Research evaluation of therapeutic support services for children: A local area study

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February 2022

Acknowledgements

We would like to express our appreciation to Rachel Leslie (Youth Counselling Team Manager) at Children North East for her support in referring potential participants for the study. Sincere thanks to the four caregivers who participated in the study, for sharing your thoughts, reflections and views on the support your children received. Furthermore, we would like to thank Together for Children for commissioning the research and the Department for Education for funding the project.

Please cite this report as:

Martin-Denham, S. and Scott, N. (2021) *Research evaluation of therapeutic support services for children: A local area study*. Sunderland: University of Sunderland.

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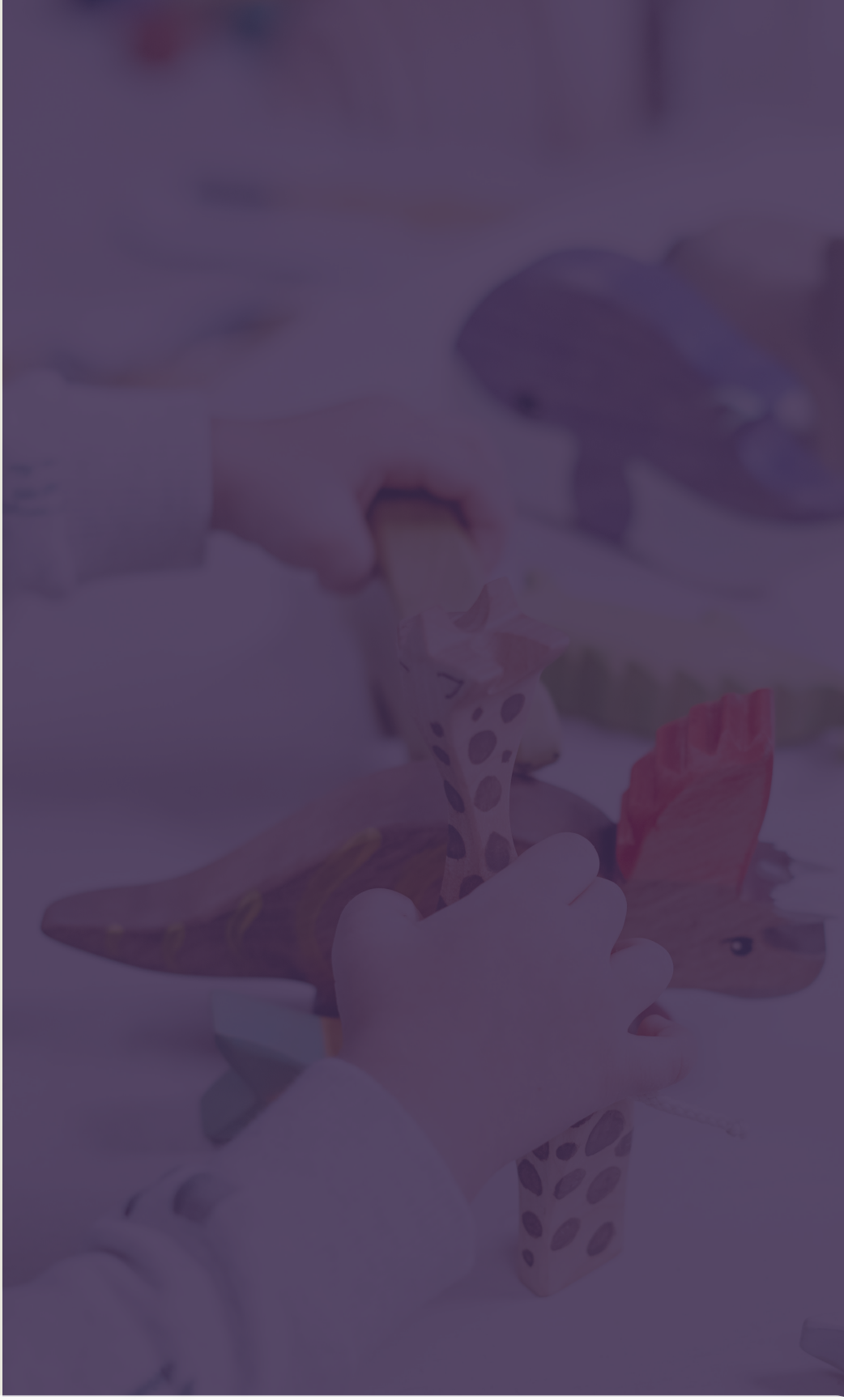

Executive summary

This report disseminates the findings of a small-scale study exploring the lived experiences of four caregivers whose children accessed a ten-week talking and play therapy programme. At the time of writing, Children North East (CNE) were the commissioned provider of the therapeutic services evaluated in this report. The semi-structured interviews took place during the COVID-19 pandemic and associated restrictions across England. This meant that the programme was delivered predominantly online, rather than the usual practice of therapeutic services supporting children in their schools.

The therapies offered by the charity include cognitive behavioural therapy (CBT), eye movement desensitization and reprocessing (EDMR), play therapy, and integrative methods such as sand tray, story and metaphor narrative therapy.

This study forms part of a wider project funded by the Department for Education and commissioned by Together for Children at the University of Sunderland (Martin-Denham, 2021a; 2020b; Martin-Denham and Scott, 2021).

The project had the following objectives:

- Identification of processes that supported participants to access therapeutic services
- Determine what impact therapeutic services had on the lives of the children and their families
- Analyse how services for children exposed to domestic abuse could be improved
- Recognise opportunities for enhancing user engagement with support services for families

Through interpretative phenomenological analysis (IPA), the research highlighted the detrimental impact of exposure to domestic abuse on children's mental health and wellbeing, something that has previously been well documented (Hester et al., 2000; Children's Commissioner's Office (CCO), 2020; Martin-Denham, 2021a; 2021b). The children of the caregivers participating in this study had been exposed to domestic abuse.

The caregivers participating recognised the harmful effect on their children and sought support from various mental health support services. The caregivers felt that therapeutic services could effect change for children who had experienced domestic abuse by helping them to express their feelings and understand their experiences. Carers highlighted that therapists' ability to build trusting relationships with the children was particularly important. Despite noting these benefits, caregivers were concerned about the lack of continuing support once they had reached their funded 10-session limit as some of the children had just begun to show progress at the point of termination of support. All the caregivers reported that the children who accessed therapeutic services appeared to be settling into life at school and home as a development following the incidents they witnessed.

In this report, 'family time' refers to 'contact', in line with the preferences of Together for Children.

Recommendations

1. For Sunderland City Council to continue to commission therapeutic interventions for children and young people exposed to domestic violence and abuse.
2. To give consideration in any specification for therapeutic services that there is an option to extend the period of therapeutic intervention where this is deemed beneficial.
3. To raise, with commissioners for Sunderland and South Tyneside Community CAMHS, the detrimental impact of the number of exclusion categories on the special circumstances list on families accessing prompt support.
4. In education, health, social care and the public domain, develop knowledge and awareness of the range of mental health services available to children and young people. This should include signposting families to universally available services, including those in the third sector (particularly when a child does not meet a threshold for support).
5. To consider providing local training for foster carers, kinship carers and adopters on evidence-based approaches to supporting children with challenging, violent and aggressive behaviours and emotional needs.

Glossary

Acronyms

ACEs	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
BERA	British Educational Research Association
CAMHS	Child and Adolescent Mental Health Services
CCO	Children's Commissioner's Office
CNE	Children North East
COVID-19	Coronavirus disease
CYPS	Children and Young People's Mental Health Service
DNA	Deoxyribonucleic Acid
DVA	Domestic Violence and Abuse
EMDR	Eye Movement Desensitization and Reprocessing
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
PTSD	Post-Traumatic Stress Disorder
UK	United Kingdom
WHO	World Health Organisation

Definitions of terms

COVID-19	Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus (World Health Organisation (WHO), 2020).
DNA	The DNA molecule, apart from carrying genetic information, plays a crucial role in a variety of biological processes (Aggarwal et al., 2020).

Definitions of terms

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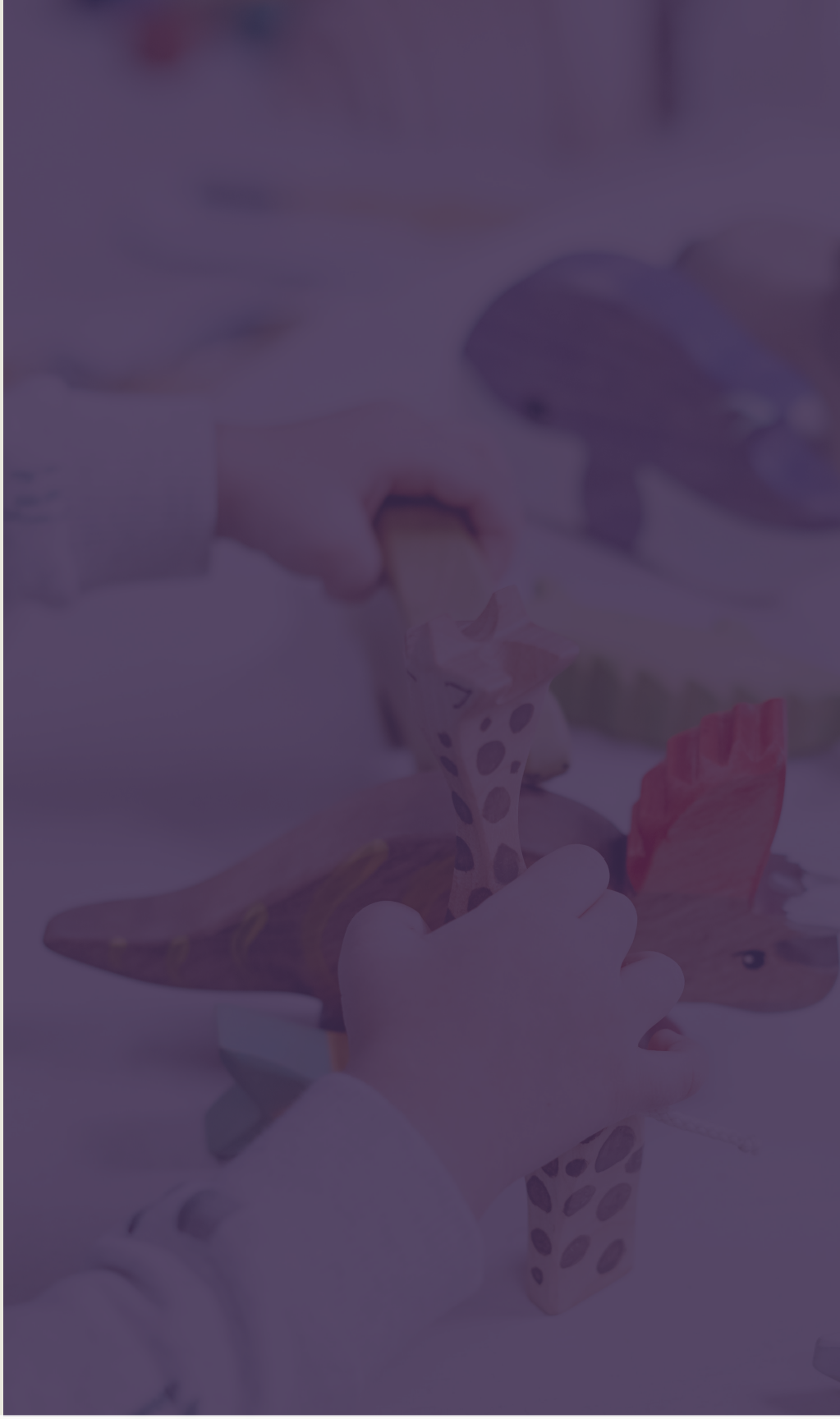
DNA	The DNA molecule, apart from carrying genetic information, plays a crucial role in a variety of biological processes (Aggarwal et al., 2020).
Eye movement desensitisation and reprocessing (EMDR)	Developed by Francine Shapiro, EMDR is a structured therapy that encourages the patient to briefly focus on the trauma memory while simultaneously experiencing bilateral stimulation (typically eye movements), which is associated with a reduction in the vividness and emotion associated with the trauma memories (American Psychological Association, 2017).
Play therapy	Play therapy helps children understand muddled feelings and upsetting events that they haven't had the chance to sort out properly. Rather than explaining what is troubling them, as adult therapy usually expects, children use play to communicate at their own level and at their own pace, without feeling interrogated or threatened (British Association of Play Therapists, 2014).
Post-traumatic stress disorder (PTSD)	PTSD can be defined as a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape or other violent personal assault (McCallum, 2018).



