The Safe Nest Group pilot project:

Early intervention for mothers and infants who have experienced family violence

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ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children

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This report is dedicated to the memory of Luke Batty 20 June 2002–12 February 2014.

Acknowledgement of Country
ANROWS acknowledges the Traditional Owners of the land across Australia on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past and present, and we value Aboriginal and Torres Strait Islander histories, cultures and knowledge. We are committed to standing and working with First Nations people, honouring the truths set out in the Warawarni-gu Guma Statement.

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Author dedication
This report is dedicated to honour Bianca Morrison, who sadly passed away before the project was finalised. Affectionately referred to as the "baby whisperer", Bianca's wellspring of unconditional love nourished and supported both mother and child. She had an extraordinary ability to hold space and understand the infant's experience while always remaining humble and kind. She was such a strong advocate for the needs of women and their children impacted by family violence. Bianca will be greatly missed and was loved by everyone who had the good fortune to know her. It is hoped that this love will be carried forward, to support women and infants who have experienced family violence as a gift given freely and in abundance especially during times of adversity and hardship.

Acknowledgement of lived experiences of violence
ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include 1800RESPECT (1800 737 732), Lifeline (13 11 14) and, for Aboriginal and Torres Strait Islander people, 13YARN (13 92 76).

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List of acronyms

ADBB	Alarm Distress Baby Scale©
ANROWS	Australia's National Research Organisation for Women's Safety
AIHW	Australian Institute of Health and Welfare
CALD	Culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Services
CAP	Children Are People Too
CBT	Cognitive behavioural therapy
CDI	Child-directed interaction
CPP	Child–parent psychotherapy
DART	Domestic Abuse, Recovering Together
DASS	Depression, Anxiety and Stress Scales
DFFH	Department of Family, Fairness and Housing
IPV	Intimate partner violence
FI-OP	Family Intervention for Improving Occupational Performance
FV	Family violence
ITQ	International Trauma Questionnaire
MCRI	Murdoch Children's Research Institute
PCIT	Parent–child interaction therapy
PIR-GAS	Parent–Infant Relationship Global Assessment Scale
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PTSD	Post-traumatic stress disorder
RCFV	Royal Commission into Family Violence
RCH	Royal Children's Hospital
SNG	Safe Nest Group
Shut-D	Shutdown Dissociation Scale
RCTs	Randomised controlled trials
TF-CBT	Trauma-focused cognitive behavioural therapy
WHO	World Health Organization

Definitions and concepts

Family violence

In this report, family violence (FV) is used to refer to psychological, physical or sexual abuse and/or coercive control by a former or current intimate partner, or any other adult family member. We used this term as the women who participated in our pilot project experienced different types of FV, including violence from other family members who were not intimate partners. Further, FV is the legal term recognised by the sector and in the *Family Law Act 1975* (Cth; see Judicial College of Victoria, 2013), which represents the best interest of children. Family violence was also the term used in the 2015 Royal Commission and was defined according to section 5 of the *Family Violence Protection Act 2008* (Vic; see State of Victoria, 2016b). The Commission made note that the "most common manifestation of family violence is intimate partner violence committed by men against their current or former female partners. This violence can also affect children. It is the form of FV that we know most about, and it is the key focus of most services and programs" (State of Victoria, 2016b). While men can also experience violence perpetrated by an intimate partner or adult family member, this report focuses on women who have experienced FV in recognition of the Safe Nest Group program inclusion criteria and the fact that women are more likely to be affected by FV.

Homelessness

For the purpose of this study, we used the definition of homeless consistent with the Australian Institute of Health and Welfare (see Australian Institute of Health and Welfare [AIHW], 2021). A person is considered homeless if "they are living in non-conventional accommodation (such as living on the street), or short-term or emergency accommodation (such as living temporarily with friends and relatives)" (AIHW, 2022). The current research also drew on Mackenzie and Chamberlain's (1922) cultural definition of homelessness, which includes three specific categories: primary (living without a roof over their heads – cars, street); secondary (refuges, shelters, couch surfing); and tertiary (boarding houses, living in a place without self-contained facilities such as a hotel, or do not have a lease; see Homelessness Australia, 2024).

Executive summary

Background

There is an increasing number of women and children impacted by family violence (FV) across their lifetime. Exposure to FV increases a woman's risk of significant mental and physical health issues, as well as suicide (Brown et al., 2020; Campbell et al., 2002; González Cases et al., 2014; World Health Organization [WHO], 2005; Lagdon et al., 2014; Stewart & Vigod, 2017). Children exposed to FV are also at increased risk of psychological, developmental, cognitive and social-emotional problems (Åkerlund & Sandberg, 2017; Evans et al., 2008; Holt et al., 2008; Howell et al., 2016; Wood & Sommers, 2011). These effects can be immediate and/or manifest over time (Holmes, 2013).

We need to better understand the effectiveness of interventions which are already embedded within community services and designed to be accessible to a range of women and their children, including those from culturally and linguistically diverse (CALD) backgrounds. This report describes a pilot evaluation of one such intervention: the Safe Nest Group (SNG) in Melbourne, Australia.

Project aims and methodology

Aims

To gather preliminary evidence about the outcomes of the SNG program for women and their children. The specific aims were to assess pre- to post-intervention changes in:

- maternal depression, stress and anxiety
- trauma symptoms experienced by mothers
- relational withdrawal behaviours in the infants
- the quality of the relationship between mothers and their infants.

A secondary aim was to explore the mother's subjective experience of the SNG program, including the perceived outcomes of their participation, along with their satisfaction with the content and delivery of the program.

About the Safe Nest Group program

The Safe Nest Group (SNG) is a weekly, six-session group intervention for women and their infants (aged 0 to 3 years) who have recently experienced FV and who are currently living in refuges or other stable residential housing. The program was developed jointly by Emerge Women and Children's Support Network and Swinburne University and adapted from the Peek-a-Boo Club™ (Bunston et al., 2016).

The main aim of SNG is to prioritise the needs of the infant such that they can heal and start their recovery from the impact of FV. Key here is strengthening and repairing the mother–infant relationship and supporting women to become safe and attuned caregivers. The 2-hour group sessions are underpinned by trauma-informed, psychodynamic and infant mental health principles and are structured to include infant-led play and the dyad-focused intervention components. Although manualised, there is flexibility in the content (e.g. how FV has affected play, identifying infant strengths, setting boundaries, co-regulation) and activities provided (e.g. sensory toys, puppet play, music and movement, bubbles) so that the program can be tailored to the age, needs and interests of the infants and their mothers.

The SNG is infant led, meaning that equal consideration is given to the mother's and infant's experience of FV, which are not necessarily the same. We responded to a need to better understand the infant's experience of FV, which we know is largely under-represented in this adult-centric field. The program is influenced by attachment and trauma theory. It was also designed to be inclusive of women and children from CALD backgrounds who have become homeless because of FV and who are living in refuges or other stable residential housing. Many of the clients who access Emerge are from CALD backgrounds and, as such, the SNG tries to be considerate of the needs of these women. Emphasis is given to play and arts-based activities rather than to activities with culturally specific language requirements. The activities are culturally sensitive and also amenable to having interpreter involvement, if necessary. The project lead was Associate Professor Katie Wood from Swinburne University, and

the partner organisations were Emerge Women and Children's Support Network and Murdoch Children's Research Institute (MCRI).

Methodology

This pilot project used a single group pre-, post- and follow-up design with a nested qualitative study. The project was approved by Swinburne University of Technology's Human Research Ethics Committee (HREC number 20191241-1399) and ran between September 2019 and August 2021. Adult women and their children (0 to 3 years) who were currently living in refuges or other stable residential housing were eligible for the study. Other inclusion criteria for women included having recently left a violent relationship (within 12 months), no reported illicit substance use within the past month, no active psychotic symptoms and/or active suicidal/homicidal thoughts, no evidence of major cognitive impairment and conversational proficiency with the English language. There were no specific inclusion criteria for the children. It was predicted that some infants would see their father during the program as per legal mandates. Emerge's constitution states that dual consent is not required for children accessing services. However, potential issues of safety and risk are assessed at the time of referral into the service. Where safety cannot be upheld Emerge does not provide a service, and in the case of this project, the infant–mother pair (referred to herein as dyad) were not deemed eligible to participate.

A total of 17 women were asked to complete a series of questionnaires about themselves and their children and to participate in a parent–infant observation measure prior to the group commencing, after the group and at approximately 1-month follow-up. Participating mothers were also invited to take part in a semi-structured interview about their experiences of the group program. Given that most of the groups were delivered during the COVID-19 pandemic, some modifications to the original methodology were required to ensure that COVID-19 safe protocols were followed consistent with Victorian Government regulations. These included hand hygiene, social distancing and temperature checks on arrival. There were some unavoidable delays to the groups due to the rolling lockdowns in Victoria.

Key findings

While tests of significance could not be performed to assess changes in outcomes on the key variables due to the small sample size ($N = 17$), the results of the current pilot study highlighted the benefits of the SNG program for many of the mothers. These included noticeable and clinically meaningful reductions in their symptoms of depression and trauma. However, there were no reductions in mothers' reported levels of stress from pre- to post-intervention, suggesting that stress might remain a more stable aspect of mental health despite intervention. The qualitative data highlighted the benefits of the program in helping women to feel safe to share their experiences of FV, to better understand the impact of FV on their children, and to create more opportunities to engage with their children in play while reflecting on how they interact with their children when they are both expressing difficult emotions. The women reflected on the importance of having an intervention that was focused on them and their child that they felt was less stigmatising. The SNG also provided women with a sense of connection and community, with some women keeping in touch with each other after the group. Women learned more about their children's development and provided valuable insights into the important barriers and facilitators to engagement in the therapeutic program. There were also benefits of the program for the children. Based on maternal reports, there was evidence to suggest that the children enjoyed attending the group and benefitted from having a reliable and predictable group structure. There were also reports that the children showed more confidence in their socialisation and self-confidence.

Implications and recommendations for policymakers

Implications

- Women's and young children's mental health, physical health and wellbeing can be impacted by FV.
- Young children impacted by FV are often overlooked by treatment providers in Australia, as are the specific treatment needs of the mother–infant dyads.
- There continues to be a relative lack of research on women and their children from CALD backgrounds who have left violent relationships and who are living in refuges or transitional housing. This pilot project highlighted that these women and children are willing to engage in therapy programs aimed at supporting their recovery from FV. The women are also able to provide valuable information about their experiences that can inform the future planning of prevention and intervention research.
- Most aspects of the SNG group therapy program for mothers and their young children impacted by FV were acceptable to program participants. Based on the current findings, women and children need to feel comfortable with the participants and facilitators before sharing aspects of their lives. Policymakers should be mindful of how intervention programs are promoted, with some of the women in the current project preferring to liken the program to a playgroup rather than a therapy group. Also important is the type of practical support provided to these participants to facilitate engagement and participation. For example, the provision of taxi vouchers made it easier for some participants to attend.
- Program developers and group facilitators involved in therapeutic programs should continue to be guided by the diversity-informed tenets for infant mental health practice (Ghosh Ippen, 2012). This requires flexibility and a willingness to understand the family's story, its culture and history, and how this shapes the family's experiences of FV. The SNG is evidence based, manualised, and lends itself to a train-the-trainer model of care that will help to build a trauma- and attachment-informed workforce to support mothers and their young children from diverse backgrounds who are impacted by FV. The manualised nature of the program also extends its reach across metropolitan and rural locations.

Recommendations

- Continue to develop and evaluate the SNG and its application to other service providers and client groups in the FV sector. Client groups could include mothers and children from the LGBTQ+ community, Aboriginal and Torres Strait Islander women and children, and young mums and their children.
- Continue to understand the barriers and facilitators to engagement in therapeutic programs in the FV sector.
- Actively consider the changing needs of women and their children at different points along the FV cycle.
- Develop a fully funded wraparound service model that provides women and children impacted by FV with continuity of care rather than brief touchpoints that do not respect their complex needs over time. Critical to such continuity of care is planned and ongoing collaboration between the different service providers working with the family system. Participation in the SNG program is an important part of such a model, particularly during the early stages of recovery when both practical and therapeutic support is needed.
- Continue to provide women impacted by FV with valuable points of therapeutic engagement that help them to feel more confident and ready to access other FV services and more generalist health care for themselves and their children.
- Maximise the knowledge and skill of people on the ground in the women's and children's local community. It is often local networks that provide women who have experienced FV with initial support, guidance and a non-stigmatising response to their experience (Vaughan et al., 2015). This could be done through creating more opportunities for training local community workers as well as investing in more community-led programs. This would require stable community funding to ensure that such an initiative could be maintained over time.

