes *2 / 2 – 100%*	1. Yes 2. Partial 3. Partial *2/6 – 33%*	**65%**

Bell, H. (2003). Strengths and secondary trauma in family violence work. *North America*	1. Yes 2. No 3. No 4. Partial 5. No 6. No	7. Yes 8. Yes 9. No 10. Partial 11.No 12.No *8 / 24 – 33%*	1. Yes 2. Partial 3. Yes 4. Yes 5. Yes 6. Yes	7. No 8. Yes 9. No 10.Yes 11.Yes 12.Yes 13.Yes	14.No 15.Yes 16.Yes 17.No 18.No *27 /36 – 75%*	1. Partial *1 / 2 – 50%*	1. Partial 2. No 3. No *1 / 6 – 17%*	**44%**
Goldblatt, Buchbinder, Eisikovits & Arizon-Mesinger (2009) Between the Professional and the Private. The meaning of working with intimate partner violence in social workers' lives. *Israel*	1. Yes 2. No 3. Yes 4. Partial 5. Yes 6. No	7. No 8. Yes 9. Yes 10.Yes 11.Yes 12.Yes *17 / 24 – 71%*	1. Yes 2. Yes 3. Yes 4. Yes 5. Yes 6. Yes	7. Yes 8. Yes 9. Yes 10.Yes 11.Yes 12.Yes 13.Yes	14.Yes 15.Yes 16.Yes 17.Yes 18.No *34 / 36 – 94%*	1. Yes *2 / 2 – 100%*	1. Yes 2. Yes 3. Yes *6 / 6 – 100%*	**91%**

Mixed Method Research Studies

Study Title ***Origin***	**Truth Value**		**Applicability**				**Consistency**		**Neutrality**		**Total Score**
Ben-Porat & Itzhaky (2009) Implications of treating family violence for the therapist: secondary traumatisation, vicarious traumatisation and growth *Israel*	Qual. 1. Yes 2. Yes 3. Yes 4. Partial 5. No 6. Partial 7. No 8. No 9. No 10. Yes 11. No 12. No *10 / 24 – 42%*	Quant. 1. Yes 2. Yes 3. N/A 4. N/A 5. No 6. Yes 7. No *10 / 14 – 71%*	Qual. 1. Partial 2. Yes 3. Yes 4. Yes 5. Partial 6. No 7. No 8. Yes 9. Yes 10. No	11. N/A 12. N/A 13. No 14. No 15. Yes 16. No 17. No 18. No *18 / 36 – 50%*	Quant. 1. Yes 2. Yes 3. N/A 4. Yes 5. N/A 6. Yes 7. Partial 8. No 9. Partial 10. Partial 11. Yes 12. Yes 13. N/A	14. N/A 15. N/A 16. No 17. No 18. No 19. Yes 20. Yes 21. Yes 22. No 23. Yes 24. Yes 25. No *35 / 50 – 70%*	Qual. 1. Yes *2 / 2 – 100%*	Quant. 1. Yes *2 / 2 – 100 %*	Qual. 1. Yes 2. No 3. No *2 / 6 – 33%*	Quant. N/A	**63%**
Jenkins, Mitchell, Baird, Whitfield & Meyer (2010) The counsellor's trauma as counselling motivation:	Qual. 1. Yes 2. Yes 3. Yes 4. Yes 5. No 6. Partial 7. No 8. Yes 9. Yes	Quant.* N/A	Qual. 1. Yes 2. Yes 3. Yes 4. Partial 5. Partial 6. Yes 7. Yes 8. Yes 9. Yes	11. N/A 12. N/A 13. No 14. Yes 15. Yes 16. No 17. No 18. No	Quant. N/A		Qual. 1. Yes	Quant. N/A	Qual. 1. Yes 2. No 3. No	Quant. N/A	

Vulnerabilit y or stress inoculation	10.Yes 11.Yes 12.Yes	10.Yes			
America	*19 / 24 – 79%*	*26 / 36 – 72%*	*2 / 2 – 100%*	*2 / 6 – 33%*	**71%**

Appendix 5

Summary of findings studies assessed as good, moderate or poor methodological quality

Study and Quality	Analyses and findings
Good Quality (n = 6) (1) Bemiller & Williams (2011)	• Descriptive – Average levels of BO • Multiple Regression Analyses – Predicting BO – Hours per week* and after hours responsibilities*; Access to Tool* has negative influence. Length of stay, autonomy, and working with outside agencies has no effect. Predicting BO - (adding worker perceptions about their work environment, and personal motivations to do job) Positive aspects outweigh negative aspects* (negative influence), Hours per week*, Rewards decrease stress* (negative influence), Tools* (negative influence), Working with outside agencies*. After hours is no longer significant. o Part-time workers – model fails to show relationships for co-worker stress, job rewards decrease stress and positive outweigh negatives. o Newer workers (less than year) – after hours stronger predictor of BO; model failed to show co-worker stress
(2) Slattery & Goodman (2009)	• Descriptive – Clinical levels of STS • Correlations among social support, clinical supervision, shared power and STS • Social support, positive clinical supervision, shared power all negatively correlated with STS • Multiple Regression Analyses – Predicting STS – Past personal trauma*; Shared power* (negative influence) • Hours worked not predictive of STS
(3) Goldblatt et al. (2009)	• Between work and couple hood: The blurring of boundaries as a source of reflection on intimate partnership • Violence as an emerging worldview
(4) Baird & Jenkins (2003)	• Descriptive – Average levels of BO; No clinical evidence of STS or VT (Paid staff and volunteers did not differ on personal trauma history, STS, VT, or general distress) • T-test comparisons of paid staff and volunteers on education; counselling experience; trauma counselling experience' exposure (hrs a week; clients a week); BO total; EE; D; PA o Paid staff had higher scores on EE, D and PA, but not overall BO. • Correlations of educational levels and job role with BO o More educated and more experienced staff had higher EE and PA o Younger workers had higher BO and EE