Background

Domestic violence and abuse

Various terms are used to describe violence and abuse in households, such as 'domestic abuse', 'domestic violence' and 'intimate partner violence' (WHO, 2013). In the UK, the definition of domestic abuse is:

'Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:

a. A and B are each aged 16 or over and are personally connected to each other, and
   b. the behaviour is abusive.
c. Behaviour is "abusive" if it consists of any of the following:
   d. physical or sexual abuse;
   e. violent or threatening behaviour;
   f. controlling or coercive behaviour;
   g. economic abuse;
   h. psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.'

(Domestic Abuse Act, 2021, part 1, s.1).

Prevalence of domestic abuse

Over time, the estimated figures for domestic abuse have varied considerably. Cawson et al. (2002) proposed that the proportion of children and young people (CYP) exposed to at least one domestic abuse incident in their household could be as high as 26%. However, Meltzer et al. (2009) suggested a much lower figure of 4%. Women's Aid (2018) proposed that the number of CYP exposed to domestic abuse during childhood is higher, at around one in seven (14%). During the COVID-19 pandemic, the National Society for the Prevention of Cruelty to Children (NSPCC) (2020) reported increasing numbers of people contacting them through the NSPCC and Childline helplines with concerns about CYP being exposed to domestic abuse during the government's stay-at-home guidance. Other emerging evidence found increases in the UK and beyond due to economic stress, forced co-existence and fears about COVID-19 (Fraser, 2020). Furthermore, the Office for National Statistics (2020) reported a 12% increase in domestic abuse cases being referred to victim support in mid-May 2020, following the easing of lockdown measures, compared to the previous week.

Adverse childhood experiences (ACEs)

The term adverse childhood experiences (ACEs) was first introduced by Felitti et al. (1998) in the Kaiser Permanente ACE study, which remains one of the most substantial investigations into childhood abuse, neglect and household challenges. Since then, there continues to be variability in the literature in terms of defining adversity and trauma (Martin-Denham and Donaghue, 2020). For example, Kelly-Irving et al. (2013, p. 2) put forward a definition of ACEs as: 'Intra-familial events or conditions causing chronic stress responses in the child's immediate environment. These include notions of maltreatment and deviation from societal norms'. More recently, the American Centers for Disease Control and Prevention (2019) provided a more comprehensive description:

'Adverse childhood experiences, or ACEs, are preventable, potentially traumatic events that occur in childhood (0-17 years) such as neglect, experiencing or witnessing violence, and having a family member attempt or die by suicide. Also included are aspects of a child's

environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance use; mental health problems; or instability due to parental separation or incarceration of a parent, sibling or other member of the household'.

The WHO (2019) advised that ACEs included:

'Some of the most intensive and frequently occurring sources of stress that children may suffer in early life. Such experiences include multiple types of abuse, neglect and violence between parents and caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence'.

There are a multitude of ACEs that can be traumatic for a child, including victimisation, peer to peer violence, the death of a caregiver and moving to a new home that impacts their health and wellbeing (Martin-Denham and Donaghue, 2020; Centers for Disease Control and Prevention, 2021).

Toxic stress in childhood

A degree of stress and adversity is essential to human development. However, prolonged and frequent exposure to adversity in the absence of protective factors may result in prolonged activation of the stress-response system, sometimes referred to as 'toxic stress' (Garner and Shonkoff, 2012; National Scientific Council on the Developing Child 2014; Centers for Disease Control and Prevention, 2021). It is widely understood that chronic or toxic stress can disrupt a child's brain's circuit development and metabolic systems due to adaptive neurobiological changes (Garner and Shonkoff, 2012; Johnson et al., 2013; National Scientific Council on the Developing Child 2014; Bucci et al., 2016). Courchesne et al. (2000) noted a threefold increase in the brain's weight during the first five years of life. During this period, the maturity of critical hormonal stress response systems occurs (Watamura et al., 2004). Stover et al. (2019) emphasise the detrimental impact of stress on a child during this developmental period, as it may negatively affect their biological, cognitive and social-emotional development.

The breadth of research indicates that children exposed to domestic abuse, in the absence of protective factors, have greater deficits in cognitive, social and emotional functioning (Margolin and Gordis, 2000, 2004; Kitzmann et al., 2003; Evans, Davies and DiLillo, 2008), and a higher prevalence of symptoms of Post-Traumatic Stress Disorder (PTSD) (Bogat et al., 2006). The reasons for this deleterious effect are related to the damage that toxic stress can do to the physical structure of DNA (epigenetic effects, nervous, immune and endocrine systems) (Shonkoff et al., 2012). Changes to the brain can affect decision making, learning, stress responses, attention, impulsive behaviours and emotions (Shonkoff et al., 2012). For example, Choi et al. (2012) found that witnessing domestic abuse during childhood was particularly associated with changes to white matter in brain areas responsible for 'emotional, learning and memory functions' (p. 1071). It is important to remember that toxic stress caused by witnessing domestic abuse can occur after the first five years, as the brain continues to develop particularly during the teenage years.

The impact of ACEs has been linked to declining health such as heart disease, hypertension, obesity, diabetes, cancer, asthma and other chronic diseases (Felitti et al. 1998; Kalmakis and Chandler 2015; Campbell, Walker

and Egede, 2016; Oh et al. 2018). Other effects include increased susceptibility to mental health challenges over the life course (Anda et al., 2005; Shonkoff et al., 2012; Gilbert et al., 2015) and increased risk of drugs and alcohol use (Dube et al., 2002; Dube et al., 2003). Finally, growing up with toxic stress can affect a child's ability to form stable and healthy relationships (Hughes et al., 2017; Merrick et al., 2019).

Protective factors against ACEs

Some research proposes that some children don't appear to experience deleterious outcomes following exposure to domestic abuse (Kitzmann et al., 2003). It is believed this is most likely due to the presence of a secure, non-violent attachment figure nurturing their resilience (Holt, Buckley and Whelan, 2008). Osofsky's (1999, p. 33) review of research on children exposed to violence concluded that a critical protective factor against the potentially detrimental impact of ACEs was 'a strong relationship with a competent, caring, positive adult, most often a parent'. Bellis et al. (2018) identified broader protective factors with the potential to mitigate the consequences of childhood adversity; 'sources of resilience can include but are not limited to cultural engagement, community support, opportunity to control one's personal circumstances and access to a trusted individual throughout childhood who provides a sanctuary from the chronic stress of ACEs' (p. 2). Likewise, Brinker and Cheruvu (2017), Bussing et al. (2003), Lindsey et al. (2012) and Pannebakker et al. (2018) explained that informal social support from family and friends could serve as a buffer to the negative impact of ACEs experienced by caregivers, as it encourages them to access therapeutic services. Although this buffer may exist, Karatekin and Ahluwalia (2020) and Sperry and Widom (2013) believe adults with ACEs are less likely to receive social support from friends and family, resulting in social isolation and vulnerability, and increased risk of deleterious mental health outcomes (Fleming, Mullen and Bammer, 1997; Moncher, 1995; Tucker and Rodriguez, 2014). Finkelhor (2018, p. 4) noted that state interventions were available such as 'parenting education, family therapy, and individual treatment that have been shown to help children and families facing adversities and adults suffering from the effects of adverse childhoods'. Despite these initiatives, Marmot (2017) suggests that prioritising service provision alone will not impact exposure to ACEs without fundamental cultural and economic changes to address inequalities, as ACEs can often be related to the 'toxic trio' for children so the adversity they experience tends not to be exclusively that of domestic violence in itself but part of a range of adversities. The CCO (2018, p. 3) describe the 'toxic trio' as the interaction of:

- Domestic violence and abuse within the household
- Parental substance misuse (alcohol or drugs)
- Parental mental health issues

Effect of witnessing abuse on life outcomes for children

The detrimental impact on children exposed to domestic abuse is widely documented (Goddard and Bedi, 2010). It has led to an extension of the legal definition of 'significant harm' in section 120 of The Adoption and Children Act (2002), to include 'any impairment of the child's health or development as a result of witnessing the ill-treatment of another person, such as domestic violence.' Children have a significant appreciation of domestic

abuse occurring between their parents (Butler and Williamson, 1994; Butler et al., 2003), which is often much greater than their parents realise (Buckley et al., 2007; Swanston et al., 2014). Devaney (2015) expressed that a child's age is not believed to make a significant difference to how they are affected by their exposure to domestic abuse. The breadth of research indicates exposure to domestic abuse at a young age can have far-reaching consequences, such as short-term and long-term detrimental mental health outcomes (Kitzmann et al., 2003; Wolfe et al., 2003; Evans, Davies and DiLillo, 2008). Moreover, Meltzer et al. (2009) claimed that if a child witnesses severe domestic violence, it could 'triple' their likelihood of developing conduct disorder later in life (p. 491).

Children react in a variety of ways to what they see and hear. Their protective factors to ameliorate the impact of exposure to domestic abuse may be affected if the abuser prevents or hinders caregiving (Stanley, 2011). Dargis and Koenigs (2017) uncovered further support for the notion that not directly experiencing domestic abuse but instead witnessing it – even from the next room – can still lead to harmful outcomes. The NSPCC (2020, p.3) shared insights from their NSPCC helpline and Childline counselling session from children who share the impact living in a household with domestic abuse:

'Some talk about the impact on their mental and physical wellbeing, as well as their behaviour, including anxiety, depression or suicidal thoughts; self-harming; eating disorders; nightmares or problems sleeping; drug or alcohol use; aggression; difficulty concentrating; tried or are thinking about running away from home.'

Gadd et al. (2020) describe how children exposed to domestic abuse can have an increased risk of night-waking, nightmares, bedwetting, phobias and psychosomatic problems. Daveney (2015) was more specific, suggesting babies have increased ill health, excessive screaming and disrupted attachment, with preschool children more likely to exhibit bedwetting, sleep disturbances and eating difficulties. Twenty years ago, Johnston and Mash (2001) highlighted how exposure to domestic abuse in the home could lead to concentration difficulties at school and misdiagnosis of attention deficit hyperactivity disorder (ADHD). Baldry (2003) theorised those children who cannot keep up at school due to insecurity at home might become disruptive in class, be bullied, or victimise others as they repeat violent behaviours from home. Such behaviours would inevitably negatively affect other children in the class (Carrell and Hoekstra, 2010). Underperformance at school, self-harming, running away and engaging in anti-social behaviour is believed to be more prevalent with older children as the effects of disruption at home became apparent (Humphreys and Houghton, 2008).