Implications and guidance for practitioners and service providers

The SNG has significantly enhanced the lives of women and their children impacted by FV and who are in refuges or other transitional housing. The SNG has:

- reinforced the need for specialist clinicians to validate the experiences of women who have experienced FV and to provide a consistent and reliable space for them to feel safe enough to tell their stories
- demonstrated the need to continue to promote interventions that accommodate the needs of women and their children through a trauma- and attachment-informed lens
- highlighted the importance of creating a therapeutic space without reinforcing that the women are engaging in "therapy" *per se*. This seemed beneficial for the women in the current pilot project, possibly because of the perceived stigma associated with seeking help for mental health issues
- reinforced the importance of providing women impacted by FV with the opportunity to develop a sense of agency and autonomy. Women need to feel supported to reclaim their lives – such support can create pathways for them to become independent and autonomous not just in their choice of service but in their professional and personal lives
- highlighted the ongoing need to provide therapeutic interventions for women and their children that focus on the parent–child relationship and the long recovery from the impacts of FV
- facilitated the recovery of women and their children from FV by helping to reduce some of the mental health and trauma symptoms experienced by current participants
- highlighted that, despite participating in a dyadic intervention, the stress experienced by women impacted by FV is likely to remain, necessitating the need for other ongoing interventions and long-term management.

1. Introduction

Family violence (FV) perpetrated by an intimate partner or other adult family member is a major public health concern. Globally, approximately 30 per cent of women are expected to experience physical and/or sexual violence by an intimate partner during their lifetime (WHO, 2013). Given this alarming figure, there has been growing interest in preventing the significant and often chronic negative impact of FV on women from a public policy, clinical and research perspective. In 2015, the Victorian State Government established the Royal Commission into Family Violence (RCFV). At this time, the State Premier acknowledged that FV was "the most urgent law and order emergency occurring in our state and the most unspeakable crime unfolding across our nation" (State of Victoria, 2016a, p. 1). The findings from this Royal Commission (State of Victoria, 2016a) highlighted that early intervention and evidence-based treatment programs for women and children were lacking.

Family violence does not just affect women. The Australian Bureau of Statistics (ABS, 2016) estimated that 121,400 Australian adults who had experienced intimate partner violence (IPV) by a current partner and 615,900 adults who had experienced IPV by a former partner had children living with them at the time. Previously, children who had experienced FV were referred to as having "witnessed" FV. It is now widely recognised that children can experience FV directly and indirectly. This can include seeing physical evidence of violence, being exposed to the emotional responses of either caregiver and/or through the physical and mental health impacts on their caregivers following any form of FV. Children might not be aware of the violence or the potential for violence in the home, but they are indirectly affected by the impact on their mother and the associated impact on the safety of the mother–child relationship (McIntosh et al., 2021; McTavish et al., 2016; MacMillan & Wathen, 2014). For this reason, this report acknowledges that children experience FV (McTavish et al., 2016). The terms women and mothers will be used interchangeably throughout this report to refer to the participants who took part in the current pilot project. When referring to the participating infants, the terms infants and children will be used interchangeably.

Historically, children's experiences of FV have been invisible in the human services sector (Hatzinikolaou et al., 2016). However, this has changed over the past 5 years with increased focus on the short- and longer-term impacts of FV on children (Fong et al., 2019; Gartland et al., 2021; Kimber et al., 2018). We know that children exposed to FV are impacted across multiple developmental areas, including mental and physical health, social relationships, cognitive development and learning (Åkerlund & Sandberg, 2017; Evans et al., 2008; WHO, 2005). This highlights the urgent need to direct efforts towards protecting children from the longstanding harm associated with FV and include them in our efforts towards early intervention and prevention (Murray & Powell, 2011).

Many service providers and researchers have focused on better understanding the short- and longer-term effects of FV on women and relationships with their children to develop therapeutic interventions to repair and/or strengthen the parent–child attachment. From this work, we know that many women who have experienced FV struggle with their view of themselves as a mother, including how they interact with their children (Levendosky et al., 2003; McIntosh et al., 2021). The experience of being in a violent relationship can compromise a mother's capacity to parent effectively. This can impact negatively on the child's wellbeing, which can further compromise the mother's parenting and attachment experience with her child. The stress, mental health issues and/or substance abuse that many of these women experience can further impact the quality of the parent–child relationship (McIntosh et al., 2021).

Children who experience a frightened, dysregulated and/or frightening parent can present with a disorganised/disoriented attachment style. This can be characterised by odd, contradictory and/or conflicted behavioural responses from the child to the caregiver. These children can also display poor emotional literacy, meaning that they can struggle to recognise, label and manage their emotions (i.e. emotional regulation; Brumariu et al., 2021) because they have not experienced consistent and predictable emotional attunement from their mother. This can be a result of the impact of FV on the mother's own

psychological functioning (McIntosh et al., 2021). There is also evidence to suggest that a disorganised attachment style is the most stable insecure attachment pattern over time (Groh et al., 2017; Opie, 2019). Therefore, from a clinical and treatment perspective, there is a clear need for evidence-based interventions that focus specifically on mothers, children and their relationship (Murray & Powell, 2011; Opie, 2019). While children will have different experiences to their parents, it is important that they are considered when developing intervention programs.

The main aim of the current pilot study was to evaluate the effectiveness of the Safe Nest Group (SNG), an early intervention infant-led program for mothers and their infants who have experienced FV. The program was specifically designed for mothers and their infants who have become homeless because of FV and who are living in refuges or other temporary residential housing. Many of Emerge's clients are from CALD backgrounds and the SNG tries to be considerate of the needs of these women.

1.1 Structure of the report

First, a state of knowledge review will be presented, followed by an overview of the SNG program. The aims of the pilot study will then be presented as well as the study methodology and procedures. Ethical considerations will also be considered, followed by a presentation of the quantitative and qualitative study findings. Four case studies have been included to present a more in-depth presentation of the findings that highlight specific changes for mothers, infants and their relationship. Next, the findings of the study will be discussed, including the study strengths, limitations and directions for future research. The report gives emphasis to the implications of the findings for policy and clinical practice.

2. State of knowledge review

The aim of the state of knowledge review was to systematically evaluate the available evidence regarding the effectiveness of mother–child interventions specifically targeting the mental health of children who have been exposed to FV. The review focused primarily on interventions for women and infants who left a relationship where FV had occurred, with a particular interest in studies of women living in a refuge. Due to the relatively few studies specifically evaluating interventions for young children and the large age range for many interventions, this section reviews the literature on interventions for children aged 0 to 18. The findings of the research will be discussed in the context of parenting capacity and the parent–child relationship.

This section begins with an overview of the prevalence of FV for women and their children. Recognition is then given to how the experience of FV can rupture the mother–child relationship. The research is also clear in showing how this relationship can play an important role in the healing and recovery for children and their mothers. Limitations of the available research and evidence gaps are highlighted.

2.1 Overview

The need for early intervention for children impacted by FV is highlighted by the prevalence data. An alarming one in four children in Australia are exposed to IPV (Gartland et al., 2021). American research has also found that 25 per cent of 14- to 17-year-old children had witnessed IPV in their lifetime (Finkelhor et al., 2015). More specifically, during the first postnatal year, approximately 1 in 5 women experience FV (Brown et al., 2020). It is estimated that 2.2 per cent of women experience physical abuse in their first postnatal year, and many more experience both physical and emotional abuse (5.4%) or emotional abuse alone (9%; Gartland et al., 2011). The adverse consequences of FV on women's mental and physical health are well established (Brown et al., 2020; Campbell et al., 2002; González Cases et al., 2014; Karakurt et al., 2014; Stewart & Vigod, 2017). Young children growing up in homes where FV occurs are also at an increased risk of developmental difficulties and poor physical and mental health across their lifespan (Evans et al., 2008; Holt et al., 2008; Izaguirre & Calvete, 2015; Wood & Sommers, 2011). Therefore, preventing the sequelae of poor health from early life experiences of FV is a public health priority. This can be achieved by strengthening all relevant service systems' (e.g. health, social care, justice) responses to supporting children's recovery (McIntosh et al., 2021).

Despite the need for early intervention efforts to address harm following FV, there are ongoing service system challenges in meeting the needs of women and children who have recently left a relationship where FV has occurred. For example, responding to urgent issues around safety and homelessness, managing family court and child protection involvement (Nwabuzor Ogbonnaya & Kohl, 2018), meeting the needs of families from CALD backgrounds (Segrave, 2017) and providing developmentally appropriate interventions for children of all ages. Notwithstanding these challenges, there is emerging evidence for the effectiveness of child-focused and mother–child interventions in preventing and reducing children's mental health difficulties following FV (Anderson & van Ee, 2018; Howarth et al., 2015).

2.2 Definitions and prevalence of FV

Family violence refers to violence perpetrated by a family member and is inclusive of violence perpetrated by a current or former intimate partner (AIHW, 2019). FV can include acts of physical violence such as hitting, slapping, choking and/or using a weapon such as a knife. It can also include sexual violence, such as sexual coercion or any unwanted sexual contact, as well as emotional or psychological violence, including name calling, intimidation, humiliation or controlling behaviour (Smith et al., 2017).

Although some forms of FV might be situational (i.e. a violent act resulting from an escalation of an argument), there is growing evidence to suggest that most forms of IPV include an element of coercive control (Johnson, 2006). Coercive control implies a chronic pattern of violent or non-violent behaviours used to exert power or control over a partner (Stark, 2007). Some examples of

coercive control include: isolation from friends or family, gaslighting, threats to personal safety or safety of children, financial control and/or monitoring movements (Johnson, 2006; Stark, 2007). There is increasing recognition of reproductive control as a type of IPV. This is when a partner exerts control over a woman's reproductive rights through controlling access to birth control or placing pressure/force for women to terminate a pregnancy (Grace & Anderson, 2018; Miller et al., 2010). FV can also include financial abuse and technology-facilitated abuse (Woodlock, 2015). Australian and international research has shown that women are at increased risk of FV during pregnancy and in the early postpartum period. Specific risk factors for women experiencing FV during this time include using substances, having a mistimed or unwanted pregnancy, and access to education and health services particularly for those who live in remote areas (Charles & Perreira, 2007; Gartland et al., 2014; Taft et al., 2004). The 2016 ABS Personal Safety Survey (PSS) found that 18 per cent of pregnant women had experienced FV by a current partner, and 48 per cent had experienced FV by a previous partner. In another Australian study investigating IPV for new mothers, results showed that 17 per cent of 1,507 women experienced emotional and/or physical violence during the first year postpartum (Gartland et al., 2011).

Determining the exact prevalence of FV is challenging because many women experiencing violence do not seek help or report its occurrence (KPMG, 2017). Large population-based or national surveys are often used for this purpose. However, their reporting of prevalence data is influenced by the definition and measurement of FV. This is an important consideration because the definition of FV has changed over time. Early research focused predominately on the occurrence of physical violence or aggression (e.g. slapping, kicking, choking, beating, pushing or using a weapon; Smith et al., 2017). Now greater consideration is given to the serious and lasting impact of psychological aggression, emotional abuse and coercive control (Basile et al., 2004; Smith et al., 2017).

Despite some of the challenges associated with obtaining accurate prevalence data, it is estimated that at least 30 per cent of women worldwide will experience physical and/or sexual violence within their lifetime (WHO, 2013). For instance, a large national survey conducted in the United States found rates of physical violence, sexual violence and stalking by an intimate partner to exceed one in three women (37.3%; Smith et al., 2017). In Australia, it has been estimated that one in four women have experienced IPV (Cox, 2016; Gartland et al., 2014). The *National Plan to Reduce Violence against Women and their Children 2010–2022* stated that 1.4 million Australian women had been exposed to violence from a previous partner since age 15 years (Council of Australian Governments [COAG], 2010, p. 4).

2.3 Children's experiences of FV and the health impacts

The Victorian RCFV highlighted children as the silent victims (State of Victoria, 2016a, p. 23). The ABS estimated that 121,400 Australian adults who had experienced IPV by a current partner and 615,900 adults who had experienced IPV by a former partner had children living with them at the time (ABS, 2017). Moreover, American research also found that 25 per cent of 14- to 17-year-old children witnessed IPV in their lifetime (Finkelhor et al., 2015). A recent Australian study using a subsample of 615 mother–children dyads from a pregnancy cohort of 1,507 women found that one in four children were exposed to FV in the first 10 years of life (Gartland et al., 2021).

Children do not need to directly witness FV to be negatively impacted by it (Kitzmann et al., 2003; McTavish et al., 2016; MacMillan & Wathen, 2014; Øverlien, 2010). Experiences can include a child witnessing or hearing violence between caregivers and/or attempting to intervene. It might also include seeing the physical evidence (such as bruising or grazes) or the emotional reactions of either parent following the occurrence of violence (Kimball, 2016). More recently, researchers have acknowledged that living in a house where FV occurs, or has the potential to occur, constitutes exposure (McTavish et al., 2016; MacMillan & Wathen, 2014).

Experiences of FV in childhood are associated with significant disruptions to children's health, wellbeing and development, which can be long lasting (Evans et

al., 2008; Wood & Sommers, 2011). Specifically, children experiencing FV have an increased risk of externalising and internalising problems (e.g. aggression, hyperactivity, emotion dysregulation, anxiety, depression and trauma symptoms), delays in language and cognitive development, social skills and academic functioning (Evans et al., 2008; Gartland et al., 2021; Graham-Bermann et al., 2012; Holt et al., 2008; Wolfe et al., 2003). The effects of experiencing FV can also extend to physical health difficulties such as allergies, asthma (Gartland et al., 2021; Kuhlman et al., 2012; Suglia et al., 2009) and somatic complaints (i.e. stomach-aches, dizziness), particularly in younger children (Gartland et al., 2021; Umemura et al., 2015). For example, in an Australian prospective pregnancy cohort of 1,507 women having their first baby, children (aged 10 years) who had been exposed to FV in the first 10 years of life had increased risks of language, mental health or physical health problems (Gartland et al., 2021).