	• Correlations of client exposure with BO o Exposure (hours per week) associated with higher EE, and PA, but not overall BO • Multiple Regression Analyses – VT - Education level* (negative influence); number of clients only marginally contributed. STS – no variables were found to be significant. BO – age* was only significant factor; EE – age* and being a crisis worker*; PA – being a crisis worker* and hours of exposure*
(5) Baker, O' Brien & Salahuddin (2007)	• Descriptive – Average levels of BO (D scale of the BO measure only used for descriptive purposes) • Correlations among job stressors, social support, belief in ability to cope with stressors at work, confidence in one's ability to be successful, coping strategies, BO • Multiple Regression Analyses – Predicting EE - Occupational stress variables (Time Pressure*) and self-efficacy for accomplishing tasks*. Predicting PA – Occupational stress variables (Time Pressure*; Belief in ability to cope with stressors*. • 12% believed changes in physical environment would help stressors at work; 10% felt Additional training, having more say in policy
(6) Dekel & Peled (2000)	• Descriptive – Average levels of BO; Clinical levels of 'after hours BO' • Correlations among age, education, position, and years in job with BO and Social Support o Lower PA and House support (i.e. social support) associated with 'after hours BO' o More hours worked associated with higher D and 'after hours BO' o More education and more years experience associated with lower D and lower 'after hours BO' o 'House mothers', admin staff and counsellors have higher levels of D respectively
Moderate Quality (n = 5)	
(7) Brown & O' Brien (1998)	• Correlations among stress, social support and BO o Higher EE and D associated with mental disengagement coping o PA associated with active coping, positive reinterpretation, growth and planner o Job stressors (specifically Time pressure, Red tape, physical demands, lack of participation and achievement) associated with high EE and D o Social support associated with lower EE and D
(8) Goldblatt	• 'Struggling on work and home fronts'

(2009)	○ 'The encounter with domestic violence: a challenge to nurse' professional role perception' (nurses are dealing with own perceptions being challenged by emotions and judgemental attitudes) ○ 'Separating between work and home' (where nurses attempt to block the impact of domestic violence from invading the private sphere of their home and family) • Excluded themes – stress due to general workload; abused women's suffering compared to patients' suffering
(9) Jenkins et al. (2010)	• Frequencies of Motivations (personal meaning-38.1%-desire to help others through counselling because it gave more to one's own life; Self-focused-37.1%-getting intrinsic personal satisfaction from work) and Changes • Correlations among Motivations, Changes, and Symptom Scales ○ Personal trauma motivation associated with higher STS, general distress and VT. Also associated with reporting of positive changes and helping to resolve trauma ○ Altruistic motivation associated with higher VT and general distress and past history of trauma ○ Community motivation associated with lower BO and VT ○ Higher levels of VT associated with describing positive changes and work helping to resolve trauma ○ Changes of Noticing and mentioning client effects associated with lower STS and general distress ○ Changes of Self-Other relationships associated with lower VT
(10) Iliffe & Steed (2000)	• Initial impact of DV counselling • Changes to cognitive schemas • Burnout • Personal impact of hearing traumatic material • Coping strategies • Challenging issues for DV counsellors
(11) Ben-Porat & Itzhaky (2009)	• Descriptive – No evidence of clinical levels of STS or clinical levels of VTPG • ANOVA – significant difference between DV workers and Non-DV workers on VTPG – Non-DV workers had more • ANOVA – no significant difference on STS • Chi-square t-tests (difference between DV workers and non-DV workers) – Negative changes: DV workers reported more negative changes; Positive changes: DV workers reported more positive changes
Poor Quality (n = 1)	• 10% named negative aspects - Negative aspects: clients in

(12) Bell (2003)	danger, as frustrating, as overwhelming problems, as organisations that were not rational or supportive. 40% named positive effects - Positive aspects: helping clients' recovery, • 43% could name both negative and positive effects of their work, or were unsure of its effect • Strengths – Sense of competence about coping; Maintaining an objective motivation; Resolving personal trauma; Drawing on positive role models of coping; Having buffering personal beliefs

As illustrated in Appendix 5, the papers included in the review were assessed with regards to the variables outlined by Sale and Brazil (2004). For example, the truth value appraises criteria ranging from whether a qualitative study triangulated sources, methods or investigators, to assessing if quotations were used, whilst for a quantitative study, the same goal assesses if confounding variables were acknowledged and identified during analysis, the comparability of control groups or if informed consent was gained. Consistency assesses whether an external audit of processes (i.e., within qualitative studies) or standardisation of observers is described (i.e. within quantitative studies). The neutrality goal, assessing whether assumptions and 'bracketing off' were identified by the author, applies only to qualitative papers. It is encouraging to find some articles scoring so highly, particularly as some authors may have been constricted by journal guidelines with regards to the reporting of some information pertinent to the study. For instance, a quantitative study deemed of good quality, Slattery and Goodman (2009) did not report whether ethical review had been received, undermining the 'truth' goal. It could be assumed the author was constricted by the format of the Journal, however, the confidence that can be drawn from the results of this paper remain impeded as, for example, the author failed to make a statement about non-respondents or report power calculations ('applicability' goal). A mixed-method study deemed as moderate quality (Ben-Porat and Itzhaky 2009) lacked strength in the qualitative section of their research. For example, the authors did not make use of quotations or peer debriefing ('truth'

goal), did not adequately describe data analysis, or refer to reflexivity and 'bracketing off' ('applicability' and 'neutrality' goals). The study deemed as poor quality (Bell 2003), a qualitative exploration, demonstrated weak methodological quality, particularly across the 'truth' and 'neutrality' goals. This covered both criteria that strengthens the confidence of the results found within a qualitative study (e.g. triangulation of methods and investigators; 'bracketing off' of researcher's assumptions) as well as criteria essential to research practice (e.g., consent procedures; protection of confidentiality). Again, Bell may have been constricted by journal guidelines, but regardless of this, the conclusions that can be drawn from this study remain limited due to specific criteria not addressed.