Rigterink, Fainsilber Katz and Hessler (2010) hypothesised that the difficulties encountered by children exposed to domestic abuse in forming relationships, and mental health difficulties, are related to their ability or inability to self soothe or self-regulate. This is a vital skill, as the impact of domestic abuse on the child can be hard to articulate and overcome, particularly when it is intensely traumatic, giving rise to feelings of powerlessness and grief (Liebermann, 2007). The COVID-19 pandemic has compounded children's ability to cope, as some children have been cut off from school support systems, such as teachers, friends, and school counsellors (NSPCC, 2020).

Gadd and Corr (2015) argued that it is challenging to predict who children will blame for domestic abuse, as it depends on what the children were told about the abuse and by whom. Using the language 'exposed to' domestic abuse, rather than 'witnessed' domestic abuse, overcomes the issue of whether a child interpreted the event as domestic abuse, through what they saw, overheard or picked up in the aftermath (Holt, Buckley and Whelan, 2008). Øverlien and Hydén (2009) and Swanston, Bowyer and Vetere (2014) reinforced this view, as some children do not observe the violence even though they are aware it is happening. It is also common for a child's awareness to surpass their caregivers' expectations, as they are not passive bystanders (Buckley, Holt and Whelan, 2007; Swanston, Bowyer and Vetere, 2014). The Domestic Abuse Act 2021 (part 1, s.3) recognises children as victims of domestic abuse if they:

a. see or hear, or experience the effects of, the abuse, and
b. is related to A or B.

[...] A child is related to [person A or B] if—

a. the person is a parent of, or has parental responsibility for, the child, or
b. the child and the person are relatives

(Domestic Abuse Act 2021, part 1, s.3)

Impact of exposure to domestic abuse on caregiving

One crucial factor to consider regarding child trauma is that caregivers may not always act as protective factors. Osofsky (1999, p. 33) suggested 'when parents are themselves witnesses to or victims of violence, they may have difficulty fulfilling this role.' While research indicates that positive parenting behaviours act as strong protective factors against harmful outcomes of exposure to domestic abuse (National Scientific Council on the Developing Child 2014; Racine et al., 2020), not all caregivers may be capable of providing this support. Alisic et al.'s (2012) study on caregiver perspectives of child trauma revealed that 'parents felt that their capacity to be responsive was influenced by their own level of distress' (p. 274). This is particularly relevant to trauma brought about by domestic abuse since the caregiver expected to provide support is often the same caregiver who was also a victim of the abuse. Indeed, one of Alisic et al.'s (2012) findings was that caregivers used 'hiding [their] own distress' (p. 278) as a strategy for helping a child recover from trauma. Furthermore, as pointed out by Thorley and Coates (2019), cared for children may not recognise that the placement caregiver is a safe adult who they can trust, as these relationships are built over time and are far more than complex than an adult saying they can trust them.

Another common outcome of experiencing domestic abuse is learned helplessness. Learned helplessness is a psychological outcome of stress that originates from 'uncontrollable events' (Seligman, 1972, p. 407). These uncontrollable events are often associated with repeated exposure to trauma, a characteristic often ascribed to domestic abuse (Palker-Corell and Marcus, 2004). Learned helplessness is strongly linked to depressive symptoms, as first suggested by Seligman (1972), who coined the term:

'Like learned helplessness, depression is characterised by reduced response initiation as

well as a “negative cognitive set”, difficulty in believing or learning that one’s own responses will succeed even when they do’ (p. 411).

Vollmayr and Gass (2013, p.171) similarly describe learned helplessness as a ‘coping deficit in aversive but avoidable situations’, after the victim has been exposed to repeated aversive and unavoidable situations. Research on protective factors for learned helplessness found victims who are particularly resilient and resourceful have a better ability to ‘self-regulate internal responses when coping with adversity’ (Rosenbaum, 1990; Peterson, 2013, p. 387). Forke et al. (2019) suggest that intergenerational effects, in which witnessing abuse in childhood can affect caregiving capabilities as an adult. They also found that ‘children whose parents witnessed [domestic abuse] had a considerably higher probability of having below-average health than children whose parents did not witness’ (p. 1).

Early intervention for therapeutic support

Researchers recommend that children must be given time and support to process and share what has happened to them, as ‘the nature of the experience and the range of reactions to it are almost infinitely varied’ (Gadd et al., 2015, p. 112). Accordingly, interventions for exposure to ACEs must be comprehensive, rather than narrow, if they are to address the span of ‘social-relational-cultural factors’ (Ford, 2017, pp. 9-10). A barrier to timely access to mental health support is the ‘special circumstances list’ complicated pathways to support (Martin-Denham, 2020a). Martin-Denham noted the Sunderland and South Tyneside ‘special circumstances list’ outlines 14 reasons children and young people won’t be seen by CAMHS and should instead be referred to CYPS (see appendix 1). Three of these criteria exclude children and young people who:

- Are or have been looked after or accommodated, including being adopted from care
- Have been neglected or abused or are subject to a Child Protection Plan
- Have parents with problems, including domestic violence, mental and/or physical illness, dependency, or addiction

South Tyneside and Sunderland Community CAMHS (2021)

Crenna-Jennings and Hutchinson (2018) also highlighted issues with numbers of CYP referred to CAMHS but not accepted as suitable to access the service. Their freedom of information request to CAMHS providers in England revealed that an estimated 55,800 CYP were not deemed appropriate for support, with referrals increasing by 26% in the previous five years. Unsurprisingly, many studies have shown that long waiting times for services are the most commonly cited barrier to engagement with mental health services (Golding, 2010; Vohra et al., 2014; Iskra et al., 2015; Anderson et al., 2017), deterring those who need the service from persevering to secure an appointment (McCann and Lubman, 2012).

Delaney (2015) advocates for the importance of service providers developing interventions that seek to promote and repair positive attachments between children and their caregivers or other significant adults in the child’s life. Notably, Porter, Martin and Anda (2017) believed that direct service interventions were necessary, though insufficient, as they only reach a small number of those affected by the issues generated by exposure to ACEs.

Engagement with early intervention soon after exposure to ACEs occur is believed to diminish their immediate effects, improving recovery and resilience (Spratt, Devaney and Frederick, 2019).

Play therapy is often referred to as 'a developmentally responsive intervention' (Bratton et al., 2005, p.245), which recognises children may not be able to verbally recall or articulate memories, events, or emotions in a traditional manner and may be better suited to demonstrating these through 'play'. Counsellors delivering play therapy focus on 'co-construction of meaning' (Schaefer, 2011, p. 56), whereby the children are given toys to play with and are encouraged to 'act out what they are seeing at home, or what they wish they were seeing at home' (Pingley, 2017, p. 29). Although toys are encouraged during play therapy, few studies have investigated which toys are most effective and which behaviours are associated with playing with certain toys (Ray et al., 2013). The importance of facilitating the reconstruction of traumatic memories lies in the understanding that traumatic memories are often not processed the same way as other memories. While a specific, powerful memory/event usually has a more profound representation and recall (Foa and Kozak, 1986), traumatic events are incredibly profound. Still, their representations are fragmented and poorly verbally retrieved (Gray and Lombardo, 2001). Thus, therapeutic interventions attempt to help the victim reconstruct these fragmented representations for both adults and children.

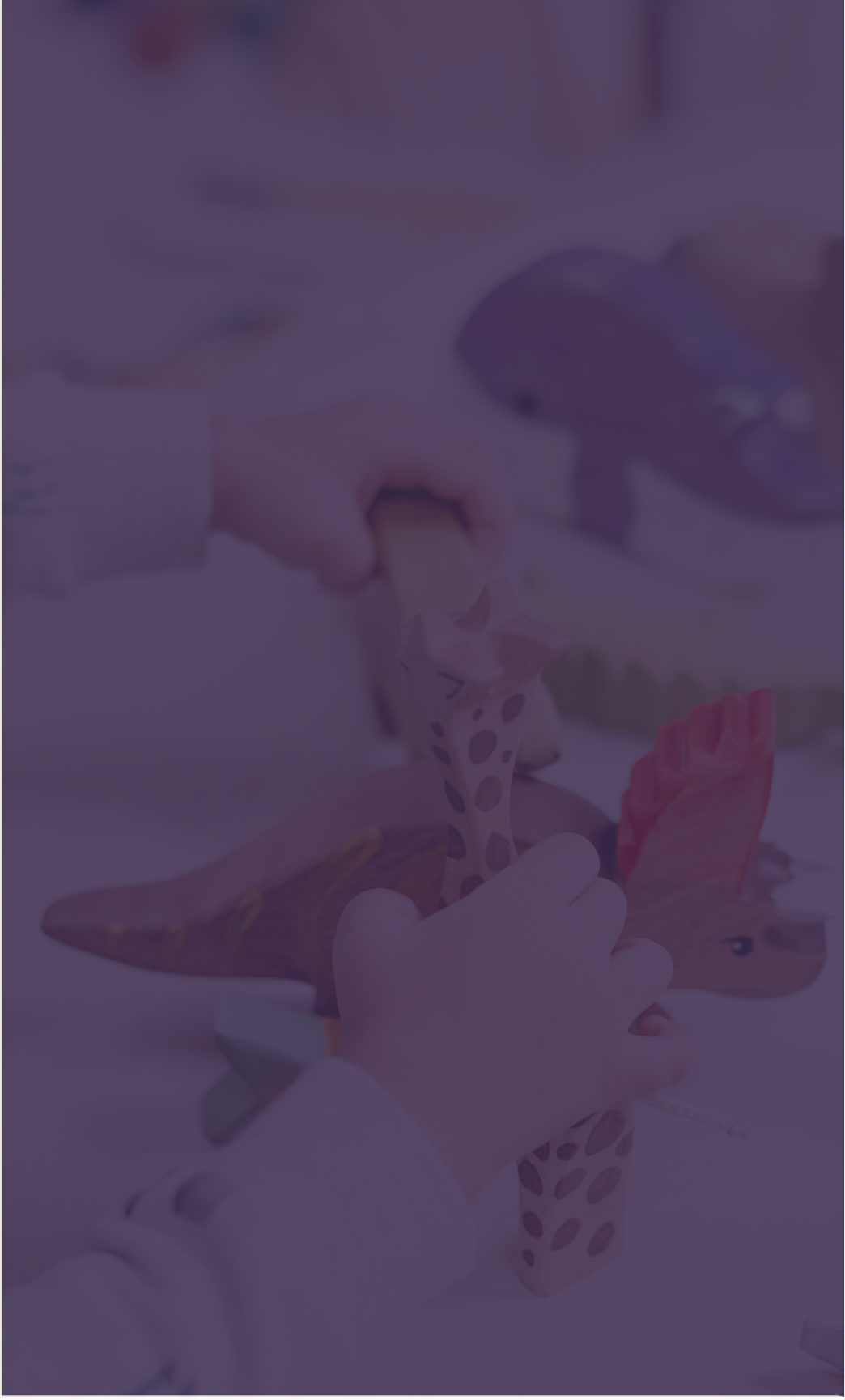
Another vital principle of children's play therapy is confidentiality. Caregivers might expect to be notified of the content discussed between a child and a therapist. However, 'maintaining confidentiality is one way to establish a trusting alliance with children' (Ware and Dillman Taylor, 2014, p. 173). In Landreth's (2013) book offering instructions for play therapy, they emphasise the importance of confidentiality between the therapist and the child (where the therapist deems the child not to be at risk of harm), as well as suggesting that the rationale be explained to caregivers, as they can often oppose the practice:

'The therapist must explain to the parents that the play therapy sessions are confidential, but that he or she will give the parents general impressions about the session such as play themes, behavioural characteristics of the child, or concerns about the child, but will not offer specifics. The issue of confidentiality can be difficult for some parents because they feel responsible for the child, are curious about what occurs in the playroom, or are overly involved in the child's problem' (p. 89).