Although children of all ages exposed to FV are at risk of developing mental health difficulties (Gartland et al., 2021; Holt et al., 2008; Wolfe et al., 2003), research suggests that young children and infants might be particularly vulnerable (Gartland et al., 2021; Graham-Bermann et al., 2012). Infancy and early childhood are characterised by periods of rapid and sensitive growth (Schore, 2001b). The occurrence of stress or the experience of traumatic stress symptoms during this time can impact immediate mental health and have significant and serious implications for child development (Lupien et al., 2009; Perry, 2009). During this developmental period, there is a high dependency on caregivers and often increased proximity to the violence, which might contribute to an increased vulnerability to developing trauma-related symptoms (Graham-Bermann et al., 2012; Howell, 2011; Levendosky et al., 2013).

2.4 Toward an understanding of the mechanisms underlying the impact of FV on child health

Understanding the ways in which FV can impact children's health and development is a critical step toward identifying potential targets for intervention and support.

There are several ways in which FV can influence a child's development over time. Key mechanisms include: 1) via neurobiological responses to acute and chronic stressors in the home environment where FV occurs; 2) via the impacts of FV on mothers' mental and physical health; and 3) via the impacts on the parent–child relationship and parenting behaviour that are placed under considerable strain. Interruptions to attuned and responsive caregiving and a child's sense of safety arising from these three mechanisms compromise a child's development. Each of these will be discussed briefly, highlighting the potential for targeted interventions and support.

2.4.1 Neurobiological stress responses to FV and co-occurring life stressors

Young children who experience FV might also experience a range of co-occurring life stressors as they grow up, including socio-economic disadvantage, poor parental mental health, transient lifestyle and parental substance use (Hoytema van Konijnenburg et al., 2018; Nwabuzor Ogbonnaya & Kohl, 2018; Wood & Sommers, 2011). The Adverse Childhood Experiences (ACEs) studies (see, for example, Dong et al., 2004) consistently show increased risk of disadvantage for children who have experienced more than three adverse childhood experiences, including socio-economic disadvantage, poor parental mental health, homelessness, FV and parental substance use. This research is clear in showing the cumulative effect of life events associated with high stress on the development and mental health of infants and children. After leaving a relationship where FV has occurred, life stress can also include legal proceedings and child protection involvement (Gewirtz & Edleson, 2007; Nwabuzor Ogbonnaya & Kohl, 2018).

There is also growing evidence that traumatic events such as FV can adversely impact the brain structures involved in the child's emotional, social, physical and cognitive development (Anda et al., 2006; Lupien et al., 2009; Perry, 2009). FV can also affect development via the hypothalamic-pituitary-adrenal axis (HPA axis), which forms the stress response system (Levendosky et al., 2016; Sturge-Apple et al., 2012). If activated for lengthy periods

of time, this system can be permanently changed, which can have adverse consequences for brain development and associated biological systems, increasing a child's risk for poor mental and physical health across their lifespan (Cicchetti & Rogosch, 2012; Schore, 2005; Talge et al., 2007). Understanding the impacts of trauma from a neurodevelopmental perspective highlights the need for the earliest possible intervention to mitigate the short- and long-term effects of FV on children's development (Perry, 2009; Perry et al., 1995).

2.4.2 Impact of FV on women's social, mental and physical health

It is well established that FV can have a significant and long-lasting impact on women's social, mental and physical health (Dillon et al., 2013; Stewart & Vigod, 2017; Trevillion et al., 2012). Many women experience FV for extended periods of time and make several attempts to leave a violent relationship before doing so (WHO, 2005). As a result, these women experience prolonged and chronic exposure to violence, control and fear (Basu et al., 2013; Lapierre, 2008). Qualitative studies with women have highlighted that the experience of FV is like living in a state of constant danger with the associated need to continually monitor the home environment in an attempt to avoid physical violence (Fogarty et al., 2019; Haight et al., 2007). Women might be forced to flee their home to escape violence and to take their children with them (Panzer et al., 2000). Some women are able to access specialist FV shelters in order to maintain their safety and that of their children (Baker et al., 2010). Data from the 2016 ABS Personal Safety Survey (PSS) indicated that while the majority of the 1.3 million women who left a violent relationship were likely to stay with friends or relatives (81%), approximately 13 per cent stayed in refuges or shelters, and 5 per cent slept rough (Department of Social Services [DSS], 2018). The AIHW (2021) also found that 42 per cent of Australians accessing specialist homeless services between 2017 and 2018 had experienced FV. International research has indicated that women who access refuges are more likely to have experienced high levels of physical violence, depression and trauma symptoms, socio-economic disadvantage, housing instability, and belong to an ethnic minority group, compared to women who do not access these services (Galano et al., 2013).

It is not surprising that FV can have an enduring impact on women's physical and mental health. Women who experience FV are at increased risk of physical health problems such as injury, chronic pain, gastrointestinal symptoms (Campbell et al., 2002; Stewart & Vigod, 2017) and mental health problems, including depression and anxiety (Carbone-López et al., 2006; Ludermir et al., 2010; Woolhouse et al., 2015). The results from a recent Australian study (Woolhouse et al., 2015) of over 1,500 first-time mothers, showed that women who reported experiencing IPV following the birth of their child were up to four times more likely to report clinically significant depressive symptoms at 4-years postpartum than women not exposed to FV. They also reported a range of physical health difficulties, including physical injuries, chronic pain, gastrointestinal symptoms and hypertension. This is consistent with other studies that have found an increased risk of physical and mental health difficulties in women exposed to FV (Brown et al., 2020; Campbell et al., 2002; Stewart & Vigod, 2017). Trauma symptoms, including dissociation, flashbacks and withdrawal, are also common in women who have experienced FV (Brown et al., 2020). In some cases, these symptoms can be part of post-traumatic stress disorder (PTSD) or a complex trauma presentation (Basu et al., 2013; van der Kolk et al., 2005). Woman who experience trauma symptoms and/or other mental health difficulties might struggle to consistently and sensitively respond to the cues provided by children, which can impact on the mother–child relationship (Gustafsson et al., 2012; Levendosky et al., 2012).

2.4.3 Direct and indirect impacts of FV on the parent–child relationship and parenting behaviour

Family violence can have a serious impact on the development of a secure attachment between the child and their non-offending caregiver. A secure attachment between a primary caregiver and the infant acts as a significant protective factor or buffer against psychological distress across the lifespan (Bowlby, 1979; Schore, 2001a). Secure attachments provide infants and

children with a secure base or "safe haven" from which they can go out and explore the world and return to caregivers in times of distress (Bowlby, 1979). When caregivers are attuned to their children then they can reliably and consistently respond to their emotional and physical needs. Such attunement lays the foundation for the development of emotion regulation skills, resilience and self-awareness (Siegel, 2001).

Children with a caregiver(s) who they experience and/or perceive as frightening and/or frightened (Lyons-Ruth & Jacobvitz, 1999) can develop attachment trauma that is ongoing and cumulative, disrupting an infant's psycho-neurobiological ability to feel and trust that they are safe. This is a source of attachment trauma that is ongoing. Consistent disruption to the attunement between the infant and primary caregiver because of individual and/or psychosocial stressors associated with experiences of FV is a risk factor for the development of a disorganised attachment style (Schore, 2001b). Children who experience this type of early life attachment trauma can experience persistent difficulties with regulating their emotions, sustaining meaningful relationships and coping with change or transitions (Schore, 2005; Siegel, 2001). This disorganised style of attachment can also place the infant at risk for persistent mental and/or physical health difficulties (Granqvist et al., 2017; Groh et al., 2017).

Family violence can represent a direct threat to the mother–child relationship. Men can use violence, including tactics that directly or indirectly disrupt this relationship (Humphreys, 2011). Such tactics include criticising or abusing a mother in front of her children or exerting control over parenting behaviours (Lapierre, 2010; Peled & Gil, 2011; Radford & Hester, 2006). In addition, the impact of abuse (e.g. trauma symptoms or psychological distress) can make it hard for caregivers to notice, identify, respond to and validate their child's distress. This can impact on a child's sense of safety and the development of a secure attachment (Schechter & Rusconi Serpa, 2014).

Parenting behaviour has been identified as a pathway influencing the impact of FV on children's outcomes. It has been suggested that women who experience FV might be more likely to engage in more negative parenting behaviours compared to those who have not experienced FV. A recent systematic review found a moderate association between harsh parenting and the experience of FV (Chiesa et al., 2018). Harsh and hostile parenting techniques are well-known risk factors for the development of emotional and behavioural difficulties in children (Flouri & Midouhas, 2017; Grasso et al., 2016; Huang et al., 2010). These parenting behaviours within the context of experiences of FV can further increase a child's risk for such difficulties. The psychological, financial and social toll of FV may also reduce mothers' capacity to engage emotionally and consistently with their children (Howell et al., 2010; Martinez-Torteya et al., 2009). There is also evidence to suggest that FV can have significant and lasting impacts on women's self-esteem and parenting self-efficacy, which can further deplete their emotional resources and coping ability, especially when formal and informal supports cannot be accessed and the violence is considered severe (Pels et al., 2015). Here parenting self-efficacy relates to the extent to which a mother feels confident to raise her infant (Bandura, 1977; de Montigny & Lacharité, 2005). In addition, women experiencing FV often lack support from their parenting partner who might directly target their parenting as a control tactic (Fogarty et al., 2021; Radford & Hester, 2006).

Despite the focus on how FV might disrupt parenting and the mother–child relationship, there is a body of research highlighting the protective role maternal factors can have in promoting positive adjustment or resilience in children exposed to FV. Specifically, the presence of maternal psychological wellbeing, emotional communication, warm and sensitive parenting have all been associated with children's emotional-behavioural resilience within the context of FV (Graham-Bermann et al., 2009; Martinez-Torteya et al., 2009). When parents are using emotion communication, they are signalling different emotions through verbal and non-verbal language as well as validating them for the child. This helps the child to develop the ability to regulate their emotions (Brumariu et al., 2021). This research is particularly important to consider when thinking about how early interventions might prevent the development of mental health difficulties in children who have experienced FV. It

is equally important to take these findings into account when addressing the immediate harm and distress of children experiencing FV. Specifically, outcomes for children could be improved if the non-abusive parent supports their recovery (Humphreys et al., 2006; Katz, 2015). There is also some research to suggest that there are no differences in the parenting styles between women who have experienced violence from a partner and those who have not (Radford & Hester, 2006). In a culturally diverse sample of women, Pels et al. (2015) also found that some participants developed coping strategies to protect their children from partner violence during and after its occurrence, including talking about the violence, seeking external help and avoiding quarrels.

Although research suggests that FV can impact child health and wellbeing through mothers' parenting and mental health, it is important to note the significant strength and resilience demonstrated by mothers who have experienced FV. Research has demonstrated that mothers who have experienced FV display warm and attentive parenting styles (Ateah et al., 2019) and often enact compensatory and protective strategies to support their children (Fogarty et al., 2019; Haight et al., 2007; Lapierre, 2010; Nixon et al., 2017). For example, a Canadian study of 350 mothers who had experienced FV found that mothers commonly reported using multiple protective strategies to support and protect their children, including being affectionate with their child and making their children feel good about themselves (Nixon et al., 2017). Moreover, a recent study of 1,211 mothers found no differences in positive parenting interactions among abused and non-abused mothers (Ateah et al., 2019).

2.5 Interventions and support for children and mothers

It is clear that early intervention efforts are needed to support women's and children's recovery from FV and to prevent the sequelae of poor health across the life span. In Victoria, over 1.8 billion dollars is spent per year supporting women and children affected by FV (KPMG, 2017). In this section, an overview of services for women and children experiencing FV is discussed along with challenges in providing these services, followed by a brief overview of interventions targeting the promotion of children's outcomes following FV.

2.5.1 Services for children and mothers who have experienced FV

A range of therapeutic services are becoming more available for women and children who have experienced FV to assist with their immediate and long-term recovery. Although women and children often experience trauma and other mental health symptoms, immediate issues of housing and safety are typically prioritised. Many women rely on crisis and specialist FV services to assist them with court and legal issues, financial issues and finding stable accommodation (Panzer et al., 2000; State of Victoria, 2016a).