Appendix 6

Appendix 6 outlines a discussion of the measures adopted by papers within the review.

Burnout

The most commonly used measure to assess the negative impact of working with victims of DV was the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986), adopted in four of the reviewed studies (Brown & O' Brien, 1998; Baken, O' Brien, & Salahuddin, 2007; Dekel & Peled, 2000; Baird & Jenkins, 2003). It is comprised of three scales measuring emotional exhaustion (EE), depersonalisation (D) and personal accomplishment (PA). It is a 22-item self-report inventory which produces a total score of BO, and a score representing each subscale. Alpha coefficients for total scale have been shown to be .83, whilst reliability coefficients of the subscales ranged between .71 and .90 (Maslach & Jackson, 1986).

Secondary Traumatic Stress

Measurement of STS varied across studies. Slattery and Goodman (2009) chose the PTSD Checklist-Stressor Specific Version (PCL-S; Weathers, Litz, Herman, Huska, & Keane, 1993). This is a 17-item self-report instrument measuring the degree of posttraumatic stress disorder symptoms, as defined by the Diagnostic and Statistical Manual of Mental Disorders (4^{th} ed.; DSM-IV; American Psychiatric Association 1994). The PCL-S has high internal consistency for this sample, with a Cronbach's alpha of .91. The Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegedis, & Figley, 2003) is a 17-item self-report measure examining symptoms (i.e. intrusive; avoidant; arousal) that arise in counsellors who work with trauma victims. The authors (Ben-Porat & Itzhaky, 2009) translated this questionnaire into Hebrew and the Cronbach's alpha for internal reliability was found to be .93 and for internal consistency, .88. Finally, the Compassion Fatigue Self-Test for Practitioners, (CFST, Figley, 1995) is a 40-item questionnaire assessing the degree of STS across two sub-scales

measuring burnout and compassion fatigue. In Baird and Jenkins' (2003) study, Cronbach's alpha reliability for the total measure was found to be .90.

Vicarious Trauma

With regards to VT, Baird and Jenkins (2003) used the Traumatic Stress Institute Belief Scale (Pearlman, MacIan, Johnson, & Mas, 1992), which assesses disruption in beliefs about self and others which may arise through a helping relationship. This is an 80-item questionnaire. Cronbach's alpha for the total scale was found to be .95. This study also included a general measure of symptomtology and well-being, the Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1983).

Vicarious posttraumatic growth

With regards to the positive emotional experience of working with this client group, one study (Ben-Porat & Itzhaky, 2009) used a quantitative assessment measure, the Post-traumatic Growth Inventory (PGI; Tedeschi & Calhoun, 1996). The PGI is a 21-item self-report measure examining positive changes in individuals after traumatic events. The authors adapted this to evaluate the changes experienced as a result of their sample's work and Cronbach's internal reliability was found to be .93.

Impact outside of work

The impact of work-related concerns on professionals' functioning outside of work was measured in one study (Dekel & Peled, 2000) with the 'After Hours Burnout' (AHB, Gorelik, 1997, as cited in Dekel & Peled, 2000). The AHB adopts two questions, "Are you disturbed by clients' problems and difficulties beyond work hours?" (i.e. measuring emotional disturbance) and "Does your work interfere with your functioning in other domains?" (i.e. measuring functional disturbance). It is reported to have satisfactory face validity (Gorelik, 1997, as cited in Dekel & Peled, 2000) in an unpublished thesis.

Qualitative Studies

The qualitative studies measured the negative emotional experience of working with victims of domestic violence through semi-structured interviews. One study simply asked participants to describe the changes in themselves as a result of their work (Jenkins, Mitchell, Baird, Whitfield, & Meyer, 2010), whilst another adopted a grounded theory approach in which the questions evolved as the study progressed (Bell, 2003). Other studies based their semi-structured interview on previous research and clinical experience (Iliffee & Steed, 2000; Goldbaltt, 2009; Goldblatt, Buchbinder, Eisikovits & Arizon-Mesinger, 2009). Finally, methods of investigation varied across the studies (e.g. interpretative phenomenological and content analysis) and all studies explored both positive and negative emotional experiences.

Personal Trauma

The presence of personal trauma was measured through demographic information in several studies (Baird & Jenkins, 2003; Slattery & Goodman, 2009; Jenkins et al., 2010). Bell (2003) also explored personal trauma, including whether participants felt this was resolved (e.g. personal therapy) through semi-structured interviewing.

Coping and Self-Efficacy

Coping strategies were empirically examined by the COPE (Carver, Scheier & Weintraub, 1989) (Baker & O' Brien, 1998) or with subscales extracted from the Brief COPE (Carver, 1997) (Baker, O' Brien, & Salahuddin, 2007). Several of the qualitative studies (Iliffe & Steed, 2000; Bell, 2003; Goldblatt, 2009) also explored particular coping strategies adopted when working with DV victims, whilst Bell (2003) recognised aspects of self-efficacy and confidence in her sample.

Social Support

Measurement of social support varied. Baker and O' Brien (1998) used the Perceived Social Support Scale (House & Wells, 1978), an adapted version of the 'House Questionnaire' (Gorelik, 1997) was used in another (Dekel & Peled, 2000), whilst other authors (Slattery and Goodman, 2009) focused on co-worker cohesion, taking a subscale from the Work Environment Scale (Moos, 1994). Social support was also qualitatively explored (Bell, 2003).

Motivations for work

Motivations for working with this population were assessed in several of the studies (Brown & O' Brien, 1998; Bell, 2003; Jenkins et al., 2010). The earliest study used an adapted measure (Motivation for Employment Scale, Black, 1992) for this purpose, whilst the others adopted qualitative investigations.