During the COVID-19 pandemic, practitioners, including therapists, had to adapt how they counselled children. Many in-person therapy sessions were delivered online due to the pandemic, with inconsistent findings in research on how both participants and therapists perceived the online approach. In their study, Humer et al. (2020) found varying attitudes towards remote psychotherapy but reported a general consensus that face-to-face therapy and remote therapy were 'not totally comparable'. Furthermore, they found that behaviour therapists in particular assessed remote therapy 'less favourably than therapists with other theoretical backgrounds' (p. 1). Békés and Aafjes-van Doorn (2020) noted that satisfaction with remote therapy depended on the type of therapy. It could be argued that therapy with children, in which toys are often required, is likely to have been more negatively affected by the change to remote therapy than other approaches.

In addition to potential COVID-19 related delays, service users may also be affected by sudden cessation of therapy due to session limits. Ronnenberg et al. (2020) noted therapists and therapy providers 'may not be realistic sources of ongoing, long-term support' (p. 690) since there are often session and time limits to therapeutic interventions.

A significant barrier to engagement with support services and the effectiveness of interventions is nondisclosure of abuse. This is a common feature of abuse victims' experiences, who often require long periods of emotional and cognitive processing before disclosing events (Linell, 2017). This can particularly be the case for children, for whom 'research consistently indicates' that they 'maintain the secret or delay reporting for significant periods of time' (Paine and Hansen, 2002, p. 290). The timing of disclosure and the extent to which experiences are disclosed can also depend on the type of abuse, with physical abuse often being identified through 'nondisclosure evidence' such as injuries (Rush et al., 2014, p. 113).



Methodology

Interpretative Phenomenological Analysis (IPA)

A qualitative approach was chosen to capture participants' accounts of their experiences of therapeutic services. As IPA is an exploratory method, it has the potential to reveal insights into under-researched topics (Smith, Flowers and Larkin, 2009; Tompkins and Eatough, 2012). With theoretical foundations in phenomenology, IPA capitalises on the assumption that there can be different subjective interpretations of a single phenomenon (Guba and Lincoln, 1994; Lewis and Staehler, 2010). Researchers analyse detailed individual accounts in IPA, allowing insight into the participant's lived experiences (Smith, Flowers and Larkin, 2009; Flick, 2018). The study aimed to uncover the caregivers' interpretations of their world by drawing out biographical stories that humans often form regarding specific moments in their lives (Brocki and Wearden, 2014; King, Horrocks and Brooks, 2019; Cuthbertson, Robb and Blair, 2020). IPA was chosen for this study because it lends itself to complicated and emotionally significant topics (Smith and Osborn, 2015, p.1).

IPA was a suitable method due to its utility in capturing qualitative data from a small sample (between four and ten participants). The method is more concerned with the quality of analysis than quantity (Smith, Flowers and Larkin, 2009).

Method

The project was approved by the University of Sunderland Ethics Committee (application no. 007091). After gaining informed consent from participants, semi-structured interviews were conducted in June 2021. All caregivers lived in Sunderland, in the North East of England. An IPA approach was used throughout.

Aim, objectives and research questions

The study's overarching aim was to investigate the lived experiences of caregivers who accessed support for children in their care who had been exposed to domestic abuse. Table 1 shows the research aim, objectives and questions. For the complete list of research questions (appendix 2).

Table 1. The research aim, objectives, and key research questions

Research aim: To investigate the lived experiences of caregivers who accessed support for children in their care who had been exposed to domestic abuse.	
Research objectives	**Research questions**
Identification of processes that supported participants to access therapeutic services	Did therapeutic services positively impact the lives of the children and their families?
Determine what impact therapeutic services had on the lives of the children and their families	How can services for children exposed to domestic abuse be improved?
Analyse how services for children exposed to domestic abuse could be improved	What are the processes that supported caregivers in accessing therapeutic services?
Recognise opportunities for enhancing user engagement with support services for families	How can we improve overall user engagement with support services for families?

Recruitment of caregivers

The counselling team manager at the North East charity identified 47 caregivers whose children had completed their therapeutic intervention and invited them to participate voluntarily. During their conversation, 12 were deemed inappropriate to participate due to personal issues caused by the COVID-19 pandemic, and 24 declined to take part. Eleven were interested and provided consent for their contact details to be shared with the researchers, after which they were contacted by email and an introductory phone call to explain the project in greater depth and to gain formal consent. Four caregivers responded to the email and, after giving their informed consent, took part in the study.

The original intention was to invite children of the caregivers to participate. Following discussions with their caregivers, a joint decision was taken not to include children. The reasons for this are outlined in Table 2.

Table 2. Recruitment of participants

Caregiver recruitment		
Number who consented to be contacted	Number of non-responses (from caregivers) to introductory email	Final number of caregivers interviewed
10	6	4
Child recruitment		
Number of children whose caregivers and social workers gave consent for them to be interviewed	Number of children not suitable for interview (Child A-C)*	Final number of children interviewed
3	3	0

*Child A (cared for): foster placement move upcoming.
Child B (cared for): shy, does not discuss therapy.
Child C: changes in home circumstances.

The sample

The sample consisted of two mothers, one stepmother and one foster carer. All four participants identified as white British females. All caregivers were given pseudonyms.

Table 3. Demographic information and interview duration

Participant	Relation to child	Age	Employment status	Interview duration (mm:ss)
Amelia	Stepmother	20-29	Unemployed	25:34
Marla	Mother	30-39	Employed	30-39
Holly	Foster carer	40-49	Employed	40-49
Jenna	Mother	30-39	Employed	30-39

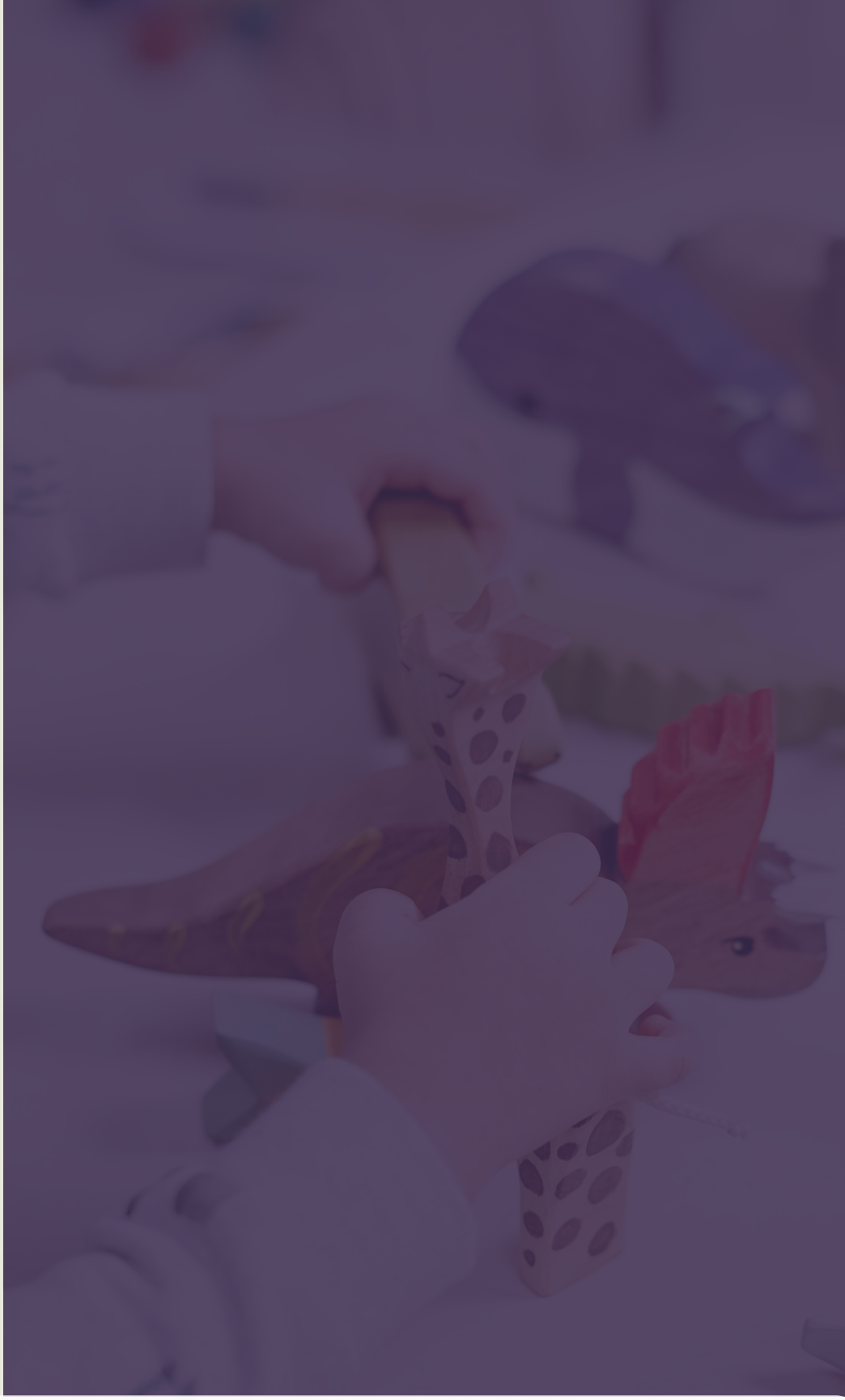
Data collection and storage

Interviews were completed employing 'the ethics of care' approach (Noddings, 2003; Held, 2006; Preston, 2001). The participants stated they were at home at the time of the interview, with interviews lasting between 16 and 33 minutes (Table 3). The focus of the discussion questions related to the carers' experiences with therapeutic services for their child. While some participants chose to disclose their children's exposure to domestic abuse, this sensitive information was not requested. The interview recording and transcripts were transcribed verbatim and anonymised.

Data analysis

IPA provided a detailed and thorough insight into the participants' first-hand experiences, which is the core objective of data capture (King, Horrocks and Brooks, 2019). As suggested by Smith, Flowers and Larkin (2009), the data were analysed in the following stages:

- Listening to the recordings while reading the transcript, to re-familiarise with each interview (tone, language, intonation, context and content) and identify necessary corrections
- A line-by-line analysis of the understanding, views, concerns and claims of each participant in turn
- Establishing the relationship between the themes to allow for 'reduction' through 'collapsing' and 'merging' using Nvivo12 (qualitative data analysis software)
- Cross-checking the Nvivo12 entries alongside the IPA word tables to ensure the analysed data could be traced from the initial comments, clustering and thematic development to final superordinate themes and themes
- Collaboration with a fellow researcher to quality assure 'and develop the coherence and plausibility of the interpretation'
- Development of the narrative



Results and discussion

Figure 1. The superordinate themes and themes

One hundred and seventy three (173) themes emerged during the line-by-line reading of the four transcripts. Through reduction, collapsing and merging, two superordinate themes and six themes emerged, bringing together the data from the four interviews.