While therapeutic services are available for women and children impacted by FV, the RCFV (State of Victoria, 2016a) recommended that funding for these services be increased. Women face many challenges when trying to access these services. For example, some services require that women are in stable housing, which is not always possible in the immediate aftermath of leaving a violent relationship (DSS, 2018). Moreover, women and children from CALD backgrounds experience additional barriers in seeking help from mainstream FV services in Australia for reasons including language barriers, unfamiliarity of available services, fear of being reported to Government bodies (e.g. immigration or child protection) and service responses which might not be culturally sensitive. Furthermore, women who are in Australia on a temporary migration visa might not be eligible for housing and financial support, may fear deportation, may have experienced significant trauma and/or persecution in their home country, and in a small number of cases, may have been victims of human trafficking (DSS, 2015; Segrave, 2017).

Finally, a key issue is the relative lack of evaluation studies of therapeutic programs provided to women and children who are residing in domestic violence refuges or other transitional housing, particularly for those who are Aboriginal and Torres Strait Islander.

For example, Save the Children (n.d.) offers therapeutic interventions to Aboriginal children residing in refuges, but evaluations are not available, and it is unclear how this program supports the mother–child relationship. Several international studies offer some evidence for the efficacy of therapeutic interventions to support culturally diverse mother–infant dyads residing in domestic violence specific shelters (Bain, 2014; Keeshin et al., 2015), but caution is needed when generalising to culturally and linguistically diverse women and children in Australia who have different experiences with migration, citizenship rights and pre-arrival trauma.

2.5.2 Interventions for mothers and children exposed to FV

Internationally, there has been an increased focus on the evaluation of interventions for children exposed to FV, which have the potential to prevent long-term impacts on their health, wellbeing and development. However, recent literature reviews have highlighted the wide variability which exists between the types and modality of interventions, as well as their intended outcomes (Anderson & van Ee, 2018; Hackett et al., 2016; Howarth et al., 2015; Latzman et al., 2019; Rizo et al., 2011). In addition, the scarcity of replication or follow-up studies makes it challenging to develop a strong and relevant evidence base. Key differences were identified between interventions that work solely with the child or mother and those which work with children alongside their non-offending caregiver (typically mother; Howarth et al., 2015; Rizo et al., 2011). Interventions that include mothers and their children are of particular interest given that FV can disrupt the mother–child relationship, and because a strong mother–child relationship is so important for the recovery of mothers and children from FV (Bunston et al., 2016). There is also variety within these interventions as to whether children and their caregivers attend the intervention together or whether the child and caregiver component are conducted parallel to each other (Latzman et al., 2019).

2.6 Search methodology for the state of knowledge review

Search terms were developed with a librarian from the Royal Children's Hospital (RCH), and the four databases, MEDLINE, APA PsycInfo, PubMed and Sociology Abstracts, were searched for articles published between 1 January 2000 and the 14 August 2021. Reference lists of relevant articles were also searched. Search results were exported into EndNote and the titles and abstracts screened for eligibility. Studies were included in the review if they met the following eligibility criteria:

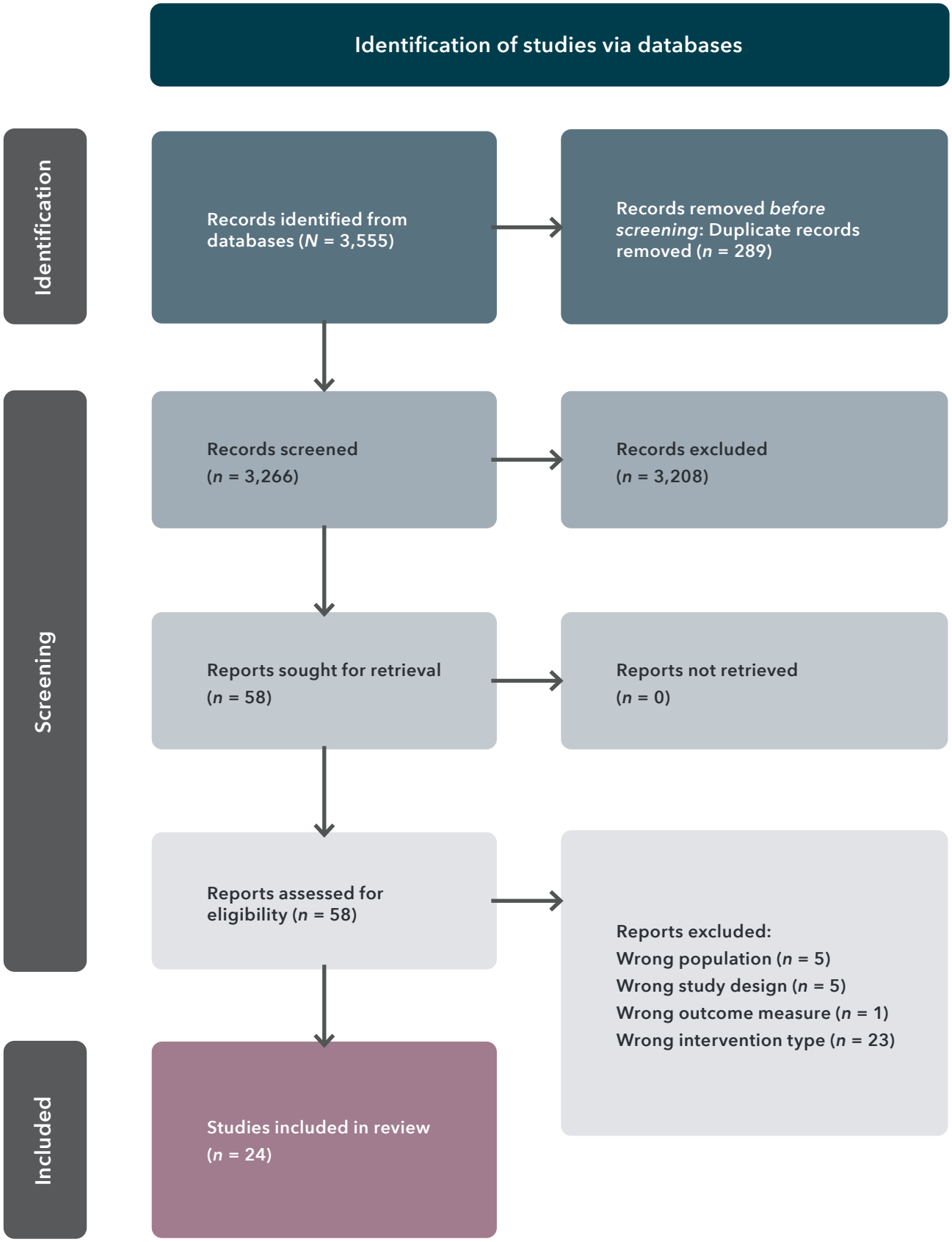
1) The study evaluated outcomes associated with participation in an intervention for children (aged 0 to 18 years) exposed to FV.
2) The intervention involved participation from the child exposed to FV and a non-offending caregiver.
3) Quantitative outcome data were collected for at least one outcome relating to the child's psychological wellbeing.
4) The study was written in the English language.
5) Interventions comprising solely of advocacy were excluded from the review.

One of the reviewed studies (Carter et al., 2003) included a small number of non-offending partners and offending fathers where the father had successfully completed a FV treatment program. Given that these families represented a small proportion of the overall study population (18%), this study was included in the review.

2.7 Results of search methodology

The search strategy identified 3,265 articles. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) was used to guide the search methods. Figure 1 shows the number of citations retrieved from the search and the processes of reviewing articles for inclusion, in line with PRISMA reporting.

Figure 1: Details of study selection



Appendix A shows the key characteristics of the included interventions. Following the scanning of titles and abstracts, the full texts of 58 articles were reviewed with 24 articles included in the review. Three different modes of delivery were identified, including:

- dyadic interventions with mothers and children participating together in the intervention ($N = 9$), where dyadic refers to the interaction between mothers and their children
- interventions which had separate mother and child components running concurrently ($N = 10$)
- interventions combining dyadic and concurrent components ($N = 5$).

Of these 24 studies, we classified 15 as group interventions and nine as interventions delivered individually to each dyad or family. Sample sizes across the studies varied from 11 to 192 with a mean of 61. Five randomised controlled trials (RCTs) were identified across the 24 studies. Appendix B provides a summary of the key characteristics and findings of the included studies.

2.8 Outcomes of mother–child dyadic interventions

Of the nine mother–child dyadic interventions identified, the majority were provided to individual dyads/families. One intervention was delivered to a group of dyads/families (Bunston et al., 2016). With the exception of Project Support, which targeted 4- to 9-year-old children (Jouriles et al., 2009; Jouriles et al., 2001; McDonald et al., 2006), most dyadic interventions were for preschool or early school-aged children (Lieberman et al., 2006; Lieberman et al., 2005; Timmer et al., 2010) or infants and toddlers (Bunston et al., 2016; Waldman-Levi & Weintraub, 2015). Three of the studies reviewed were RCTs (across two interventions; Jouriles et al., 2009; Jouriles et al., 2001; Lieberman et al., 2006; Lieberman et al., 2005), with the remaining using a quasi-experimental or non-randomised experimental design.

The efficacy of Project Support has been evaluated in numerous studies (Jouriles et al., 2009; Jouriles et al., 2001; McDonald et al., 2006). This skills-based intervention provides social and instrumental support to mothers and children while also helping mothers to learn how to manage their children's conduct problems through direct instruction and feedback. Sessions are delivered primarily in the participant's home and occur weekly for approximately 8 months following transitioning from a FV shelter. An RCT of 36 mothers and children aged 4 to 9 years found that, compared to those receiving monthly phone support, participation in Project Support was associated with significantly lower acting-out behaviours in children, as well as improvements in mothers' behaviour management skills (Jouriles et al., 2001). These findings have been replicated in two other studies (Jouriles et al., 2009; McDonald et al., 2006).

In another RCT, Lieberman et al. (2005) evaluated the effectiveness of a 50-week child–parent psychotherapy (CPP) intervention for 75 mothers and their children (aged 3 to 5 years). This intensive dyadic intervention is based on attachment theory and aims to improve the mother–child interactions through dyadic psychotherapy sessions (60 minutes in duration). Parent-only sessions are also included as indicated and referred to as "collateral" sessions. Compared to children receiving case management, children in the CPP group displayed fewer behavioural and trauma symptoms. The mothers also reported fewer avoidance symptoms at treatment end (Lieberman et al., 2005). At the 6-month follow-up, both mothers and children had fewer trauma symptoms than those in the case management group (Lieberman et al., 2006).

A non-randomised control evaluation of the Family Intervention for Improving Occupational Performance (FI-OP) was conducted with 37 mothers and their children aged from 1 to 5 years living in domestic violence shelters in Israel (Waldman-Levi & Weintraub, 2015). This program is influenced by attachment theory and play therapy, with the aim to improve the mother–child relationship and children's play across eight 30-minute sessions. Compared to the control group, families who participated in FI-OP demonstrated significant improvements in overall mother–child interactions and maternal sensitivity and limit setting.

Some improvements in children's play were observed (Waldman-Levi & Weintraub, 2015).

Parent–child interaction therapy (PCIT) was developed to improve conduct problems in children. More recently, this therapy has been trialed using a quasi-experimental design with children exposed to FV (Timmer et al., 2010). In the first stage of therapy (child-directed interaction [CDI]) the focus is on strengthening the mother–child relationship (7 to 10 sessions). The second stage is focused on improving behaviour management skills (7 to 10 sessions). The study of 129 children, aged 2 to 7 years, and their mothers found a reduction in children's acting out (i.e. externalising) and emotional (i.e. internalising) symptoms following stage 1, and even stronger reduction upon completion of stage 2. Results also showed a small but significant reduction in maternal psychological symptoms following treatment despite no significant change in parenting stress (Timmer et al., 2010). More recently, a feasibility and effectiveness study of PCIT was conducted with 21 mother–child dyads living in a FV shelter (Herschell et al., 2017). There was a significant reduction in children's behavioural problems and improvements in parents' disciplinary skills, perceived parenting control and mental health difficulties following the intervention (Herschell et al., 2017).

In Australia, there has only been one known evaluation of an intervention published during the search period of this paper for mothers and children who have experienced FV. The Peek-a-Boo Club™ is an 8-week infant/child-led, relational repair group for infants and children aged 0 to 4 years and their mothers (Bunston et al., 2016). The aim of the group is to repair ruptures in the mother–child relationship. The single group pre–post evaluation of 128 children and mothers from 20 groups running from 2007 to 2011 found that children were more social and had fewer behavioural problems following the intervention. There were also improvements in the quality of the mother–infant attachment and relationship (Bunston et al., 2016).

2.9 Outcomes of concurrent mother and child interventions

Nine concurrent mother and child interventions were identified, and all were delivered as a group-based program. The age of the children varied considerably, with a number of interventions focusing on school-aged children (Graham-Bermann et al., 2007; Macmillan & Harpur, 2003; Overbeek et al., 2013; Pernebo et al., 2018) and others targeting children aged between 3 to 19 years (Becker et al., 2008; Carter et al., 2003; Grip et al., 2012). Only one study (Overbeek et al., 2013) used an RCT design, with the remaining utilising quasi-experimental or non-randomised experimental designs.