Education and Experience

Further education and experience was measured by demographic information in two studies (Dekel & Peled, 2000; Baird & Jenkins, 2003).

Occupational Stress

Occupational stress was measured by an adapted version of the Jobs Stress Index (JSI; Smith & Sandman, 1988) in two studies. This is a self-report measure where respondents indicate the degree of their perceived stress as either 'no', 'sometimes' or 'yes'. The initial adapted version (Baker & O' Brien, 1998) used five of the original subscales (i.e. 'lack of participation', lack of achievement', 'red tape', 'time pressure', 'physical demands and danger') due to their relevance to crisis workers, whilst the subsequent adaptation (Baker, O' Brien, & Salahuddin, 2007) used four of these subscales (i.e. omitting 'lack of participation'). This was in response to the findings in Baker and O' Brien's study which demonstrated positive correlations across these subscales with EE and D, as measured by the MBI (Maslach

& Jackson, 1986). Alpha coefficients for these subscales range between 0.68 and 0.82. A further adaptation of the JSI, the Shelter Stress Inventory (McRaith & Brown, 1991) was also used in Baker's 1998 study. No reliability or validity data was reported. Iliffe and Steed's (2000) phenomenological analysis also explored challenging issues pertinent to DV work environments.

Shared Power

This factor was measured by one study (Slattery & Goodman, 2009) through a questionnaire developed by the authors, the Shared Power Scale. It was shown to have strong internal consistency (Cronbach's alpha coefficient = .93) and construct validity in correlation with the WES-Autonomy subscale (Moos, 1994), a measure of decision-making and self-sufficiency in the workplace (r = .68), and the Conditions for Work Effectiveness Questionnaire (Chandler, 1986), a measure of work empowerment (r = .82).

Level of exposure

Level of exposure was measured by demographic information in four studies (Dekel & Peled, 2000; Baird & Jenkins, 2003; Bell, 2003; Slattery & Goodman, 2009).

Appendix 7

Additional approaches considered for research

Other approaches were considered. Narrative approaches complement investigations of experiences involving transitions and identity negotiation; however it was felt that IPA would allow relevant narratives to be heard. Grounded theory (Charmaz, 2006), with a suitable perspective to the research question, could inform our understanding of resilience at an explanatory level, for instance, the factors which influence coping and resilience across generations. This would provide a rich conceptual formulation of the construct through the generation of abstract concepts and the formulation of the relationships between these concepts (Kearney, 1998, as cited in Charmaz, 2006). It is also acknowledged this approach would provide a structured protocol to the work, however a larger sample is necessary than for IPA and the limited time period constraining the research proved this option unfeasible. Furthermore, IPA can produce a more detailed analysis of the richness and complexity of experiences, which could go on to form the basis for future grounded theory enquiries if needed (Smith, Flowers & Larkin, 2009).

Appendix 8

Ethical Approval

Appendix 9

Family Information Sheet

Why is the research being done?

Living through domestic abuse can be extremely stressful. Some young people turn to members of their families for help and support so they can cope with their thoughts and feelings about what happened.

We would like to talk to young people, their mothers and their grandparents to find out more about the way they support each other and understand the strengths that you and your family have developed. This will enable us to find better ways to help other young people and their families who have lived through domestic abuse.

Why am I being asked to take part?

You have been asked to take part because you and/or your family get help from some local domestic abuse services.

What will I be asked to do?

If you would like to participate, you will be asked to come to a local clinic (you will be given money for the bus or train to help you get there). You will then meet with Rebecca and you will be able to talk about the strengths and coping that you and your family have shown. This will take about 60 or 90 minutes.

Our talk will be recorded onto a tape so we can remember the things that you have said. This will be kept in a safe place (University of Birmingham) where no-body can access them except the researchers.

Pseudonyms (fictional names) will be used and the tape will be destroyed to make sure your story is confidential. Your name or any other information that might identify you will NOT appear in the recording, or any other written material.

Do I have to take part?

NO – you do not have to take part if you do not want to. This will NOT AFFECT ANY services you and your family receive.

What are the possible advantages and disadvantages of taking part?

Talking about you and your families' strengths and how you all coped together with the domestic abuse can often be a positive and helpful experience. But the experience of domestic abuse is very difficult and therefore, we will make every effort to put you at ease during our meetings.

It is unlikely that you will become upset, but you can stop the interview at any time and you may leave the room if you wish. If you are upset after the interview, you can speak to me or any other professional who is helping your family.

Every family who takes part in the study will be given a family cinema ticket as a way of thanking you and your family for the help you have given us. You will also be placed in a prize draw and have the chance to win an MP3 player.

What do I do if I want to take part?

If you would like to take part, you, your mother and your grandparent will all need to fill in and sign the consent forms to say that you would like to take part. You will each need to sign a separate form. In this pack there is an addressed envelope for you to post them back to me.

When I receive your consent forms I will then contact you to arrange a time to meet.

Safety

We will not be able to keep things private if you tell us that you or someone else is at risk or in danger of getting hurt. In this case, I will follow the Local Safe-Guarding Children's procedures and pass on information to the relevant professionals in child services to make sure that you and those close to you have the best support.

What if you change your mind about taking part?

It is not a problem if you say that you want to take part in this project, but then change your mind. You can just speak to Rebecca or another person you are

working with and let them know. You can change your mind at any time and this will NOT affect any of the support you and your family receive.

What happens after the interview?

After the interview, you will have another chance to ask any questions about the study, and will also be able to talk about any thing that may have upset you. There is also lots of information at the end of this leaflet about free support agencies you can contact if you want to. We will write to you to tell you some of the things we think were important from all of the interviews.

If you wish, you can send back some feedback or comments about this.

If you wish, we will contact you to arrange a time to discuss any statements from your interview that you may not want written in the final report.

What if I have further questions?