Living with adversities

Childhood adversities

Amelia explained that her stepson lived with her and the child's father: 'They live with me under a child arrangement order due to witnessing domestic violence through his mam'. She recalled that the child disclosed the domestic violence to her:

'I was the one who found out it was all going on. When I met his dad, his mum had just had a baby and got in a relationship with this other person. Until then, we weren't aware of what was going on. The family knew but didn't say anything. He used to come [for family time] and stay at my house on a weekend. He was sat having his breakfast and said "He [mother's new partner] pulled my mum off the bench by her hair" and I went "what?" and he went "He pulled my mum off the bench by her hair" and I said, "what do you mean?" Even though he was only little, he was able to show exactly what happened.'

Amelia described the long-term impact of witnessing domestic abuse on the child, 'still when he sees an ambulance, he'll say, "Oh, he pulled my mam off the bench by her hair and then fell off the bench". And that's actually what happened. That is what he witnessed.' Later, she reflected that the child was two years old when he was exposed to the domestic abuse

'He was two years old because he was still going to nursery. The social workers rang to talk to my partner. They said, "well we've been involved for a few weeks because of things that [mothers' new partner] had done in the past." But like there was no concerns to the kids; it was just about him because he was known to be a domestic violence perpetrator.'

Amelia seemed relieved when recalling how the child's mother agreed to stop contact with her new partner to protect the children in her care. However, she described how Children's Social Care became involved when the child disclosed his mam was 'hiding him in the shed' closely followed by 'disclosures of abuse.' Jenna shared that her son was subjected to physical abuse by his father and recalled him saying: "My daddy wasn't very nice [...] my dad used to hit me [...] my dad used to lock me in rooms [...] my dad would push me off settees." She added that:

'He never used to like baths – well, he did like them and then all of a sudden, he didn't like them, and we couldn't work out what had happened. He would scream, absolutely scream when we'd put him in the bath. Then we found out that he'd put him in boiling water in the bath. And hence why he didn't want to go in. So, obviously, I think, in the end, it was actually my mam who found everything out.'

Like Amelia, Marla's relationship with her child's father ended due to domestic abuse that she and her son were exposed to, 'there was a lot that went on; he witnessed stuff and everything, shouting and everything.' During the relationship breakdown, the child was told his father was not his biological father. Holly's foster child had a history of exposure to abuse and neglect by his birth family and had ongoing adversities due to the upcoming separation of siblings as part of their permanent placements as cared for children.

The caregivers' reflections illustrate the detrimental effect of exposure to ACEs in childhood. Their accounts of the short- and long-term impacts on the children they cared for correlate with the many definitions and descriptions of ACEs. Indeed, the environment

the children were exposed to 'undermined their sense of safety, stability and bonding' (Centers for Disease Control and Prevention, 2019). It is likely that intra-familial events they were exposed to caused chronic stress responses (Kelly-Irving et al., 2013). From the caregivers' descriptions of events, the children may not have had the presence of a secure, non-violent, protective caregiver to mitigate deleterious outcomes (Osofksy, 1999; Holt, Buckley and Whelan, 2008). Furthermore, in the case of Marla, domestic abuse may have prevented her from fulfilling her protective role due to their heightened levels of distress (Osofsky, 1999; Alisic et al., 2012).

Support needs of children

The children required support for several reasons, such as emotional or behavioural difficulties that sometimes endangered themselves and others. During or after receiving help, some caregivers felt their children still needed support in addition to therapy and other services such as Children and Young People's Mental Health Service (CYPS) and school counselling. Participants also commented on the logistics of receiving support and how factors such as the COVID-19 pandemic affected the support they received.

Amelia and Jenna reported difficulties in which their children exhibited aggressive behaviour, leading to them needing therapeutic support. Amelia described her concern regarding how her child's behaviour was affecting a younger sibling:

'This sounds absolutely awful because I know he'd never hurt them, but my youngest, I had to sort of not let him touch her because he was very aggressive about how he would hold her, how he would like to cuddle them and things like that. Not meaning to intentionally hurt them, I don't think. It was just his way of being like, "right, someone needs to talk to me."'

She also explained that he exhibited aggression at school:

'He was quite aggressive; he was getting wrong at school for hitting people. For instance, if he was with a kid and the kid wouldn't give him a toy it was, "oh well, I'll just punch your face in." He was saying things like that.'

Jenna's foster child was also exhibiting aggressive behaviour and emotional difficulties. She recalled, 'He would lash out a hell of a lot. He just would hit a lot, and he would kick a lot because he couldn't tell you how he was feeling.'

While not all the caregivers described aggressive behaviour from their children, most sought support due to their emotional and behavioural difficulties. Amelia specifically requested counselling for her child for this reason: 'So, I'd spoke to the social worker at the time and said "Listen, this kid's like, emotionally messed up, like he needs some sort of counselling or something."' Marla was 'struggling with the children's behaviour' and shared that they were 'anxious about school'. Holly referred to her child's difficulties when recalling how the support helped them: 'We've helped him sort of make sense of some of these images, and some of the fears and things that he had'. Jenna felt that her child's emotional difficulties were caused by an inability to articulate feelings: 'He couldn't handle his emotions very well, and I think he didn't know how he was feeling because he couldn't ever really describe it'.
Most participants felt, due to the length, timing or type of support, that their child was not

receiving sufficient help. For example, Amelia felt that her child could have benefited from earlier support than she eventually received:

'I'd rang social services, and I was like, "Listen, this kid needs someone to talk to who knows what they're doing. Because I don't know what I'm doing." Do you know what I mean? Because I don't know what to say, I don't think I'm the right person to be doing this. I'm like trying to be his mother, and then we tried to get him into CAMHS, but they wouldn't have him, then last year CNE. I think they got signed off in April two years ago. And they got allocated a social worker, a counsellor, in June, I think it was, so we didn't wait that long, but I think the damage was already done.'

Most caregivers acknowledged the importance of prompt intervention from services to give them time and space to process what had happened. Their comments accord with Spratt, Devaney and Frederick (2019), as they identified their children needed prompt support to improve their chances of recovery. Furthermore, as Gadd et al. (2020) described, and as shown in the caregivers' responses, the nature of what the children were exposed to and the range of reactions are infinitely varied. Considering this, there is a justified argument for a comprehensive range of interventions for children exposed to ACEs, which might begin to address the range of social, relational and cultural factors (Ford, 2017).

Amelia reflected that more than ten sessions could have been beneficial:

'Maybe he needed a few more sessions. I know obviously, it's a paid service, but I think it should be maybe more like twenty sessions, 'cos I know from my experience with him, it takes him a while to come round and warm to yer. So, I just don't think ten sessions was adequate. I mean, don't get us wrong, some things that she obviously had told him has worked because he's not as aggressive and things like that. But I think she might have been able to take it a little bit further if she'd been allocated more sessions with him.'

Holly believed that her child's therapy had been cut short and was concerned by the sudden cessation of support:

'He's finished. Personally, I feel he needs more. But when we've made enquiries, it's- because he has become a looked-after child, and he's got a lot going on in his life. They've just found out what the final outcome of the court is; they're busy separating him from his brother. They're wanting him to be settled with permanence. The plan is for him to be permanent here before they do any more sessions with him. I think letting him wait now isn't right for him because it's sort of... we started work with him and opened up sort of a lot of feelings and emotions with him. And then we've just sort of stopped, and they've sort of said, well, you'll have to wait until you're settled a little bit more.'

Since Marla's child's therapy ended, she reported that they have not been receiving any other mental health support:

'In terms of anyone giving him any sort of therapy, counselling or chances to chat about his feelings and emotions, he's not getting that from anywhere. Just what we would do on a normal daily basis for any child.'

On the other hand, Jenna felt that the length and timing of the therapy were adequate. When asked by the counsellor whether she felt her child needed more sessions, she said, 'I

actually think he's done quite well' and 'we felt that it was enough, however many he had'.

Furthermore, caregivers often reported contact with other support services, sometimes comparing them to the support they received from therapeutic services. Some of the children, including Amelia's, were receiving additional counselling at school:

'He was obviously getting counselling at school. She's goes in and sits and plays with him, takes him to the side and sees if he's got any worries. But she's not like a registered counsellor, if you know what I mean.'

Holly had 'worked with psychologists' with her other children previously and received some support from the school. However, she was awaiting a response from CYPS. Marla had also had 'support from other agencies', and mentioned Together for Children and Early Help, for whom she had completed a self-referral. Jenna also worked closely with the child's school:

'I spoke to the school about it, and that's when they recommended he went to see a counsellor. And then it went from there, and then I think they recommended Children North East.'

She also spoke about how CYPS were the first service to explain the importance of finding support:

'He was seeing CYPS because he kept sort of making statements about what his dad used to do to him, and that's sort of really where it started. And then I think he was still saying it, and I think I spoke to the school about it. Because obviously, the ex did things to him, and CYPS had said that we probably won't even know half the stuff of what did happen because he was only little at the time. But we might never know.'

CAMHS were also referenced, but Amelia reported that they were unable to help her and the child at the time:

'He didn't have a stable home. Because obviously, he'd just come to live with us, and he was going to see mam as supervised contact, so they were seeing mam every day after school. And that got brought up too on the weekend, and they just said because his home life wasn't stable, he hasn't got that safe place, like if he knows he's going home, he can take all his frustrations out there. And that was the reason they gave, which I don't understand how they said that because he's been coming to my house all the time.'

Caregivers struggling to access services due to the 'the special circumstances list' exclusion criteria was also raised as an issue by Crenna-Jennings Hutchinson (2018) and by Martin-Denham's (2020) study on factors leading to school exclusion. Being a cared-for child or being part of a family with domestic abuse would prevent access to CAMHS due to the exclusion criteria on the 'special circumstances list' (Sunderland and South Tyneside Community CAMHS, 2021).

Finally, all caregivers commented on the logistical aspects of the support from therapeutic services and other services, primarily referencing changes to the format due to the COVID-19 pandemic. Marla and Holly noted that adjustments had to be made to sessions due to the pandemic. They were both impressed with the way therapeutic services adapted to the circumstances:

'My children came down with COVID, so we were isolated for three weeks. So, that put a stop to face-to-face, and then with the lockdowns again, sort of to the beginning of this year. But again, the CNE counsellor kept in touch with us by text message, just to make sure how things were going. And although she wasn't able to see him, I was still able to have that contact with her [during COVID-19] and she offered to speak to him over the phone.'

'As much as I'm saying that [too much screen time], it was totally out of everybody's control. So, the fact that they changed the way they delivered stuff, to allow it to still continue, was fantastic.'

Some participants made comments about the venues that were sometimes used, both in-person and virtual. Marla recalled that the sessions sometimes occurred late at night, so schools could not be used as venues as they were closed. Jenna also felt that school would be the ideal venue if possible, stating:

'COVID put a stop to it, and then it was done, and the counsellor wasn't allowed back in the school, so the last few sessions had to be done over Zoom. I think [counsellor] maybe did a couple extra because he was struggling with the lockdown. I think school probably would have been better.'