In their RCT, Overbeek et al. (2013) assessed a community-based intervention for mothers and children following FV exposure. Children (aged 6 to 12 years) attended a group called "It's my turn now!" based on the Kids Club group (Graham-Bermann et al., 2007) which focused on improving children's emotion regulation skills. At the same time, mothers attended a group that provided psychoeducation about trauma and attachment and how to accurately interpret their child's emotions and behaviours. Although there was a decrease in externalising, internalising and trauma symptoms for participating children, this was not significantly different from children who accessed the non-specific group program (Overbeek et al., 2013).

The Kids Club group has been previously evaluated using a quasi-experimental design (Graham-Bermann et al., 2007) where 181 children (aged 6 to 12) either participated in: a) the Kids Club group only; or b) the Kids Club group while their mothers participated in the Mom's Empowerment Program. The key aim of The Kids Club group is to develop a sense of safety, a therapeutic relationship and to assist in developing a common language to express emotions and experiences of violence. The Mom's Empowerment Program provided education about the impact of FV on child development and aimed to build parenting capacity, increase social connection and provide a safe place to discuss concerns. Compared

to those children allocated to the Kids Club only, children who participated in the Kids Club concurrent to the Mom's Empowerment Program had significantly fewer externalising-behaviour problems at post-intervention. This finding was maintained at the 8-month follow-up.

A revised version of this intervention for preschool-aged children and their mothers, the Preschool Kids Club and Mom's Empowerment Program (Graham-Bermann et al., 2015) found similar positive intervention effects. Following participation, children reported significantly larger reduction in internalising symptoms at post-intervention compared to the control group. This study also found that female children who participated in the intervention had significantly larger decreases in internalising symptoms from baseline to follow-up compared to those in the control group (Graham-Bermann et al., 2015). In contrast, a later evaluation of the Kids Club and Mom's Empowerment Program with 36 younger children aged 3 to 5 years found no significant difference in outcomes between the intervention group or the waitlist control group following participation in the intervention (Basu et al., 2009).

A community-based 12-week group intervention called the Haupoa Family Component was evaluated with 106 mothers and children (aged 3 to 17 years) of Asian and/or Pacific Islander background (Becker et al., 2008). This program covers topics such as safety skills, trust building, self-awareness, self-blame and gender stereotypes with content tailored to the developmental age of each group. There were significant reductions in children's internalising and externalising symptoms and improvements in parenting skills, including discipline and providing emotional support.

Similar to the Haupoa Family Component, the 15-week Children Are People Too (CAP) group provides psychoeducation about violence, safety planning, emotions, as well as mother–child communication (Grip et al., 2012). In a study of 46 children aged 4 to 19 years and their mothers, there was a significant reduction in children's emotional-behavioural difficulties at post-intervention. However, these improvements were not sustained at the 1-year follow-up.

More recently, a Swedish study compared the CAP intervention with a trauma-focused psychotherapeutic intervention running as a child and adolescent mental health outpatient unit. Fifty children aged between 4 to 13 years participated in the study (Pernebo et al., 2018). The psychotherapeutic intervention was based on attachment and psychodynamic theory and included concurrent mother and child group sessions. Children in both intervention groups experienced a significant reduction in trauma symptoms and emotional-behavioural difficulties, while the mothers also reported fewer PTSD symptoms. At the 6- and 12-month follow-ups, the effect sizes were larger for children who participated in the psychotherapeutic group compared to those who participated in CAP (Pernebo et al., 2019). Furthermore, compared to CAP, children in the psychotherapeutic group reported significantly greater improvements in pro-social behaviour such as healing, sharing and cooperating, emotion regulation, and fewer depression and anger symptoms (Pernebo et al., 2019).

Several other concurrent community mother and child treatment groups have been evaluated. For example, Carter et al. (2003) conducted a pilot evaluation of a psychoeducation and play therapy-based group for children ($N = 192$) aged from 4 to 18 years and their parents ($N = 64$). Both groups covered safety planning, emotion regulation, and strategies for improving social and family relationships. Following the intervention, significant improvements were observed in children's distress, somatic symptoms, social problems and interpersonal relations, as well as emotional expression. Parents also reported a reduction in parenting stress at treatment end. A similar group program was evaluated by Macmillan and Harpur (2003) within a Canadian setting. The results showed significant improvement in children's internalising and externalising symptoms along with parental stress levels in a sample of 47 parent–child dyads.

2.10 Combined dyadic and concurrent individual mother–child interventions

Five of the interventions identified incorporated dyadic and concurrent sessions for mothers and children.

One intervention was delivered to individual families (Cohen et al., 2011), while the remaining were delivered as group interventions (McWhirter, 2011; Smith et al., 2015; Sullivan et al., 2004; Woollett et al., 2020). All of the interventions targeted school-aged children (6 to 14 years) and two used an RCT design (Cohen et al., 2011; McWhirter, 2011).

Cohen et al. (2011) conducted an RCT of trauma-focused cognitive behavioural therapy (TF-CBT) with the aim of reducing trauma-related symptoms in children (aged 7 to 14 years) who had experienced FV. This 8-week intervention was conducted with 124 mother–child dyads and consisted of individual sessions and two dyadic sessions where children were encouraged to share their experiences of FV with their mother. Compared to children receiving child-centred therapy, those in the TF-CBT group reported significantly greater reduction in trauma and anxiety symptoms.

Another RCT compared the efficacy of a goal-oriented CBT group program (motivational interviewing and goal setting) and an emotion-focused CBT group (skills building in emotion regulation, coping and healthy relationships) with 46 mother–child dyads living in FV shelters in the American Southwest (McWhirter, 2011). Children (aged 6 to 12 years) and mothers met separately for 45 to 60 minutes before coming together for a joint 1-hour group session. Mothers in both groups reported reduced depressive symptoms, increases in family bonding and readiness for therapeutic change. Children's emotional wellbeing and self-efficacy also improved in both groups. Following the intervention, mothers in the goal-directed intervention reported significantly lower family conflict than mothers in the emotion-focused group. Conversely, mothers in the emotion-focused group reported higher social support than those in the goal-directed group at post-intervention (McWhirter, 2011).

One of the first published studies of a 9-week concurrent and joint mother–child intervention was conducted by Sullivan et al. (2004). The aim of this intervention was to improve coping, correct dysfunctional cognitions and develop safety planning skills for children. The concurrent mother group also aimed to develop safety planning skills, strengthen parenting skills and social support. There were 46 mothers and 79 children (mean age of 8 years) who participated in the study. At treatment end, there were significant reductions in children's perceived sense of self-blame, internalising, externalising, and trauma symptoms and parenting stress (Sullivan et al., 2004).

Promising findings have come from the Domestic Abuse, Recovering Together (DART) group (Smith et al., 2015). This is a 10-week group intervention for children aged 7 to 11 years and their mothers living in refuges. Five sessions are delivered as concurrent child and mother groups, while the other five are delivered to mothers and children together. Smith et al. (2015) found improvements in mothers' self-esteem and parenting efficacy and a reduction in children's emotional/behavioural difficulties in their study of 95 mother–child dyads. These changes were maintained at the 6-month follow-up.

Recently, a small pilot evaluation was conducted of a trauma-informed art and play therapy group for children (aged 5 to 14 years) and their mothers residing in domestic violence shelters in New York and Johannesburg (Woollett, et al., 2020). This intervention combined trauma-informed CBT with creative expression through art and play-based therapeutic exercises and consisted of 12 weekly 1- to 2-hour child group sessions. Mothers attended three group sessions across the course of the child intervention. Analysis of pre–post data revealed significant improvements in child's depressive symptoms but not PTSD symptoms following participation in the intervention (Woollett, et al., 2020).

2.11 Summary of key findings from research on mother and child interventions

Children have been identified as the "silent victims" of FV, with potentially serious and long-lasting impacts on their health, wellbeing and development (McTavish et al., 2016). The RCFV (State of Victoria, 2016a) called for a stronger evidence base underpinning interventions for children following exposure to FV. However, the evidence in Australia remains relatively scarce. It is becoming

increasingly evident that the mother–child relationship can be affected by FV (Humphreys, 2011; Katz, 2015; Radford & Hester, 2006), and that strengthening this relationship following FV is an important step in the healing and recovery for children. The search strategy identified 24 evaluations of dyadic mother–child interventions aimed at improving aspects of children's mental health. Heterogeneity across the studies in terms of mode of delivery (group vs individual, mother–child dyadic sessions vs individual sessions for mothers and children delivered concurrently); intervention length; intervention setting (home, centre-based, shelter); and children's age range made it difficult to draw overall conclusions about the level of evidence of interventions for children exposed to FV. Despite this, it is important to note that five interventions were evaluated across seven studies employing RCT designs (Cohen et al., 2011; Jouriles et al., 2009; Jouriles et al., 2001; Lieberman et al., 2006; Lieberman et al., 2005; McWhirter, 2011; Overbeek et al., 2013) and showed promising evidence of their effectiveness to improve the mental health of children exposed to FV.

This review highlighted significant similarities in program content, with many reviewed interventions focusing on children's emotion regulation, safety planning, improving mother–child interactions and parenting. Despite these similarities, dyadic interventions demonstrated the strongest level of evidence in improving child outcomes. The current review identified three RCTs of two dyadic interventions: CPP and Project Support (Jouriles et al., 2009; Jouriles et al., 2001; Lieberman et al., 2006; Lieberman et al., 2005). While their mode of delivery differed, both interventions aimed to improve the mother–child relationship. Project Support specifically focused on reducing conduct problems, and this differed from CPP's broader aim to improve children's emotional, cognitive and social functioning. Both interventions demonstrated effectiveness in decreasing children's acting out behaviours, with CPP also demonstrating a reduction in children's trauma symptoms, and these were sustained at a 6-month follow-up. A further two RCTs were identified that included dyadic and concurrent mother and child sessions (Cohen et al., 2011; McWhirter, 2011). The results of these RCTs, along with those from the non-randomised dyadic intervention included in this review (Bunston et al., 2016; Herschell et al., 2017; Timmer et al., 2010; Waldman-Levi & Weintraub, 2015) make it clear that having mothers and children participate in sessions together is an effective treatment format for children exposed to FV. This is consistent with research highlighting the importance to the mother–child relationship in the healing and recovery for families following FV (Humphreys et al., 2006; Katz, 2015).

This review also highlighted promising evidence for group-based interventions for children and mothers. Thirteen studies of group-based programs were identified with largely positive findings. For example, an RCT of the "It's my turn now!" program demonstrated significant reductions in children's internalising and externalising symptoms (Overbeek et al., 2013). Similar results were found across other interventions. While these interventions were not randomised, they demonstrated methodological strengths, including use of control groups, follow-up assessments and validated outcomes measures (Graham-Bermann et al., 2007; Pernebo et al., 2018, 2019). Importantly, only one of the included group studies was dyadic (Bunston et al., 2016), with the remainder of the group interventions running concurrent mother and children groups. Group therapy offers a cost-effective approach of servicing a higher number of clients and has the added treatment gain of normalising individual's experiences and providing social support with people who have had similar experiences (Yalom, 1995). Consequently, there is a need to develop a stronger evidence base around the effectiveness of dyadic group interventions for children exposed to FV.

This review identified three main gaps in the published intervention literature. First, few evaluations of interventions for very young children and infants have been conducted. Only two interventions were found for children under 3 years of age. These included the Peek-a-Boo Club™ and PCIT (Bunston et al. 2016; Herchell et al., 2017; Timmer et al., 2010). Despite increased recognition into the impact of FV on children, this review found that infants are largely absent from intervention studies. Infants and young children are particularly vulnerable to

the adverse effects of trauma and/or chronic stress during this critical period of early brain development (Anda et al., 2006; Chu & Lieberman, 2010; Levendosky et al., 2013; Schore, 2001b). Therefore, future research needs to focus on interventions designed for infants and young children.

Second, only four studies were of interventions delivered to women and children living in transitional housing, including shelters/refuges, for those recently leaving a violent relationship. These included FI-OP, PCIT, DART, and a trauma-informed art and play therapy group (Herschell et al., 2017; Smith et al., 2015; Waldman-Levi & Weintraub, 2015). FV refuges offer an opportunity to provide early intervention services to those families who may not otherwise access therapeutic services. A systematic review by Howarth et al. (2019) found that although domestic violence refuges can be unsettling for families, they also have the potential to provide a stable place for therapeutic interventions.

Finally, although the review was limited to studies in English and there may be studies in other languages from other countries, the results of this review highlighted the need for further research on the effectiveness of interventions for women and children from CALD backgrounds. While studies included CALD participants, few details were provided on how many had English as a second language. Such women have specific experiences of FV, which include unique challenges to accessing and participating in interventions (DSS, 2015; Segrave, 2017). There is also a need to ensure that interventions are culturally appropriate for the individuals accessing them as well as being trauma informed. Research with women and their children from CALD backgrounds, including those who are of refugee or migrant background, is needed to understand how to best provide short- and longer-term support after they have left a violent partner. This research should be conducted with specific cultural groups to ensure support can be tailored to the specific needs of the women and their children. This is reinforced by the high proportion of CALD clients staying longer in refuges in Victoria (Safe Steps Family Violence Response Centre, 2015). For example, approximately 86 per cent of the clients who attend Emerge are from CALD backgrounds (Emerge, 2021).