Please contact Rebecca at the details below if you have any further questions. Thank you for your help

Rebecca Ryan School of Psychology, University of Birmingham,

Edgbaston, Birmingham. B15 2TT Email: [redacted]

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Childline: 0800 1111. 24 hours a day. Calls are free, even from mobiles and the calls will not show up on bills.

Samaritans: 08457 90 90 90 **National Society for the Prevention of Cruelty to Children**: 0808 800 5000

Women's Aid: 0808 2000 247

Young Minds (parent's helpline): 0808 802 5544

Reducing Domestic Violence Project: 0121 693 6143

www.respect4us.org.uk

www.nspcc.org.uk

www.itsnotyourfault.org

www.thehideout.org.uk www.youngminds.org.uk

www.ymca.org.uk

www.there4me.com

www.childline.org.uk

www.womensaid.or.uk

www.actionforchildren.org.uk

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Appendix 10

Consent to be contacted form

I agree to be contacted about the following study:

Research study: Growing Together – How do families cope with Domestic Abuse?

Name of Researcher: Rebecca Ryan

Please provide the following details so that contact can be arranged appropriately:

Name:

……

Address:

……..

……..

……..

……..

Telephone Number:

……

I agree to be contact by about this project, by:

(Please tick all that apply)

Telephone ☐

Letter ☐

Date: …….

Signature: ……..

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Appendix 11

Consent Forms for Grandparent, Mother and Young Person

GRANDPARENT'S CONSENT FORM

Identification Number:.....

Researcher: Rebecca Ryan Please initial box

1. I confirm that I have understood the information sheet about this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that it is my choice to take part and that I can stop at any time during the research interview, without giving any reason. ☐
3. I understand that the research interview will be audio-recorded. ☐
4. I can refuse to answer any questions I wish. ☐
5. I understand that direct statements from my interview may be put in a report available to the public, but that my name or any other information that might identify me will not be included. ☐
6. I understand that the researcher will destroy the tapes of our discussion after the research is finished. ☐
7. I agree to take part in the above study.

....

Your name (Printed) Date Signature

Thank you for your help!

Growing Together – How do families cope with domestic abuse?

Rebecca Ryan, Trainee Clinical Psychologist, School of Psychology, University of Birmingham, Edgbaston, B15 2TT. Email: [redacted]

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MOTHER'S CONSENT FORM

Identification Number:.....

Researcher: Rebecca Ryan Please initial box

1. I confirm that I have understood the information sheet about this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that it is my choice to take part and that I can stop at any time during the research interview, without giving any reason. ☐
3. I understand that the research interview will be audio-recorded. ☐
4. I can refuse to answer any questions I wish. ☐
5. I understand that direct statements from my interview may be put in a report available to the public, but that my name or any other information that might identify me will not be included. ☐
6. I understand that the researcher will destroy the tapes of our discussion after the research is finished. ☐
7. I agree to take part in the above study. ☐

....

Your name (Printed) Date Signature

Thank you for your help!

Growing Together – How do families cope with domestic abuse?

Rebecca Ryan, Trainee Clinical Psychologist, School of Psychology, University of Birmingham, Edgbaston, B15 2TT. Email: [redacted]

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YOUNG PERSON'S ASSENT FORM

Identification Number:.....

Researcher: Rebecca Ryan

Please initial box

1. I confirm that I have understood the information sheet about this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that it is my choice to take part and that I can stop at any time during the research interview, without giving any reason. ☐
3. I understand that the research interview will be audio-recorded. ☐
4. I can refuse to answer any questions I wish. ☐
5. I understand that direct statements from my interview may be put in a report available to the public, but that my name or any other information that might identify me will not be included. ☐
6. I understand that the researcher will destroy the tapes of our discussion after the research is finished. ☐
7. I agree to take part in the above study. ☐

.....	.....	.....
Your name (Printed)	Date	Signature
.....	.....	.....
Your mother's name (Printed)	Date	Signature

Thank you for your help!

Growing Together – How do families cope with domestic abuse?

Rebecca Ryan, Trainee Clinical Psychologist, School of Psychology, University of Birmingham, Edgbaston, B15 2TT. Email: [redacted]

Appendix 12

Interview schedules for Young people, Mothers and Grandparents.

Interview Schedule – Young Person

1. *"How did you, your mum and your grandparent come to be involved with the [redacted]?"*

Additional prompts: One reason families come into contact with the centre is because mum and dad are not getting along sometimes. Can you tell me about that in your family?

What was it in your family that brought you in contact with the centre? What support has been most helpful? Can you tell me a bit more about that? How did that make you feel?[2]

2. *"How has being part of [redacted] influenced your relationship with your mum and grandparent?"*

3. *"Looking back to the time when your mum and dad were not getting along, what was your relationship like with your mum and grandparent?"*

Additional prompts: How has this changed? How has this stayed the same?

Can you tell me a bit more about that? How did that make you feel?

What was good about having your mum / grandparent there at that time?

How do you think that time would have been if grandparent was somewhere else?

Do you and your mum and grandparent do anything now that you couldn't do then?

4. *"I was wondering if you could tell me something or draw me something about your relationship with your mum and grandparent now."*

Additional prompts: Can you tell me a little about what you have drawn?

Can you say a little more about that?

5. *"Tell me about you, your mum and your grandparent facing difficult times together?"*

Additional prompts: What was helpful about this? What was unhelpful about this? Was this usual for your family or not? Is there anything about having your mum and grandparent that helps you deal with difficult things? What stops you all from moving on from difficult

[2] Example of additional prompts used for young people, mothers and grandparents

times? What do you get out of having your mum and your grandparent with you? What's the best thing about having your mum / grandparent around when things are hard? What's the worst thing about having your mum and grandparent around when things are hard?

6. *"Tell me about you, your mum and your grandparent celebrating happy times together?"*

   Additional prompts: What was helpful about this? What was unhelpful about this? Was this usual for your family or not? What helps you remember the happy times together? What do you get out of having your mum and your grandparent with you during happy times?