The caregivers' remarks concerning the impact of COVID-19 on therapy reflect recent research on the same subject. Caregivers found it difficult to make inferences about how their children's treatment changed between face-to-face therapy and remote therapy, aligning with Humer's (2020) suggestion that these types of therapy are 'not totally comparable'. However, caregivers' impressions of how therapeutic services adapted to remote therapy were generally positive, overcoming some of the obstacles perceived by other therapists during COVID-19 (Békés and Aafjes-van Doorn, 2020).

Caregivers' support needs

Most caregivers commented on the support they needed and received from multi-agency services. Through analysis, the caregivers needed support with how best to respond to and support children with their presenting physical and emotional behaviours. Amelia explained: 'We didn't get nae support, to be honest, it was just family. Like my mam, my mam's partner, things like that. There wasn't really support put into place for us, to be honest.' Likewise, Jenna shared that her parents were the primary source of support and advice in supporting her son. He had been abused and was displaying challenging and aggressive behaviours:

'He was only little, and I think because he was going through something, we were both... I was as well. My mam and dad have been an absolutely massive support. And I couldn't have done it without them. Because I don't think really... I don't know how good a mother I was at the time when I was going through what I was going through. It was very difficult.'

Marla experienced a similar dilemma to Jenna, in that they both felt that their status as a victim of the same abuse, witnessed by their children, made it difficult for their children to open up to them:

'I knew he wouldn't talk to me, and I just wanted to make sure he was alright and everything... He doesn't want to worry me neither about stuff.'

Amelia was concerned about how to best support her stepchild following the domestic abuse he witnessed from his mother's new partner, while not in her and his dad's care:

'I struggled on, like when he was saying all these things. Knowing the right things to say to him, no matter how many times I said to him, "I know, son, he is a bad man" and things. Maybe that wasn't the right thing to be saying to him. That's what I was saying to him, but obviously, that didn't work.'

The caregivers' experiences in this study closely mirror caregiver experiences reported in other research on domestic abuse. Marla seemed to struggle with encouraging her child to open up. Jenna's explanation that she and her child were going through similar experiences, and subsequent admission that she was uncertain about her caregiving capabilities, reflect both Osofsky's (1999) and Alisic et al.'s (2012) concerns that caregivers who are subjected to violence and abuse may be unable to fulfil their role as protective guardians when their child is processing traumatic experiences and memories.

Later in the interview, Amelia shared that she had received support from a parenting class she attended, and had felt the course helped her support him:

'Some of her tips worked because, well, instead of getting angry with him, saying like "I'm very disappointed that you've done that... we'll move on from that", and that worked. So I think, together with Children North East seeing him, and me seeing them, we'd made a package.'

She also said it was the social worker who suggested therapeutic services to support the child. Holly acknowledged the support she received from Together for Children (TfC) as a foster carer: 'We have access to a counsellor, employed by TfC, and we've also got our fostering officers, the social workers, and we sort of go on numerous training sessions.' She felt the support enabled her to 'understand a lot of what children had or have been going through.'

Jenna talked positively about the support she received from Wearside Women in Need (WWiN) and the courage they gave her to remove her partner from the family home: 'I'd been to women in need, I think, a couple of days before. And I'd got the courage to kick him out, and anyway, he left, and that was it, and he didn't come back'. Through advice from the police and WWiN, Jenna stopped contact with the father. She described how she needed support due to the fear she had of her partner's abusive behaviours:

'I was very scared at the time. I thought, goodness, if I don't let him see him, and what's going to happen? It was domestic violence, and that obviously, he had suffered as well. It was all a bit of a shock today from one to the other. Women in Need had to get the social involved, because of him, they agreed that he wasn't to see him, and he wasn't to be left in his care.'

Effecting change

Forming relationships

The caregivers all remarked on the lengths that the counsellors went to form relationships with the children. They also appreciated that, while they retained confidentiality regarding the session's content, they were transparent about the process and what they had planned for their sessions. Amelia recalled that the counsellor introduced herself over the phone and made an effort to tailor the sessions to the child's interests:

'She was like, "I'm gonna come in, I'm gonna see ya, and we're gonna have a chat and things like that". She was like, "is there anything that you like doing? Do you like drawing? Is there certain things you like?" and things like that. So, she was really good because she'd made sure that she knew exactly what he liked, so he didn't feel so pressured and say, "why is this woman coming to see us?" sort of thing.'

Marla explained how impressed she was that the counsellor had formed a close relationship with her child, and that this helped him 'come out of his shell' and express his 'fantastic personality'. She also complimented the effort that the counsellor went through to personalise the sessions: 'She knew he liked drawing, so I think she supplied him with pencils. He had his own pencil case and everything, so I think they've done a lot around drawing and talking about emotions and everything.'

There was also an appreciation for counsellors being understanding of caregivers' concerns regarding the therapy. Holly described how she and the counsellor collaborated often:

'The counsellor had a session with myself, so I could explain any sort of worries, fears that I had with him. Also, we kept her up to date of what was happening with his plans, where his case was, and so forth. We had to find new ways of working with him. So, I would bring the Lego downstairs. I'd put the laptop on the floor to try and make it as if they were in the same room as much as possible. So, the therapy could work in the best way possible.'

Jenna also had some idea of how the counsellor built a relationship with the child, stating, 'he would take my iPad and she would go upstairs and do things with him, like treasure hunts'.

The play therapy provided by the therapeutic services was deemed an appropriate intervention by the caregivers, who had struggled to discuss abuse and other sensitive experiences with their children, hence the method's popularity for such cases (Bratton et al., 2005). While caregivers were unable to articulate exactly how their children and the therapist 'co-constructed' meaning through play (Schaefer, 2011), they did feel that greater expression of emotions was achieved, according to the general impressions of the sessions given to them by the therapist.

Steps toward recovery

The caregivers elaborated on the role that therapeutic services played in their child's road to recovery after having witnessed or experienced domestic abuse. They explained that their children needed time to process and make sense of the events they had witnessed, and understood that they might need a confidential environment to achieve this. While not privy to all the contents of the therapy sessions, the interviewees were confident that

the therapy helped their children learn how to express their feelings and emotions about adversity. Finally, they shared indicators that their children were settling into their new lives because of their steps toward recovery.

All caregivers recognised that their children would need time to process the adversities they had experienced. They expressed an understanding that they may have to be patient and that their child's account of their adversities may become clearer over time. Amelia described the current status of her communication with her child surrounding their therapy:

'He hasn't really come in and said, "oh we were doing this and we were talking about this." He's quite, like, guarded, if you know what I mean. Like he'll only tell you bits that he wants to tell ya until he's ready to tell ya, then it'll all come out.'

'He's got his way of explaining it to you, and that's the way the counsellors try to explain it to him, for him to process it a little bit better.'

Holly also recalled that her child found it difficult to make sense of past events, which the therapy helped with: 'He's able to make sense of some of the stuff that he's got mixed up in his head, that he doesn't fully understand.' She also specifically noted that the therapy did not necessarily lead to him changing his behaviour but rather that he gained an 'understanding of what's happening and why it's happening'. Jenna noticed that her child was not disclosing their account of their abuse when prompted and needed time before they would do so: 'He's definitely somebody who you can't force to talk about anything. If he wanted to talk about it, he'll just randomly talk about it.'

The lengthy delay experienced by some caregivers before their children disclosed the details of witnessing and/or experiencing abuse is congruent with previous research in this area (Paine and Hansen, 2002). However, it should be noted that the caregivers spoke more about their children revealing specific details of the abuse rather than the initial discovery/disclosure of the abuse, which is the subject of interest in most prior literature - delays in disclosure. Furthermore, there is little research examining the disclosure of whether a child has witnessed abuse or not, as most of these studies focus on children who have directly experienced abuse (Paine and Hansen, 2002; Rush et al., 2014; Linell, 2017).

Another stage in the recovery process was that caregivers understood the confidentiality agreement, in which the content of the therapy would not be revealed to them unless willingly disclosed [to them] by the child. Amelia felt that therapeutic services would be an essential outlet for her child to express their worries and fears, and she recognised that they might need somebody other than her to speak to. She reasoned, 'I don't wanna push him to say, like, "oh well did yous talk about anything nice?" or anything like that' regarding her child's therapy sessions. Marla also understood that her child may not want to speak about their experiences and would be better suited to counselling:

'I just wanted to sort of make sure that he was okay. So, it was just to give him an opportunity to talk. Just, I knew he wouldn't talk to me, and I just wanted to make sure he was alright and everything... He doesn't want to worry me neither about stuff. That's why he sort of wasn't comfortable in talking to us. But he's sort of let the counsellor know that he is fine and if there was any worries or concerns, he knew he could talk to us.'

Holly had a slightly different experience in that her child sometimes disclosed what the therapy sessions had entailed. She did, however, note that her child was more vocal about the counsellor than the therapy itself:

'He would talk about his counsellor. Sometimes he'd let us know what they talked about, and what they were doing during the sessions.'

Jenna had a similar experience to Amelia and Marla in that her child did not talk to her about what they discussed during therapy. Jenna experienced this to such an extent that she felt she often 'forgot the days she would come because he just didn't talk about it'. Jenna was also the only caregiver that expressed some difficulties with this strict confidentiality and compared it to an experience with CYPS:

'We wouldn't talk about what they talked about, whereas CYPS did. CYPS let me know what was said and what was discussed. Whereas I think what I found a little bit more difficult was that what happened almost stayed between them two. And obviously because he was so little. I think it probably would have been beneficial for me to know what happened. It did bother me not knowing what he talked about. And I know that there's a level of confidentiality, but I couldn't quite understand that when he was as young as what he was. And the fact that the reason he was having it was because of domestic abuse with the ex, and I just felt that possibly having some input into what was discussed, and even just knowing. I just, I think that might have helped a little bit.'

In line with Landreth's (2013) recommendations, all caregivers were informed about the importance of confidentiality between the therapist and the child. While all caregivers understood the rationale behind the confidentiality, they varied in the extent to which they felt informed of 'general impressions about the sessions' (Landreth, 2013, p.89). Furthermore, Landreth's suggestion that caregivers may oppose the strict confidentiality was also observed, with Jenna explicitly mentioning that she felt her input could have been valuable. Caregivers also noted that the therapists established a level of trust with the child. However, they did not directly attribute this to the confidentiality agreement, as also observed by Ware and Taylor (2014).

One of the caregivers' most frequently discussed benefits of the therapy was that their children learned strategies and ways of expressing their emotions and feelings. There were suggestions of emotional difficulties by some of the caregivers, who explained that the therapy had helped their children express their emotions in a way. Amelia highlighted that therapy changed how her child conveyed their feelings:

'It had quite a positive impact because he sort of like, not so much in an adult way, but he understands if he feels a little bit angry or something, he can come and talk to people, like he has got people he can talk to and he's not gonna get wrong for doing that. I think when all this was going on with mam and stuff, I feel he felt if he told anybody, he would get wrong because it was a secret, that sort of thing. But I think after seeing Children North East, he knows now that if he feels he has something to say, he won't get wrong for saying it.'