2.12 Review of non-evaluated community-based programs for mothers and children exposed to FV

Conducting evaluations of interventions for children exposed to FV comes with ethical, methodological and resource challenges (Rizo et al., 2011). Consequently, there are many interventions being delivered by community services which, although may lack empirical evidence, can provide important knowledge and guidance to the field. For example, Buschel and Madsen (2006) described two case studies of children who participated in a trauma-informed mother–child art therapy program in a domestic violence shelter in the United States. These case studies highlighted that art therapy can allow children to express their experiences in a non-verbal manner, which is developmentally appropriate. Moreover, For Baby's Sake is an intervention conducted in the United Kingdom for families with young children (aged 0 to 2.5 years) impacted by FV. Involving both parents where safe to do so, the aim of this intervention is to end violence and increase parents' sensitivity to their baby's communication through motivational interviewing, inner child work and transactional analysis therapy (Domoney et al., 2019).

There are also services within Australia delivering mother–child interventions for children following IPV. Although an intensive review of all services within Australia was not possible within the scope of this review, Appendix C outlines some of the interventions currently delivered within Victoria. This information was sourced through consultation with services and through internet searches of local agencies which work with women who have experienced violence. Appendix C shows that there are numerous interventions being delivered throughout Victoria that have a focus on either the mother alone or with her children. However, for most of these interventions there are no known published evaluations.

2.13 Limitations of research on the effectiveness of mother–child dyadic interventions

Despite a growing evidence base of mother–child interventions for children who have experienced parental IPV, there are some limitations worth noting. This review echoes the findings of past reviews that highlight the small sample sizes often present among studies and the small number of RCTs, which limit the generalisation and strength of the results (Howarth et al., 2016; Latzman et al., 2019). Only a small number of the reviewed studies included a follow-up design to determine whether treatment gains were sustained. Moreover, few study replications have been conducted (Basu et al., 2009; Herschell et al., 2017; Jouriles et al., 2009; Pernebo et al., 2018) despite past literature reviews emphasising the need to consolidate evidence rather than develop new interventions (Howarth et al., 2016; Latzman et al., 2019). The authors of the current study also acknowledge this need. However, they note that there are many evidence-informed interventions currently embedded in domestic violence services within Australia that have not been properly evaluated.

Most of the included studies were conducted in the United States or Canada with a small number conducted in Europe ($N = 5$), Israel ($N = 1$), South Africa ($N = 1$) and Australia ($N = 1$). As a result, the findings of these interventions could not be generalised outside of these contexts. Moreover, although ethnic diversity was reported in most studies, this cultural diversity is likely to differ to that seen in countries such as Australia. There is an urgent need for mother–child dyadic intervention evaluations within Australia, including interventions designed for mothers and children who are experiencing homelessness and FV. Homelessness amongst women and children in Australia is increasing, and FV is one of the main reasons for women and children becoming homeless (see Australian Housing and Urban Research Institute [AHURI], 2023a, 2023b).

Caution must be taken when interpreting the results of some included interventions that did not use control groups (e.g. Becker et al., 2008; Bunston et al., 2016; Herschell et al., 2017; MacMillian et al., 2003). The absence of control groups within this field has been well-documented, with previous reviews of the literature calling for future studies to improve their designs in order to strengthen the evidence base in this field (Howarth et al., 2016; Rizo et al., 2011). It is important to note the challenges of conducting research for community health services. For such services, a control group might be perceived as unethical as it may involve denying support to families who are in need. This is particularly relevant in the current landscape where therapeutic support for children is limited. When conducting evaluations of interventions, which have already been implemented within services, pilot evaluations which include single-group pre–post assessments can be beneficial if combined with explorative qualitative techniques to understand the perceived usefulness of the intervention for families. This might assist with informing more rigorous evaluation studies.

2.14 Strengths and limitations of the state of knowledge review

There are a number of limitations of the current literature review. First, although the search strategy used within this review was systematic and rigorous, we did not include a second reviewer in the screening of articles for inclusion. As a result, decisions to include or exclude articles may have been biased by the interpretation of our sole reviewer. In addition, this review did not include a formal appraisal of the quality and risk of bias of included studies, limiting the objectiveness of our appraisal of the literature. Despite these limitations, the current literature review provides a systematic assessment on the current state of the literature of the effectiveness of dyadic interventions for mothers and children recovering from FV.

2.15 Summary of key findings and conclusions

The current review synthesised the findings from 24 studies that evaluated the effectiveness of interventions targeting children who have been exposed to FV and their mothers. The review found promising evidence for dyadic mother–child interventions. Support was also found for those interventions involving both concurrent mother and child components and dyadic sessions.

There was evidence to suggest consistency in the content and focus between the mother–child interventions identified. Common elements included: strengthening emotion regulation skills, safety planning, education around violence, and improving mother–child interactions and parenting skills. Although the majority of interventions reviewed demonstrated positive effects on children's mental health and wellbeing, the strongest evidence was for mother–child dyadic interventions (Jouriles et al., 2009; Jouriles et al., 2001; Lieberman et al., 2006; Lieberman et al., 2005). Despite promising evidence, few studies investigated the effectiveness of group-based interventions, which offer the potential to reach a larger number of families and offer additional social support.

Despite the vulnerability of infants and young children to relational trauma and exposure to chronic stress (Schore, 2001b), there remains a relative lack of interventions including and/or targeting this developmental period. There were also few studies with women and their children from CALD backgrounds who left a violent relationship to go into refuges or other transitional housing. Lastly, this review highlighted interventions currently being provided across Victoria and internationally which have not yet been evaluated. There is a need to better understand the effectiveness of interventions, which are already embedded within community services and tailored to the needs of the local populations.

3. The current research project

The state of knowledge review highlighted the need for targeted interventions for mothers and their young children that focus on improving their mental health as well as the mother–child relationship. While there have been numerous intervention studies in this area, there is a relative lack of research on the effectiveness of infant-led interventions that are informed by relevant theoretical models. The Safe Nest Group (SNG) was developed to address this gap. The current pilot project provided an evaluation of this group program for mothers and their infants who had experienced FV. A description of the program and delivery model is presented in this section.

3.1 The Safe Nest Group program

The SNG is a weekly, six-session group intervention for women and their infants (aged 0 to 3 years) who have recently experienced FV and who are currently living in refuges or other stable residential housing. The program was developed jointly by Emerge Women and Children's Support Network and Swinburne University and adapted from the Peek-a-Boo Club™ (Bunston et al., 2016). Emerge is a specialist and independent FV service for women and children that provides housing and support services (see Emerge, 2024).

The SNG is a closed group intervention informed by attachment and trauma theory. The program recognises the impact of early relational trauma and disrupted attachment on children's development and the mother–child relationship (Schore, 2001a, 2001b). The SNG program also gives voice to the needs of the mother and the infant, which is necessary to move both family members to a position of empowerment. The main aim of this intervention is to be infant led, prioritising the most pressing needs of the infant so they can start their recovery from the impact of FV. The program also aims to promote the infant's inherent capacity to be an active agent in the therapeutic process and gives meaning to their subjective experience (Bunston et al., 2021). Their experience is heard, understood and attended to in a way that helps them to heal from trauma. This requires strengthening and repairing the mother–infant relationship and supporting women to become safe and attuned caregivers.

In the current pilot study, each of the four groups had a maximum of six mother–infant dyads and were facilitated by two specialist clinicians from Emerge who had master's-level qualifications in counselling and psychotherapy and arts therapy with advanced training in infant mental health. Group facilitators also had extensive experience working with women and children following experiences of FV. One master's-level counselling student helped to facilitate each group and assisted with set up and collating the evaluation measures.

The 2-hour group sessions incorporate psychodynamic and infant mental health principles, which include the core theoretical concept of providing a holding and containing space for participants. This refers to a literal space that offers emotional protection as well as a metaphorical space that holds the feelings that come up during the group process (Paul & Thomson-Salo, 1997). The group is strongly grounded in the principles of trauma-informed care. Techniques and activities from music, art, play and somatic-processing therapies are incorporated because of their established effectiveness in trauma recovery (e.g. Lieberman & van Horn, 2008; Marshall-Tierney, 2010). Sessions 1 and 6 are structured with key activities essential in setting up and terminating the group, such as ice-breaker activities, establishing group rules and processing the ending of the group. Although manualised, there is flexibility in the activities delivered and resources used in the infant-led play and the dyad-focused intervention components (Sessions 2 to 5). Content topics are chosen from the SNG program manual based on the needs of the group. Content topics can include: love and care for children, safety planning, strengths, boundaries, co-regulation, how FV has affected play, and mindfulness. These topics are informed by trauma and attachment theory. They are also topics relevant to FV that have been discussed by women who have attended past mother–infant groups offered by Emerge. These topics combine issues pertinent to clinical practice in working therapeutically with this cohort and issues salient for women and children

who have experienced FV. Activities and resources can include sensory toys, puppet play, ball games, music and movement, singing, bubbles, painting and drawing. Providing a broad range of activities and resources allows the facilitators to tailor the activities to the age, needs and interests of the infants and their mothers. It also means that activities that support cultural diversity and cultural safety can be included. For example, Ghosh Ippen (2009) stressed the need to consider how historical trauma, including genocide, forced separation of parents and children, human rights atrocities, cultural racism and systemic oppression can impact parenting and interpretations of parenting. The group facilitators give careful and regular consideration to the choice of activities and interventions ahead of time, while also reflecting critically on how stereotypes and dominant views might be influencing the program components and development of ideas. The potential influence that the facilitator's own cultural background has on shaping attitudes and biases is also considered. Diversity in parenting is welcomed, with women offered ongoing invitations to share stories of parenting, being parented and historical trauma, interwoven with wondering about the infant's experiences. The most frequently implemented activities delivered in the current SNGs included singing with actions, music and movement, bubble play, drawing and ball rolling. While the content of these sessions might vary, the overall structure remains consistent across the six sessions. For example, there is an opening and closing song and a mid-session snack.

A key strength of the SNG is that it is facilitated as a therapeutic playgroup where the available toys and activities are deliberately chosen to create opportunities for attuned relational engagement while encouraging positive reciprocal interactions between the dyads, their peers and the other adults. These interactions are supported through different types of play (e.g. group, dyadic, individual, side-by-side, symbolic, sensory) which help to convey a sense of safety and promote reflective functioning. For example, Slade (2007) described the importance of bubble blowing for modelling attunement and curiosity and animating affect to create opportunities to enter a child's inner world that are the building blocks of reflective parenting. According to Slade (2007), "blowing bubbles helps parents become more observant and appreciative of their child's experience. [Activities such as bubble blowing] also facilitate play and mutual pleasure and are thus great allies in the deepening of reflective awareness" (p. 650). The group progressively builds on these moments with the introduction of additional toys and therapeutic activities that help to strengthen the relationship. Changing states of play in each session, over time, create natural openings for mothers and infants to share difficult and uncomfortable thoughts, feelings and memories that relate to their experience of FV.

3.2 Research aims

The key objective of the current pilot study was to gather preliminary evidence about the outcomes for women and children participating in the SNG program. The more specific aims of the research are to assess pre- to post-intervention changes in:

- maternal depression, stress and anxiety
- trauma symptoms experienced by mothers
- relational withdrawal behaviours in the infants
- the quality of the relationship between mothers and their infants.

A second aim is to explore women's subjective experience of the SNG, including their satisfaction with the content and delivery of the program.

3.3 Method

This pilot intervention used a single-group pre-, post- and follow-up design with a nested qualitative study. It was approved by Swinburne University of Technology's Human Research Ethics Committee (HREC number 20191241-1399).

3.3.1 Participants

Participants were 17 mother–infant dyads participating in one of four SNGs run in the south-eastern suburbs of Melbourne between September 2019 and August 2021.

Adult women and their children (aged 0 to 3 years) who were currently living in refuges or other stable residential housing were eligible for the study. Other selection criteria for women included:

- recently left a violent relationship (within 12 months)
- no reported illicit substance use within the past month
- no active psychotic symptoms and/or active suicidal/homicidal thoughts
- no major cognitive impairment
- conversational proficiency with the English language.

Given that promoting agency and autonomy were important values of the SNG, participation was entirely voluntary and referrals for clients who were subject to a Child Protection ruling were not accepted. We also made the decision to not include women with Child Protection involvement to avoid the added complexities associated with having this organisation involved including managing risk, potential fear among the women of having information shared and a perceived lack of confidentiality. This did not mean that the facilitators and broader research team did not adhere to mandatory reporting requirements when indicated.

3.3.2 Measures

A range of validated measures were selected to assess the intended outcomes of participation in the SNG as stated in the research aims. These measures assessed: a) depressive, anxiety, stress, post-traumatic stress symptoms and dissociative and other mental health symptoms for women; b) the parent–child relationship; and c) infant distress and withdrawal. All measures were selected for their established reliability and validity, clinical cut points and/or normative data and brevity to reduce burden for participants.