7. *"What would you want to take from the way your mum and grandparent cope with difficult times?"*

Additional prompts: What do you mean by that? Why is this type of coping really important to you? Is there anything that your mum / grandparent does when she is angry / sad / worried that you think really helps her? Do you think you would do the same? Would you like to be able to act the same way as her?

8. *"What wouldn't you want to take from the way your mum and grandparent cope with difficult times?"*

Additional prompts: What do you mean by that? Is there anything that your mum grandparent does when she is angry / sad / worried that you think does not help? What is it about that strategy that makes you feel it would not meet your needs or wishes? What stops you or would help you stop doing the same as either mum or grandparent?

9. *"What would you want to take away from the way your mum and grandparent cope with happy times?"*

Additional prompts:

What do you mean by that? Do you think you would do the same? Would you like to be able to act the same way as her?

10. *"What wouldn't you want to take away from the way your mum and grandparent cope with happy times?"*

Additional prompts:

What do you mean by that? Do you think you would do something different? What makes you want to be different? How would you do that? Would you like to be able to act the same way as her?

11. *"Is there anything else that we have not talked about today that you feel would be important for me to know about how you, your mum and your grandparent cope with things together as a family?"*

Interview Schedule – Mother

1. *Tell me something about your relationship with your child and parent.*

2. *How did you, your child and your parent come to be involved in the [redacted]?*

3. *How has being part of [redacted] influenced your relationship with your child and parent?*

4. *Looking back to the time when you were living through domestic abuse, what was your relationship like with your child and parent?*
    a. How has this changed?
    b. Has it stayed the same?

5. *Tell me about you, your child and your parent facing difficult times together?*
    a. What was helpful about this?
    b. What was unhelpful about this?
    c. Was this usual for your family or not?

6. *Tell me about you, your child and your parent celebrating happy times together?*
    a. What was helpful about this?
    b. What was unhelpful about this?
    c. Was this usual for your family or not?

7. *What would you want to take from the way your child and parent cope with difficult times?*

8. *What wouldn't you want to take from the way your child and parent cope with difficult times?*

9. *What would you want to take from the way your child and parent cope with happy times?*

10. *What wouldn't you want to take from the way your child and parent cope with happy times?*

11. *Is there anything else you would like to tell me about you, your child and your parent?*

Interview Schedule – Mother

1. *Tell me something about your relationship with your child and grandchild.*
2. *How did you, your child and your grandchild come to be involved in* [redacted]*?*

3. *How has being part of the* [redacted] *services influenced your relationship with your child and grandchild?*

4. *Looking back to the time when you were living through domestic abuse, what was your relationship like with your child and grandchild?*
    a. How has this changed?
    b. Has it stayed the same?

5. *Tell me about you, your child and your grandchild facing difficult times together?*
    a. What was helpful about this?
    b. What was unhelpful about this?
    c. Was this usual for your family or not?

6. *Tell me about you, your child and your grandchild celebrating happy times together?*
    a. What was helpful about this?
    b. What was unhelpful about this?
    c. Was this usual for your family or not?

7. *What would you want to take from the way your child and grandchild cope with difficult times?*

8. *What wouldn't you want to take from the way your child and grandchild cope with difficult times?*

9. *What would you want to take from the way your child and grandchild cope with happy times?*

10. *What wouldn't you want to take from the way your child and grandchild cope with happy times?*

11. *Is there anything else you would like to tell me about you, your child and your grandchild?*

Appendix 13

Debriefing information

Thank you for taking part in this research study. Good luck in the raffle!

The main focus of this study was to learn more about how people cope with domestic abuse with the help of your mother and grandparent. You spoke about the way your mother and grandparent helped you become stronger when faced with difficult life events and this will help is to work better with other families who experience domestic abuse in the future.

If you would like more information, or have any further questions about this study, then please feel free to contact me.

Also, if for whatever reason, you decide that you no longer want your responses to be part of this study or you have been unhappy with any part of the study process then please contact me at the details below or ask your mother or grandparent to get in touch:

Rebecca Ryan, Trainee Clinical Psychologist

School of Psychology, University of Birmingham

Edgbaston, Birmingham, B15 2TT

Email: [redacted]

NATIONAL

Childline: 0800 1111. 24 hours a day. Calls are free, even from mobiles and the calls will not show up on bills.

Samaritans: 08457 90 90 90 **NSPCC**: 0808 800 5000

Women's Aid: 0808 2000 247

Young Minds (parent's helpline): 0808 802 5544

RDVP: 0121 693 6143

www.respect4us.org.uk

www.nspcc.org.uk

www.itsnotyourfault.org

www.thehideout.org.uk www.youngminds.org.uk

www.ymca.org.uk

www.there4me.com

www.childline.org.uk

www.womensaid.or.uk

www.actionforchildren.org.uk

www.freefromfear.org

www.safehouse.org.uk

www.yourfamily.org.uk

Birmingham and Solihull Area:
Birmingham Women's Aid: www.bswaid.org.uk
Lantern Project: 0121 414 5047
Coventry and Warwickshire Area:
Coventry Haven: 024 7644 4077
Action for Children:
024 7625 6611
Warwickshire Domestic Violence Support Services: 01788 537 112