Marla had a similar experience with her child, saying that their 'emotions have improved loads'. She also elaborated on how she believes her child had shown improvement, stating that they 'used different techniques

with the counsellor to sort of express how he was feeling'. She emphasised the importance of the counsellor's relationship with her child in learning these techniques:

'I think it's given, for children, that opportunity to have someone that they can build up a relationship with, and sort of express how they're feeling, talking about if they've got any anxieties or worries. Building up a good rapport with someone and feeling confident with them.'

She also suggested that her child's experience with therapeutic services has taught them that they can safely express their emotions with her as well: 'He knows that, if later down the line, he does want to ask questions, he can approach us to ask. And not to be scared and not to be worried about things.'

Jenna alluded to emotional regulation when describing her child's difficulties before therapy as well: 'It was more emotions that he can't handle or describe or know how he's feeling. That was back then; he's better now.' She asserted that her child was better at expressing their emotions after therapy:

'Things had to be fair, and if he wasn't treated fairly, he couldn't handle it. And I think that because he was never treated fairly and things happened to him, he could never understand why, 'cos he never did anything to warrant it. We were told that me and him would both have triggers, so if he was treated unfairly, it's almost triggering feelings of when his mum's ex was here, and so he would kick a lot. Now he doesn't kick or hit, and he can tell you how he's feeling in a calm way.'

Most participants said their children had settled following intervention from therapeutic services. Amelia remarked, 'His behaviour is really really good now. I'm not gonna say he's perfect because he's not but... He's quite settled at school, and I wouldn't even say he's aggressive at home anymore. To be honest, he's doing alright.' Marla's child was also able to reconcile some problematic realities about their family:

'My concern was that he's sort of got told that who he thought was his proper dad isn't his proper dad. And then he'd be getting upset and having loads of questions, although he said everything was fine. It hasn't changed and he's not upset. He doesn't worry about it; [stepdad] has been his dad from day one, and that's not gonna change.'

Jenna, like Amelia, noticed a difference in her child's experience at school:

'Gradually, yes, I think I did [notice a difference in behaviour] yeah. He's definitely got better, considering what he was like when he first started school; things have definitely improved in that respect.'

She also noted other ways in which she and the child were settling down into their new life and suggested these factors could also have contributed to improvements she saw in the child:

'I think it's also helped that I've changed the whole house. I've got rid of furniture that we had and I've got new furniture in, and the house has been decorated. He's moved different rooms, and I think everything... it's now our home and we've made it together. I've had a new bathroom and a new kitchen, so it doesn't look like it did when he was here. Which I think makes a massive difference.'

Positive experiences

All the participants felt that, overall, they and their children had a positive experience with therapeutic services. Amelia said she would 'definitely' recommend the services to others going through similar difficulties and commented that 'it has helped; they've been quite a good service'. Other participants elaborated on why they had such positive experiences. Marla felt that the counsellor went beyond her role in supporting her family:

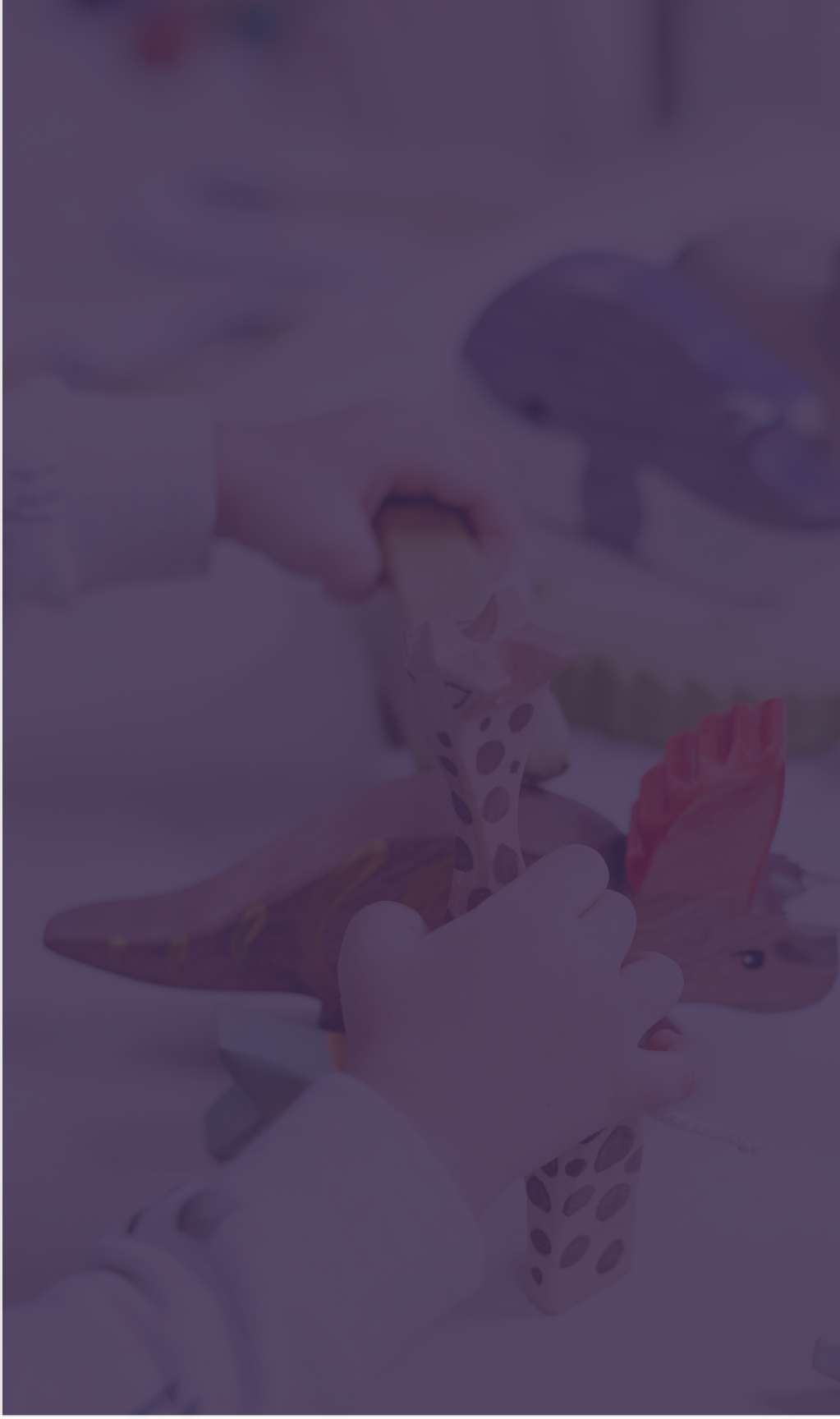
'Me being able to talk to her as well, having that communication by text messages and everything, because she went through children's services with us. She was attending meetings by Teams and everything, so she was involved with a lot of stuff. I was the main point of call, so sort of talking and making appointments and everything. After the sessions, depending on what they talked about, she'd send us a message, and check on whether he was okay and everything.'

As was the case with other participants, Holly felt that simply having an outlet to speak about adversities was beneficial to the child. She explained, 'it helped him prepare for court, and it helped him to sort of make sense of a lot of what was going on', and that the counsellor was 'brilliant with them'. According to the caregivers, the children's attitudes towards the ther sessions varied. For example, Jenna recalled, 'He always hated when it was about to happen, but then getting him off it was a nightmare 'cos he enjoyed it. But that's him all over.' Holly also reported that her child adapted to the sessions:

'I don't think he says he enjoys it. But he was always happy, or if for some reason the session wasn't going ahead, he would always look forward to it, or say, "why aren't I having me session with [...]?", so obviously he was enjoying it for wanting to do it as much as he did.'

Jenna also found it hard to gauge whether her child had a positive experience with the therapy sessions due to the confidentiality established between the counsellor and the child: 'I mean he certainly enjoyed the sessions. Whether or not he talked about what was bothering him, I'm not sure.' Amelia had a similar experience: 'I think it's actually finished now, but he hasn't really mentioned much about it, which is fine'. Holly was also uncertain whether the therapy was responsible for all the positive changes in her child's behaviour. She remarked that her child's confidence may have increased after the counselling, but that 'He's a confident little boy anyhow, so it's hard to pitch that one', and that although the child's behaviour was 'so much improved', she affirmed that 'that could be down to a number of things'. Holly had some concerns about the virtual elements of the counselling, as her child was already spending a lot of time in front of a computer screen due to the COVID-19 pandemic:

'We found in the week that, on some days, he'd get bored. He was sick of being on a computer, and it wasn't healthy for a child to be on a computer, coming home from school and being on that computer for a couple of hours every single night. But if we didn't do that, then there was no contact, no therapy sessions. So, you were stuck in that Catch-22 situation. It wasn't their fault; it was just the situation we were all stuck in.'



Conclusion

This study set out to investigate the lived experiences of caregivers who accessed support for children in their care exposed to domestic abuse. The findings support previous studies discussing the detrimental impact of domestic abuse on children's mental health and wellbeing, and the intense demands on caregivers trying to support them. From the caregivers' perspectives, the findings highlighted the value and timeliness of the therapeutic services in helping children to begin to understand their feelings and behaviours.

Participants felt a sense of urgency for therapeutic intervention to try to understand their child's needs. When speaking about the process of support-seeking, they shared some critical factors that influenced their willingness to access support services. These included the ability to recognise they needed support due to escalating challenging, violent and aggressive behaviours displayed by their children, or increased frequency and intensity of emotional difficulties. All the children had witnessed domestic abuse and some had also experienced abuse during periods when there was no available adult to protect them. The caregivers wanted to access support they felt they were not qualified to provide at the level they felt was needed. For some, this was due to their own difficulties, caused by their exposure to domestic abuse.

Contributing towards a holistic recovery was the main outcome through which therapeutic services positively impacted on the lives of the children and their families. The therapies provided were praised for enabling the therapists to talk to the children about sensitive topics. Through the sessions, caregivers identified that their children became more adept at healthily expressing their emotions and that some of their challenging behaviours had reduced. Caregivers also reported that their children were settling into life at school and at home, where they had previously exhibited difficulties. It should be noted that some participants felt that engagement with therapeutic services was not the only thing that had changed in their lives, and suggested that other factors, such as moving house or adapting to a new caregiving environment, could also have contributed towards the positive outcomes.

The caregivers in this study made some suggestions for improvement. Caregivers described needing prompt support to enable the best chance of recovery and felt the exemption criteria in CAMHS was a barrier to achieving this. Some logistical issues were also mentioned, including being rejected from particular support services due to their child not meeting the necessary criteria. The findings of this study suggest that a lack of prompt, accessible and multi-agency support resulted in exacerbation or elongation of the children's difficulties, a factor noted in other studies. Furthermore, this study found that there is little synergy between therapeutic services and other support services that participants were aware of.

The caregivers felt the therapists were effective at forming trusting relationships with their children. However, some were justifiably concerned that these relationships had an expiry date, as there were session limits in place. Furthermore, while caregivers received broadly similar amounts of information about how their child was progressing with therapy, they had different opinions on how much involvement they would have preferred. While not all participants were entirely satisfied with remote therapy compared to face-to-face

therapy, they were appreciative of efforts made by the organisation, acknowledging that they did all they could.

The most significant finding to emerge from this study is that a predetermined length of 10 weeks for a therapeutic programme needs to be reconsidered. The time-bound model doesn't consider the varying impact of exposure to domestic abuse and the individual support needs of individual children. There is a funding implication to provide an extended programme of comprehensive and universal support, though the evidence from this study suggests this is what is needed. Maximising the effectiveness and accessibility of support services is key to ensuring that caregivers can locate and promptly engage with these services. It is likely that the child, siblings and other family members would benefit from a tailored package of support as soon as families come to the attention of services.