The Depression, Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995). This 21-item self-report questionnaire measures the core symptoms of depression (e.g. I felt downhearted or blue), anxiety (e.g. I was aware of dryness of the mouth) and stress (e.g. I tended to overreact to situations). Each item is rated on a four-point scale ranging from 0 = does not apply to me at all to 3 = does apply to me very much or most of the time. Items related to each subscale are summed and multiplied by two. Clinical cut points are available for each subscale with scores ranging from 0 to 42. The DASS-21 has demonstrated good reliability and validity within Australian populations (Henry & Crawford, 2005). The DASS-21 has been translated into other languages such as Chinese, Arabic, Spanish and Vietnamese, and has been used in diverse populations including Aboriginal and Torres Strait Islander communities (see Bibi et al., 2020; Oei et al., 2013; Reifels et al., 2015).

Shutdown Dissociation Scale (Shut-D; Schalinski et al., 2015) is a 13-item structured interview used to measure the presence and severity of dissociative symptoms in the mothers. The interviewer asks participants to rate the frequency of symptoms (e.g. Have you had an "out-of-body" sensation? Have you felt like you couldn't move for a while, as if you were paralysed?) across a four-point scale ranging from 0 = not at all to 3 = several times a week/often. A total score of 0 to 39 is possible. The measure has demonstrated strong reliability and validity (Schalinski et al., 2015).

Alarm Distress Baby Scale© (ADBB; Guedeney & Fermanian, 2001) is an observational measure which assesses a sustained withdrawal reaction in infants. It consists of eight items: a) facial expression; b) eye contact; c) general level of activity; d) self-stimulating gestures; e) vocalisations; f) response to stimulation; g) relationship; and h) attraction. Each item is scored from 0 (no unusual behaviour) to 4 (severe unusual behaviour). Total scores range from 0 to 32. This measure is completed by a suitably qualified health care provider based on observations of the infant generally over a 10-minute duration. One of the SNG facilitators was fully trained and certified to administer and interpret this measure. The second SNG facilitator was partially trained to administer the measure. The training for the second facilitator was unfortunately disrupted by COVID-19 and the illness of the trainer who is located overseas; thus, one SNG facilitator assumed full responsibility for the administration and scoring of ADBB. Inter-rater reliability for this measure was not possible.

Although this is one of the first known studies to use the ADBB with infants who have been exposed to FV, strong reliability and validity has been demonstrated in an Australian context (Guedeney & Fermanian, 2001; Matthey et al., 2005). It is also reliable and valid to use with infants aged 2 to 36 months and has been used with different cultural groups (e.g. African, Asian; Zhou et al., 2021) with comparable outcomes to European cohorts.

Parent–Infant Relationship Global Assessment Scale (PIR-GAS; Zero to Three, 2005). PIR-GAS is a clinical observational tool used by facilitators to assess the quality of the parent–infant relationship. The assessment is based on the three components of behavioural interactive quality, affective tone and psychological involvement, and is conducted by the SNG clinicians during the assessment interviews. A global rating score is made on a scale of 0 to 100 with categories ranging from "well adapted" to "severely impaired". This rating score was agreed on by the SNG clinicians at each time point. Higher scores reflect higher relationship quality, and total scores under 40 are suggestive of a relationship disorder based on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–3; Müller et al., 2013; Zero to Three, 2005). Preliminary findings provide some evidence for the predictive validity of the PIR-GAS (Aoki et al., 2002); however, psychometric properties for this measure are not well established (Müller et al., 2013).

International Trauma Questionnaire (ITQ; Cloitre et al., 2018) was used to assess maternal symptoms of PTSD or complex PTSD. It is a 12-item self-report measure, which assesses symptoms of hyperarousal, avoidance, intrusive thoughts or memories (PTSD clusters), as well as disturbances in relationships, emotional dysregulation and negative self-concept (disturbances in self-organisation [DSO] clusters). Participants are asked to rate the extent to which they have been bothered by PSTD symptoms across a five-point scale from 0 = not at all to 4 = extremely, with scores of two or more indicating the presence of a symptom. Examples of symptoms include having upsetting dreams that replay part of the experience or are clearly related to the experience. Criteria for probable PTSD are met if at least one symptom is present across each of the PTSD clusters. Criteria for complex PTSD is met if PTSD criteria is met along with the presence of symptoms in each of the DSO clusters and functional impairment is present. The ITQ has demonstrated good reliability and validity with the ICD-11 diagnostic criteria for PTSD and complex PTSD (Cloitre et al., 2018; Hyland et al., 2017; Karatzias et al., 2016).

3.3.3 Procedure

The SNG was promoted via flyers (see Appendix D) at specialist FV services such as The Orange Door, Domestic Violence Victoria (now Safe and Equal), The Salvation Army, other FV refuges, as well as at local maternal and child health services, and Child and Adolescent Mental Health Services (CAMHS). Emerge also promoted the group via flyers at their services. Case workers from Emerge directly invited eligible participants residing in the refuge. The initial phone contact by the Emerge clinician involved arranging a face-to-face meeting at an Emerge site to discuss participation, assess eligibility and complete an intake assessment. This infant-led assessment, which is routinely conducted at Emerge, involved collecting demographic information, understanding the women's and children's experience of FV as well as co-occurring psychosocial stressors.

At the commencement of the intake assessment, the SNG facilitator reminded the mother that the SNG would be run as part of a research project. The facilitator outlined what was involved, including the completion of pre-, post- and follow-up questionnaires and a qualitative interview at the end of the group. They were provided with a participant information sheet and informed consent form. Two women were deemed ineligible for the study because they had active Child Protection involvement. One mother was also engaged in a mandated drug and alcohol program. These women were referred to other appropriate services in the area such as Family Life or CAMHS.

The research measures (described above) were administered by the SNG facilitators approximately one week prior to group commencement, one week post- the group completing and at approximately 1-month follow-

up. A 1-month follow-up period was chosen given the transient nature of the clients accessing the service. It was anticipated that many families would be lost to follow-up if the time frame was longer in duration. However, due to the restrictions associated with COVID-19, including number and unpredictability of lockdowns from April 2020 to November 2021, strict adherence to this time period was not always possible. Unfortunately, these restrictions also meant that the final group could only run for 5 weeks instead of 6 because the participants were not able to come back into the facility. The 1-month follow-up could also not be completed for the final group as face-to-face meetings were not possible, and it was deemed inappropriate to administer the measures online. Participants were provided with reimbursement in the form of a $20 voucher for a toyshop at the conclusion of the group program.

The 6-week group program was run at a confidential site known only to the women and facilitators. Consistent with Victorian Government regulations, the group adhered to COVID-19 safe plans during the lockdowns, including physical distancing, hygiene practices and separate packs of toys for each child participant. After each session, the facilitators completed a fidelity checklist (see Appendix F) to ensure integrity of the program delivery.

Qualitative interviews were conducted with women at approximately 1 to 2 weeks following the conclusion of the group program. These interviews were conducted by a member of the research team (not involved in group facilitation) registered as a psychologist with experience in FV and qualitative methodology. The interviews for participants in the first SNG were conducted face to face. The remaining interviews were conducted over the phone due to COVID-19 restrictions and the women's preference. A semi-structured interview schedule was used (see Appendix E), and all interviews were audio-recorded and later transcribed. Each interview lasted for approximately 30 to 60 minutes. Women were provided with a $20 supermarket voucher as reimbursement for their time. It is important to note that not all women who participated in the interviews attended all sessions of the SNG. Despite this, we believed that it was important to represent the experience of these women and children because they highlighted some key strengths of the program as well as some areas for ongoing development.

3.4 Ethical considerations

The current pilot study was approved by Swinburne University of Technology's Human Research Ethics Committee (HREC number 20191241-1399). The Chief Investigator (CI Wood) is a clinical psychologist with over 20 years' experience working with children and their families. She also works in accordance with the Australian Psychological Society (APS) Code of Ethics. The research team also worked in accordance with this Code of Ethics or the Psychotherapy and Counselling Federation of Australia (PACFA) Code of Ethics. All researchers were compliant with mandatory reporting requirements in Victoria and acted in accordance with the Child Safe Standards (Commission for Children and Young People, n.d.).

There was a protocol in place for times when the mothers and/or their infants became distressed during the interviews/group program. In these instances, facilitators acknowledged their distress and gave the mothers an opportunity to talk about how they were feeling and what their infants might be feeling. Participants were given the option of taking a break, either for a short period of time or to finish the interview on another day or to withdraw from the interview entirely. Importantly, all the women except for one had a case manager or were linked into a service that provided social support.

The researcher who conducted the qualitative interviews had an ethical responsibility to seek support for a woman if there were concerns about her safety and/or the safety of her children. Appropriate responses were taken in accordance with the ethical and professional standards. This included a handover to CI Wood about the concerns as soon as the interview came to its natural end and a collaborative plan of action decided upon. Once an approach had been agreed upon, the interviewer or CI Wood (or another senior team member) followed up with the participant within 24 hours or as soon as possible

after the session. The case manager was also involved in providing follow-up support on issues that compromised safety as well as more practical support. In the current project, this did not need to happen. There was only one occasion where the interviewer spoke to CI Wood with a concern, and this was resolved without intervention.

In light of COVID-19, adjustments were made to the study protocol, including ensuring hygiene practices that were compliant with the Victorian Government regulations. Social distancing was also maintained, as well as mask wearing. The groups were only run when it was safe to do so and in accordance with the COVID-19 risk management safe work protocols of Emerge.

3.5 Data analysis

Descriptive statistics were computed to summarise: a) referral and enrolment in the SNG; b) the demographic characteristics, mental health and psychosocial functioning of the sample; and c) the implementation of the SNGs. Descriptive statistics were also calculated to summarise women's and infant's functioning on the outcome measures at each time point; however, statistical tests to assess change in outcomes over time were not possible due to the small sample size. Given the small sample size, we chose to present four in-depth case studies of women and their infants drawing upon their psychosocial and outcome assessment data and qualitative interview data.

For the nested qualitative interview substudy, all interviews were transcribed using a confidential and secure transcription service. Interviews were transcribed verbatim, and by consequence, some grammatical errors were present. A thematic analysis of interview transcripts was undertaken to conduct an in-depth exploration of patterns and themes within the data. The thematic analysis was conducted by two researchers and guided by Braun and Clarke (2006). These researchers increased their familiarity with the data by reading over interview transcripts before they independently coded the transcripts using NVivo version 12 (QRS International, 2015) and developed a coding framework. Salient themes emerged by considering the frequency and relevancy of the codes within and across participants. Researchers met to discuss emerging themes and resolve discrepancies between codes. Data collection and analysis occurred concurrently to determine when saturation was met (i.e. the point at which no new themes were emerging). Quotes representative of the themes and subthemes were carefully considered, identified and finalised by the researchers.

3.6 Results

The following section presents the results of the study, beginning with descriptive data about: a) referral and enrolment in the SNG; b) the demographic characteristics of the sample; c) the mental health and psychosocial functioning of the sample, including clinical observations of the women and their children during the initial psychosocial assessment; and d) the implementation of the SNGs. The outcomes for women and children participating in the SNG (Aim 1) are then presented. Next, the results from the qualitative analysis of mothers' subjective experience of the SNG are presented (Aim 2). The results section concludes with the presentation of four case studies, which provide a more in-depth discussion of changes for mothers and children and the mother–child relationship. This includes an infant-led case study, which we considered important to include to give specific attention to the voice of the infant.

3.6.1 Referral and enrolment in the SNGs

A total of 19 women and their children were referred to the SNG and enrolled in the study. Six (31.6%) were referred from the Emerge refuge, two (10.5%) from another refuge, three (15.8%) from maternal and child health nurses, and three (15.8%) from The Salvation Army. One woman (5.3%) self-referred after hearing about the program from her maternal and child health nurse. Other referral sources included The Orange Door (n = 1, 5.3%) and child protection services (n = 1, 5.3%).

Of the 19 women who enrolled, two (10.5%) withdrew and did not commence the SNG after changing their minds about needing the service at that time. Another woman commenced the SNG program but dropped out after the first session (5.3%) due to the onset of a mental health crisis.

3.6.2 Demographic and psychosocial characteristics of the sample

Table 1 summarises the demographic and psychosocial characteristics of the women and infants who commenced the SNG program.

Table 1: Demographic and psychosocial characteristics of mothers and children who participated in the SNG

Demographic and psychosocial characteristics	*N* = 17
Mother characteristics	
Age (in years), *M (SD)*	31.4 (5.0) Range: 20–41
Country of birth, *n* (%)	
Australia	8 (47.1)
Philippines	2 (11.8)
Ethiopia	1 (5.9)
Russia	1 (5.9)
Somalia	1 (5.9)
South Sudan	1 (5.9)
Sri Lanka	1 (5.9)
Sudan	1 (5.9)
Vietnam	1 (5.9)
Aboriginal and/or Torres Strait Islander	-
Number of years since arrival for overseas born women, *M (SD)*	14.6 (11.7) Range: 4–35
Language spoken,[a] *n* (%)	
English	11 (64.7)
Arabic	1 (5.9)
Dinka	1 (5.9)
Russian	1 (5.9)
Somali	1 (5.9)

Demographic and psychosocial characteristics	*N* = 17
Spanish	1 (5.9)
Tagalog	1 (5.9)
Vietnamese	1 (5.9)
Oromo	1 (5.9)
Employment, *n* (%)	
Not currently employed	15 (88.2)
Part-time	2 (11.8)
Housing, *n* (%)	
Refuge	9 (52.9)
Living with family	3 (17.6)
Private housing	2 (11.8)
Transitional housing	3 (17.7)
Number of children, *M (SD)*	1.8 (1.1) Range: 1–4
Index child characteristics	
Gender	
Female	6 (35.3)
Male	11 (64.7)
Age (in month), *M (SD)*	17.4 (9.33) Range: 1–35
Country of birth – Australia	17 (100.0)
Aboriginal and/or Torres Strait Islander	1 (5.9)

[a] Percentage greater than 100 as some women spoke more than one language.