Appendix 14

Worked example of analysis

Claims and Concerns	Original transcript	Interpretative Phase
Uncertainty	Patricia: So I think that's… I think that's it, but I'm not too sure.	
	Interviewer: Okay.	
	Patricia: You can't know.	You can never know the truth?
	Interviewer: Okay. Anything else you think might… you want to talk about with the girls too? The relationship with your daughter or with Jack?	
Normal – daughter is not normal	Patricia: No. It's just normal. What I class as normal. ((laughs)). Err, Jack has witnessed a lot of domestic violence. And especially drugs as well. And he knows more about it than I've ever dreamed of knowing about it myself. I mean, I haven't got a clue. But he's seen a lot in his young life. And he's come out with little comments and that. And… if he seems someone getting hit on the telly, he'll say, "Go on!" you know, "Hit 'em!" And "Kill 'em!" or stuff like that. And I think that's not normal behaviour.	His innocence not kept safe?
Jack exposed to DV		He has seen too much and was not protected
Problems have lasting impact		Will I be able to care for him?
		DV re-enactment – hurting others like he was hurt
His behaviour is not normal		
Worry for him		
Did best I could. Tried hard		Making excuses – both Patricia and daughter.
Expecting excuses about not being able to go		Defending themselves against the problem?
	[EXTRACT REMOVED]	
Asking for help	Patricia: We… because she [daughter] lived in [redacted], so we… and I've always worked nights. So, um, it was v-, it was only like the weekends that we could normally go and visit. But she'd ring up saying, "Well don't come this weekend, I'm not here" and… she'd make excuses up.	Daughter is keeping secrets about something.
Putting family first.		
Providing safety and stability		Drop everything for her – why can't she drop things for Jack?
Don't understand why she keeps going back to DV relationships		Gave daughter and grandson boundaries to keep them safe?
	Interviewer: Uh huh.	Containing them and keeping them safe
	Patricia: Or saying she was going out or sommat's happening or this and that. And then occasionally she would ring up in the middle of the week, just… she actually… she did it quite a few times, she would ring up in the	Not able to understand? Going round in circles
Everyone would help her – it		

didn't change	week, "mum, can you come and get me?" So I'd drop whatever I'm doing and go to [redacted], pick her up, bring her back here and, um, I'd get Jack into another school. Get her a job sorted out. Within a couple of days.	She affected the whole family. She didn't take our help. Strong emotional tone of voice – resentment – gave all we could. Are we enough?
No contact with daughter	It's… and then… within a week or so she's back… back there again. And that's what I couldn't understand.	Is it her not being 'normal'?
Do not want contact with daughter	Interviewer: Okay.	
	Patricia: I would do everything to help her. Not just me. Her other sisters as well. We all tried to help her. But it	Being estranged from family? Splits in family – can they be repaired?
Too much negative for it to be repaired.	just… she kept going back. And…	
	Interviewer: Okay. Okay. Has anything stayed the same since?	
Other things are important to her, but not family.	Patricia: What, you mean, with [redacted]?	Alliance with husband
	Interviewer: Mm. In that relationship has anything stayed the same since…?	DV relationship is more important to her than her family. You need to show and communicate how you feel to others
	Patricia: Well I've not seen her. Since before Christmas last year.	
	Interviewer: Okay.	
	Patricia: I don't wanna see her.	
	Interviewer: Okay	Looking for reassurance that she is doing right /OK?
Adoration for mother –	It's… she's done too much for her to build a bridge. I mean, the way I look at it, and the same as her granddad, and her other sisters, we all think the same, her boyfriend and her drugs mean more to her than her own children. She's not done anything at all to try and get them back.	Another 'split' in family? Need to protect mothers in DV situations? Male role?
	Interviewer: Mmm. Okay.	Expected to love mother? (relationship with own daughter – does she feel loved?)
	Patricia: You understand?	
He appeared happy?	Interviewer: Mm. Okay. So it sounds as if the relationship has changed for the worse? Or am I off the mark?	
Spoiling	Patricia: Yes. Between me and… and me daughter, yeah. But Jack, he absolutely adores her. He loves her. I mean, I've said, he would protect her	Things are not as they seem – we need to look deeper 'Normal expectations' of care-giving – wondering if she is meeting these expectations? 'Filling him up'
Caring for him like a grandparent does.	to the end of the earth, I reckon. You know?	
	Interviewer: Okay. Okay.	
Physical affection	Patricia: That's his mum, isn't it?	
	Interviewer: Mm.	
Reflecting back.	Patricia: So…	

He needed physical affection and reassurance He felt protected with us. Break from DV Estranged family. She had chances. Caused problems for all of us. Checking out Checking out Accepting life for what it is. There is more time. Use your strengths Love each other. Communicate love to each other Do normal things Helping his develop reflective and thinking skills Repairing relationships after fall outs Maintaining physical affection	Interviewer: I guess thinking about Jack, then; what was your relationship like with Jack when Jack was living with his mum? Patricia: Just a normal, happy… well he seemed happy. Interviewer: What was your relationship like then? Patricia: Oh, well, it was okay, yeah. They'd get spoiled like, you know, we'd go visit him and buy him sweets and stuff like that. Interviewer: Okay. Patricia: It's what grandparents do. When we used to go down, he, um, he'd always come for a cuddle. He was very, um, cuddly. Interviewer: Okay. Patricia: He wants, um, I don't know what the word is. I think he wants to be… going back and looking at it now, he always wanted a cuddle and I don't know if that was the reassurance. Cause he was like clingy. Interviewer: Uh huh. Patricia: And we thought it was just because he missed us and… you know? But hindsight and looking back, I think it could have meant something different. I don't know. Because he might have felt protected when we were there. Knowing that nothing would happen while we were there. [**EXTRACT REMOVED**] Patricia: So that was heart-wrenching for me. Interviewer: Mmmm. Yeah. Patricia: And that's why I have no more to do with her. I don't want no more. She… she had her chance. She blew it, big time. That's not… not just Jack's life she's messed up, she's messed up my granddaughter's life as well. And whoever else baby she's carrying. You know? Interviewer: Mm. Patricia: You know?	Expectations of relationships; Showing affection; Providing containment (emotional and physical?) – wondering why he needs this? Emotional connections hard to verbalise? Time helps me understand – he *needed* reassurance We didn't do enough – believed it was about us (daughter looking out for self) Sadness; Questioning what it means, reflecting back. Need to look beyond the surface. Families give protection to each other Safety with *some* others – relief from the DV Broke heart – physical and emotional pain Physical / emotional link 'blew it' – hit it? Being split off – for adults, can make the decision to split in physical manner. For children, split is imposed – fragmented emotions Lives collapsing – catastrophic and immutable Searching for validation, recognition? Things are 'done to you'. Need to accept the past and move forward? Striving through – going through hard things makes you stronger? Making lemonade out of lemons