Recommendations

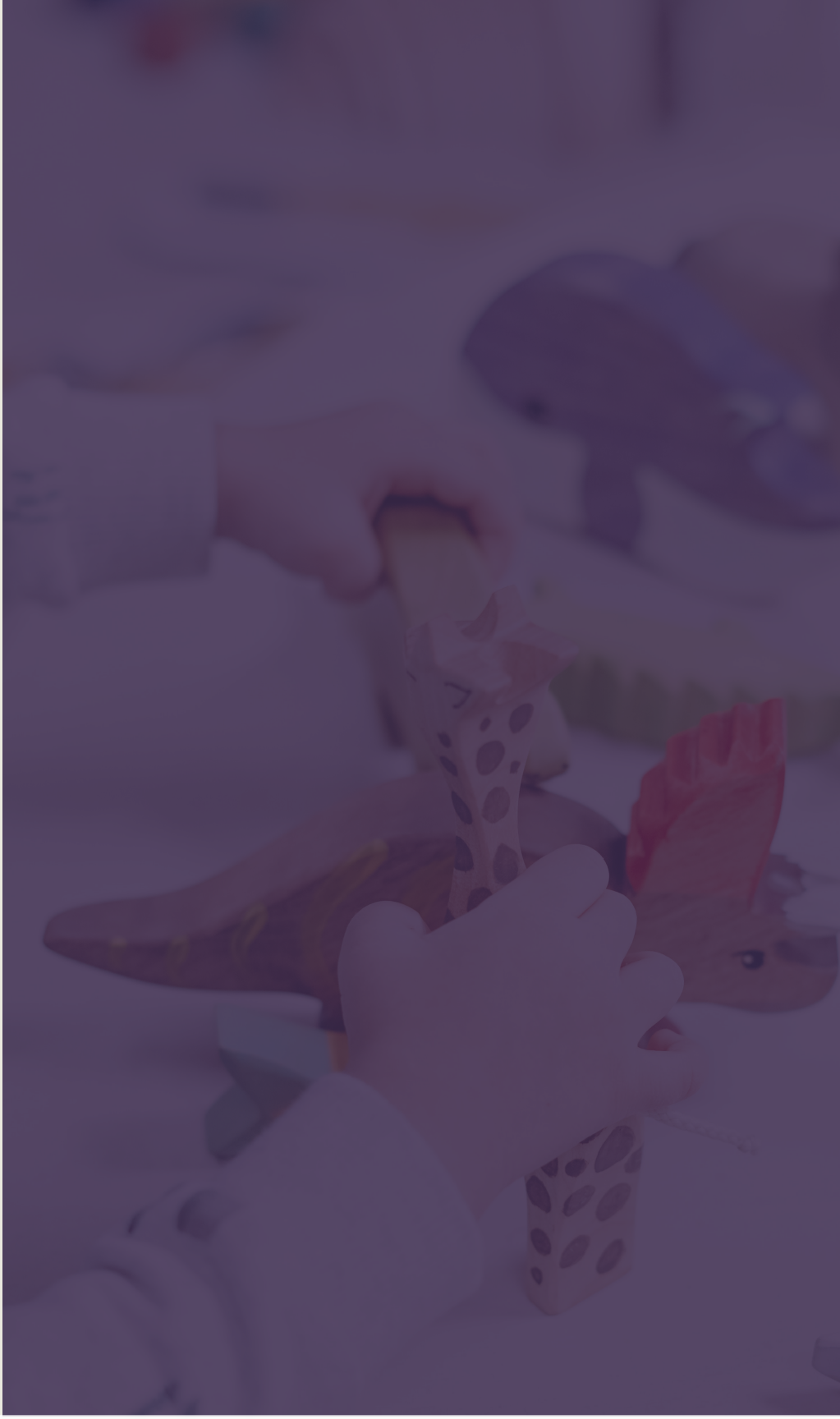
1. **For Sunderland City Council to continue to commission therapeutic interventions for children and young people exposed to domestic violence and abuse.**
2. **To give consideration in any specification for therapeutic services that there is an option to extend the period of therapeutic intervention where this is deemed beneficial.**
3. **To raise, with commissioners for Sunderland and South Tyneside Community CAMHS, the detrimental impact of the number of exclusion categories on the special circumstances list on families accessing prompt support.**
4. **In education, health, social care and the public domain, develop knowledge and awareness of the range of mental health services available to children and young people. This should include signposting families to universally available services, including those in the third sector (particularly when a child does not meet a threshold for support).**
5. **To consider providing local training for foster carers, kinship carers and adopters on evidence-based approaches to supporting children with challenging, violent and aggressive behaviours and emotional needs.**

Limitations

There are limitations to this study. First, the sample was only four caregivers. The findings may have differed with a larger sample or a sample that included caregivers with children who had accessed support services from other providers.

Second, the participants were all from one locality in the North East of England.

Third, the study took place during the COVID-19 pandemic meaning, the therapeutic services were delivered online rather than face to face in schools. However, the interviews and use of IPA have provided some insight into a hard to reach and under-represented group of caregivers on the benefits of therapeutic mental health support services for children.



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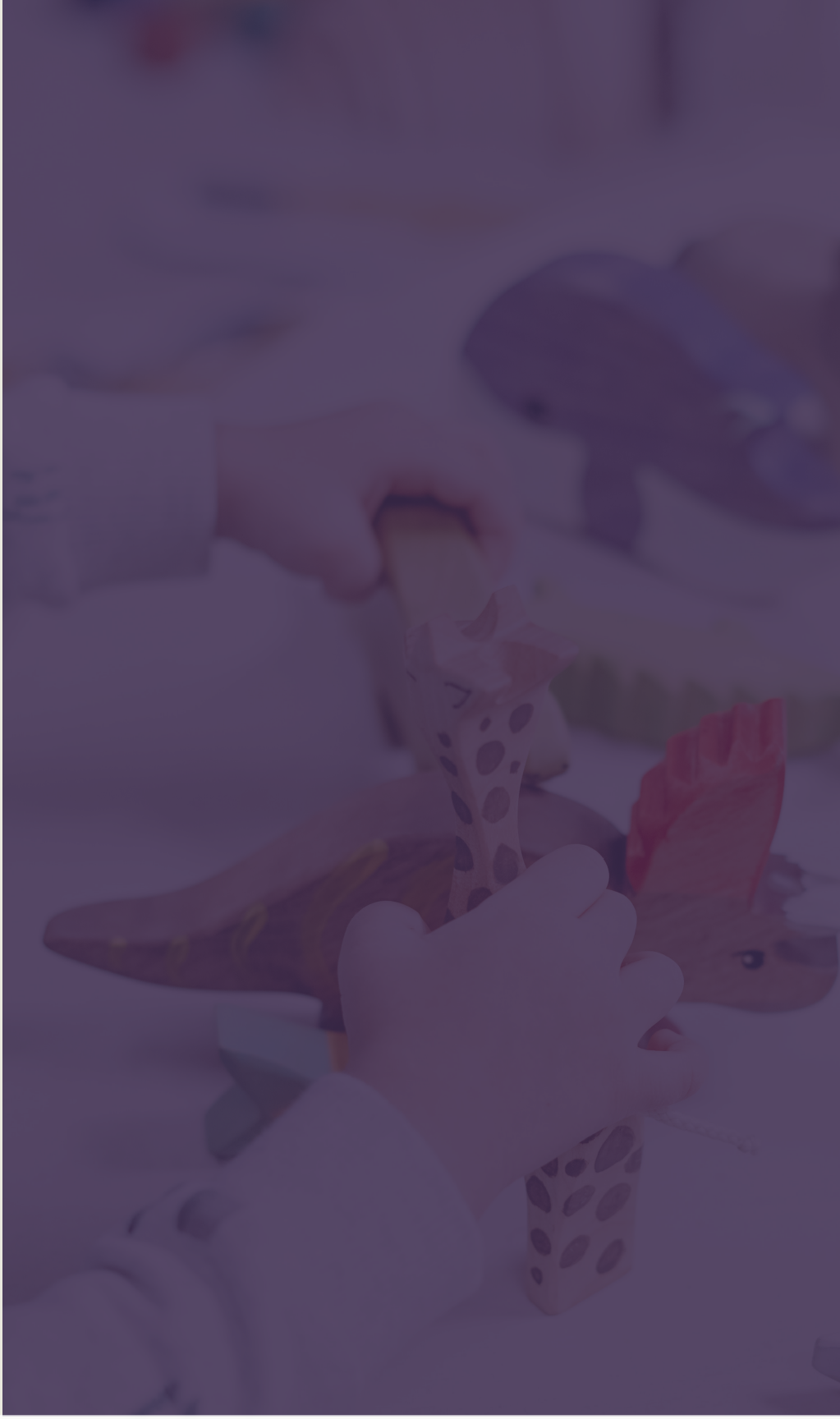

Appendices

Appendix 1

Sunderland and South Tyneside 'special circumstances list'

Does the child/young person have any of the Special Circumstances listed below?

Please tick all that apply:

Are or have been looked after or accommodated including being adopted from care

Have been neglected or abused or are subject to a Child Protection Plan

A learning disability

A learning difficulty

A physical disability

A chronic, enduring or life limiting illness

Medically unexplained symptoms

Substance misuse issues
Are homeless or are from a family that are homeless

Have parents with problems, including domestic violence, mental and/or physical illness, dependency or addiction

From a refugee and asylum seeking family

At risk of, and/or have been involved in offending

From a minority ethnic or minority cultural background including travellers

Are a young carer

NONE OF THE ABOVE

Appendix 2

Research objectives	Interview questions
Identification of processes that supported participants to access therapeutic services	• Can you tell me about the process of getting a counsellor through CNE? • Did you have to wait long for an appointment with CNE? • How many sessions did your child have with CNE? • Would it have been better to have the appointment sooner? Or did it come at the right time? • What, if anything, were the barriers to the child accessing CNE?
Determine what impact therapeutic services had on the lives of the children and their families	• Who else in your life gives you and your child support? • How did your child feel about their first appointment? • What, if anything, do they enjoy doing about spending time with the counsellor? • What, if anything, do you think helped your child talk through the difficulties they were having? • How, if at all, has CNE supported your child? • What is the best thing, if anything, about CNE? • What strategies did the counsellor give your child? • Do you think CNE helped your child cope/ understand their feelings? How? • Has their time at CNE improved their confidence at home or school? How? • Does this support help you? How?

Research objectives	Interview questions
Analyse how services for children exposed to domestic abuse could be improved	• What, if anything, would make CNE better? • Has your child accessed any other mental health support services? How do they compare to CNE? • Would you recommend CNE? Why?
Recognise opportunities for enhancing user engagement with support services for families	• How did your child feel about working with Children North East? • What, if anything, did they enjoy doing about spending time with the counsellor? • What, if anything, do you think helped your child talk through the difficulties they were having? • How, if at all, has CNE supported your child? • What is the best thing about CNE? • What, if any strategies has CNE shared with your child? • Do you think CNE helped your child cope/ understand their feelings? How? • Has their time at CNE improved their confidence at home or school? How? • Does this support help you? How?