	Interviewer: So how have you… you've said it was heart-wrenching? Patricia: Yeah. Interviewer: How have you and Jack managed it? Patricia: We have to. You've got no choice. Life still goes on. Interviewer: Okay, Patricia: Every… tomorrow's still going to come, in't it? It's not… so you have to get on with it. You have to make the best of what you've got. Interviewer: How do you do that then? Patricia: Love him. Interviewer: Sorry? Patricia: Love him. I think. To reassure him that he's loved and… and I know he loves her. And then just get on with everyday things. You have to be strong. Interviewer: Okay. Patricia: Mm. Interviewer: And has he helped you in any way? You've talked about being loving and reassuring to… to Jack. Has he… has that relationship that he has with you helped you manage it? Patricia: Well, yeah, I mean, he'll always see his mum. He'll always pick his mum first. Which I… you know, that's understandable, that's his mum. But he will… if I tell him something, he will think about it. Since the group he will think about it after a while. And then he'll come back and say, "Well, Nan, you are…" And I'll say, "That's okay. Come here", I'll say, "don't do it again". Especially with the answering back and that.	Attachments help you get through. Relationships need to be built up – communication is needed. Stability; Normality – brings about sense of safety? Comparison of her to daughter? Attachments stick and remain More can be developed Ruptures and repairs – contribute to their relationships

Appendix 15

Additional thoughts regarding self-reflexivity and reflections throughout and after the study

I aim to briefly outline the positions or factors I brought to the research. Firstly, I am a white Irish female, aged 28. I grew up near a small town in southern Ireland and the majority of my clinical and academic psychological experience has been within the UK. I do not have any children of my own, however come from a large nuclear family, which has extended over the years to now include many nieces, nephews and in-laws. This project has challenged me in many ways; one being a real reflection on how the coping styles and resilience of my grandparents have passed from them to my parents and subsequently to me and the other being a reflection on my assumptions and professional knowledge of how children and families respond to the aftermath of DV.

While growing up, the presence of grandparents in my life was limited, only having what I considered a relationship with my maternal grandmother. Although both my paternal grandparents were present, relations with them were extremely limited, and I had no contact with my maternal grandfather. Despite this, the presence of my grandparents was evident in my family and throughout my childhood I was more aware of what I considered to be a 'negative' influence, for instance, origins of arguments were easily traced back to ideas strongly held by my paternal grandparents. On occasions during the research when I was struggling to recruit 'triads', I was easily resigned to including dyads. However, I think this reaction was a result of wanting to focus on my own 'descriptive' experience of family. Furthermore, perhaps as a result of being the youngest of a large sibling group, I came to value the protective nature of siblings, rather than perhaps other family members such as grandparents. Overall, some of the themes I may have brought to the data were centred around

a stoic attitude, and the need to contain, minimise or indeed hide family 'secrets' for fear of breakdown or shame. However, I think I also brought an experience of the security, protection and support that can be felt within a 'family' and how strong familial bonds and celebrations can nurture adequate coping and resilience.

My experience and values have led me to consider positive psychology, with its focus on nurturing strengths and resources, key to working with young people and families. When discussing the research with clinicians and families, this perspective shone through. However, I was astonished at how welcoming both the families and clinicians were to this position and I continue to struggle with how a deficit-based model of experience remains such a deep-seated discourse and script within our health system. Interviewing the participants in their own homes gave me an appreciation of their context and I think holding in mind the families that I previously worked with helped me provide a sense of containment to the participants and their stories. Finally, particularly with the younger children, my empathy at hearing their stories and subsequent desire to provide containment may have impacted on the full lived experience as I attempted to balance my role as researcher and clinician.

The idea of parenthood has been brought to the fore by others in my life, yet engaging so closely with participants' experiences, I became acutely aware of such a responsibility. During the project I also personally became aware of the potential detrimental impact on others when maladaptive relational strategies are adopted to meet personal needs. However, what this project highlighted most for me was the sheer strength and adaptability of people. This was obvious, not only in individual young people, but in families and relationships as a whole which evidenced how maladaptive strategies can be modified and how anxieties can be a driving force in ensuring safety. The project was also a fulfilling reminder of how small

everyday experiences can provide the 'building blocks' of our well-being and have a fundamental impact on our lives, often without the need of further intervention.

My clinical placements over the past year have exposed me to working with adults and young people who have experienced developmental trauma and I have worked closely with different clinicians. A commonality across these experiences has been the need to hold in mind many theoretical approaches and ideas. Whilst completing the interviews and analysis, ideas from these approaches remained a key influence and I tried hard to 'bracket this off'. Yet, I often struggled with this, worrying the phenomenology and lived experiences of the participants would get lost or marred by personal assumptions. This led me to wholly engage with the participant, allowing them to walk me through and uncover 'the part' and 'whole' of their story. In doing so, I realised their lived experiences was something dominated for so long by relational difficulties, yet is now something that is going through a process of being re-told. As in all IPA analyses, having the perspective of 'the part' and 'the whole' enabled a more dynamic style of interpretations. However, the circularity of this viewpoint seemed to be intensified by the process of including several family members, whereby a 'single episode' from one participant not only helped understand 'the complete life' for them, but also shed light on 'the parts' and 'whole' of other members in their family. Finally, rather than simply producing a descriptive account, I also attempted to take the analysis deeper and draw on further levels of interpretation (e.g., Jack and the dog; Daniel, the jelly and his worry for his mother). Again, I struggled with this, questioning if I had lost the central points of the participants' stories. However, debating these interpretations and holding a dynamic relationship with the data helped me stay on track.