Approximately half of the women were born overseas in non-English speaking countries and spoke a language other than English. The majority were not in paid employment and were living in a refuge with their children. Over half (n = 10, 58.8%) of the women were first-time mothers. The children who participated in the SNG program were aged between 1 month to 2 years 11 months, and the majority were male. All were born in Australia and one child was Aboriginal. The mother of this child did not identify as Aboriginal. A small proportion of children (23.5%) were attending a childcare service.

Although not all women openly disclosed past traumatic events or adversity, 59 per cent reported a previous history of FV (i.e. occurred prior to the most recent episode of FV), childhood experiences of violence or abuse and/or homelessness. Approximately a third (35.3%) of women reported adequate family support, and the majority (~70%) were receiving some formal support from community support organisations or mental health services. Child protection services were involved with a third of families (35.3%), but they were not subject to a protective order.

3.6.3 Women's and children's experience of family violence

All women, except for one who experienced violence from her mother, had experienced violence from an intimate partner in the last 1 to 2 years. The most common forms of violence were psychological or emotional (64.7%), physical violence (58.8%) and coercive control (52.9%). Less common forms were sexual violence (23.5%)

and financial abuse (11.8%). The majority of women experienced more than one type of violence (82.3%; *M* = 2.4, *SD* = 0.9). An intervention order was in place for over half of the families (52.9%). According to mothers who openly shared detail in the psychosocial assessments, at least a third of the children were reported to have directly witnessed the violence (35.3%), and almost a quarter continued to see their father or male caregiver who used violence (23.5%).

3.6.4 Mental health assessments

At the initial psychosocial assessment interview conducted by the SNG facilitators, 13 (76.5%) women reported mental health difficulties such as depressive, anxiety and post-traumatic stress symptoms, and three reported a past history of substance use. Women were also asked to complete a range of self-report surveys about their mental health. Sixteen women completed the baseline assessments, and their results are reported below. Table 2 shows the means and standard deviations for the DASS-21.

Table 2: Proportion of women in normal and clinical ranges for depressive, anxiety and stress symptoms (DASS-21; *N* = 16)

DASS-21 Normal and clinical ranges	Depressive symptoms *n* (%)	Anxiety symptoms *n* (%)	Stress symptoms *n* (%)
Normal	9 (56.3)	8 (50.0)	11 (68.8)
Mild	1 (5.9)	-	1 (6.3)
Moderate	3 (18.8)	4 (25.0)	1 (6.3)
Severe	1 (6.3)	-	1 (6.3)
Extremely severe	2 (12.5)	4 (25.0)	2 (12.5)

As shown in Table 2, 44 per cent of women reported elevated symptoms of depression (e.g. feeling worthless, inability to feel positive feelings or look forward to things) in the clinical ranges. Half (50%) reported elevated symptoms of anxiety (e.g. worries, feeling close to panic, scared for no reason) in the clinical ranges, and 31 per cent reported elevated symptoms of stress (e.g. difficulties relaxing, feeling agitated, overreacting to situations) in the clinical ranges.

Table 3 shows the proportion of women meeting diagnosis of post-traumatic stress and complex post-traumatic stress symptoms on the ITQ.

Table 3: Proportion of women meeting diagnosis of post-traumatic stress and complex post-traumatic stress symptom clusters (International Trauma Questionnaire; *N* = 16)

Symptom clusters	*n* (%)
Post-traumatic stress symptom clusters	
Re-experiencing in the here and now	12 (75.0)
Avoidance	14 (87.5)
Sense of current threat	13 (81.3)
Functional impairment associated with PTSD symptoms	9 (56.3)
Complex post-traumatic stress symptom clusters	
Affective dysregulation	10 (62.5)
Negative self-concept	8 (50.0)
Disturbances in relationships	12 (75.0)
Functional impairment associated with disturbances in self-organisation	9 (56.3)
PTSD diagnosis met (but not complex PTSD diagnosis)	6 (37.5)
Complex PTSD diagnosis met (inclusive of PTSD diagnosis)	4 (25.0)

With respect to post-traumatic stress symptoms assessed by the ITQ, the majority of women endorsed the presence of the following symptoms: a) re-experiencing dreams, images or memories of the trauma; b) avoidance of internal (e.g. thoughts, feelings) and external (e.g. people, places, situations) reminders of the traumatic experience; and c) a sense of current threat such as feeling alert, watchful, jumpy or easily startled. Just over half experienced functional impairment in relationships, work and other important aspects of life associated with these symptoms. Two women were experiencing frequent and severe symptoms and functional impairment that were indicative of a diagnosis for PTSD (but not complex PTSD).

The ITQ also assesses additional symptoms that are characteristic of complex PTSD, including affective dysregulation, negative self-concept and disturbances in relationships. The majority of women endorsed disturbances in their relationships such as feeling distant or cut off from people or finding it hard to stay emotionally close to people. Almost two thirds endorsed affective dysregulation, which included taking a long time to calm down when upset or feeling numb or emotionally shut down. Half of the women endorsed the presence of negative self-concept such as feeling worthless and like a failure. More than half experienced functional impairment in relationships, work and other important aspects of life associated with these symptoms. Four women were experiencing frequent and severe symptoms and functional impairment indicative of a diagnosis for complex PTSD, which includes meeting the criteria for both PTSD and disturbances of self-organisation.

Additionally, women completed assessment on the Shutdown Dissociation Scale (Shut-D; Schalinski et al., 2015) which assesses derealisation and depersonalisation as a consequence of shutting down emotions, cognitions and sensations. Symptoms can include not being able to see or hear properly, unable to speak or only with effort, feeling like the body or parts of body have gone numb, heavy or tired, or having an "out-of-body sensation". Six (35.3%) women had clinically significant dissociative symptoms.

3.6.5 Clinical observations of women and children during the initial psychosocial assessment

The mother–infant relationship was assessed using the PIR-GAS (Zero to Three, 2005). This was administered by the SNG clinicians during the psychosocial assessment session. This clinical observation tool yields

a global rating score (0 to100) based on the interactive quality, affective tone and psychological involvement in the parent–infant relationship. Higher scores reflect higher relationship quality, and total scores under 40 are suggestive of a relationship disorder based on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–3; Müller et al., 2013; Zero to Three, 2005). Twelve mothers and infants (75.0%) had scores that were suggestive of a relationship disorder.

The ADBB (Guedeney & Fermanian, 2001) was conducted by a trained SNG clinician during the psychosocial assessment session. Developmentally, it is expected that during interactions with their parents, infants may briefly look away, reduce their vocalisations and level of activity or arousal (Beebe et al., 1997; Feldman, 2007). This can be an adaptive response used by infants to regulate their emotions (Feldman, 2007). However, sustained withdrawal reactions in infants may be indicative of infant mental health issues (Guedeney, 2007) and/or attachment/relationship difficulties (Zeanah et al., 2002). ADBB observations for 15 infants were completed. Of those observed, 14 of the 15 infants (93.3%) had baseline scores that were indicative of significant withdrawal behaviour. Table 4 shows the distribution of children who had mild to severe unusual behaviour in the different areas assessed.

Table 4: Proportion of infants with no, mild or clear/severe unusual behaviour on the ADBB areas (*n* = 15)

	No unusual behaviour *n* (%)	Mild unusual behaviour *n* (%)	Clear or severe unusual behaviour *n* (%)
Facial expression	2 (13.3)	6 (40.0)	7 (46.7)
Eye contact	6 (40.0)	5 (33.3)	4 (26.7)
General level of activity	14 (93.3)	1 (6.7)	-
Self-stimulating gestures	14 (93.3)	1 (5.9)	-
Vocalisations	5 (33.3)	5 (33.3)	5 (33.3)
Response to stimulation	11 (73.3)	4 (26.7)	-
Relationship (with observer)	-	10 (66.7)	5 (6.7)
Attraction (by observer)	-	3 (21.4)	11 (78.6)

As can be seen from Table 4, the majority of children had mild to severe unusual behaviour in each of the following areas, including:

- facial expressions (e.g. limited expressiveness; face fixed, frozen or sad)
- unusual eye contact (e.g. fleeting, elusive, avoided)
- vocalisations (e.g. constant crying, whimpering in response to stimulation, absence of vocalisation)
- relationship to the observer (e.g. mildly evident, delayed, positive or negative, or absence of identifiable relationship to others)
- attraction or effort needed by the observer to keep in touch with the infant (e.g. uneasy or disturbing feeling by observer, feeling of being maintained at a distance).

3.7 Delivery of the SNGs

A total of four SNGs were run as part of this pilot study. For group 1, $n = 5$ women attended, for group 2, $n = 4$ women attended, for group 3, $n = 4$ attended, and for the final group, $n = 4$ women attended. For each SNG, the women and their infants attended face to face. There were multiple disruptions to attendance because of COVID-19 and associated lockdowns. Some groups had to be delayed and restarted. The collection of follow-up data was also impacted by the rolling lockdowns in the State of Victoria.

Four SNGs were delivered by the same two facilitators and two different Master of Counselling trainees. Fidelity checklists (see Appendix F) were completed by the facilitators to monitor the content and approaches delivered in each session. Table 5 summarises the extent to which the content and approaches were delivered as planned across each group.

Table 5: Extent to which session content and approaches were implemented across all SNGs

	%
Session content	
Set up safe, warm and welcoming space with rugs, cushions and protocol toys	94.4
Welcome song	94.4
Group rules (1st session only)	94.4
Infant-led play	94.4
Mid-session snack	94.4
Infant-led play	94.4
Bird's nest drawing (1st & last session only)	94.4
Close with Twinkle Twinkle song	94.4
Session approaches	
Implemented dyad-focused interventions (e.g. bubble blowing, songs)	84.4
Implemented emotional (co-) regulation strategies (e.g. pairing a song with rhythmic movement)	94.4
Facilitators modelled watch, wait and wonder principles	94.4
Implemented group-based intervention (e.g. walk & stop activity)	83.3
Session length in minutes (M)	115.0

There was a high degree of intervention fidelity across all groups. Given that the program was manualised, the session structure was the same for all groups, but there was flexibility in the activities and approaches used during each session so that it could be tailored to the needs and interests of the mothers and their infants.

3.7.1 Women's and children's participation in the SNGs

The mean number of SNG sessions attended by women and their children was 4.31 (*SD* = 1.45; range 1–6 sessions). Three of the 17 women who commenced the SNG program attended all scheduled sessions, and one dropped out after the first session. Although there were no demographic or psychosocial factors (including mental health symptoms at baseline) significantly associated with attendance, temporal organisation in terms of disruption to the morning routine and managing other appointments were consistent reasons for non-attendance. For example, some women living in refuges stated that they could not attend because their infant had not slept well the night before or due to the behaviour of an older child. Sleep disruption seemed to provoke some disruption to the equilibrium of the dyad, moving them into a state of increased disorganisation that took several hours to recover from. Interestingly, this issue posed less of an obstacle for dyads not residing in crisis accommodation. An issue common among all families was the scheduling of health appointments during the time of the group. Wednesday is a popular day for Maternal Child Health Nurses (MCHNs) to schedule immunisations and check-ups. Other appointments included the GP, specialists and allied health services which need to be taken as they are offered. These appointments were often corroborated by the case manager or the MCHN.

3.7.2 Outcomes of participation in the SNG program

Mothers completed surveys at baseline, post-intervention and at approximately 1-month follow-up to assess changes in: a) depressive, stress and anxiety symptoms; b) post-traumatic stress symptoms; and c) dissociative symptoms. Clinicians also rated the mother–infant relationship using the PIR-GAS and infants' social withdrawal behaviour using the ADBB at each time point. Table 6 presents the descriptive statistics for each outcome measure at each time point.

Table 6: Descriptive statistics for outcome measures at pre-intervention, post-intervention and 1-month follow-up

	Pre-		Post-		Follow-up	
Outcomes	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*
Mental health difficulties (DASS-21)						
Depressive symptoms	16	12.00 (12.7)	16	10.15 (10.9)	14	9.6 (9.5)
Anxiety symptoms	16	13.6 (14.22)	13	13.5 (15.1)	14	12.1 (9.0)
Stress symptoms	16	14.9 (11.5)	13	16.5 (9.8)	15	15.2 (9.5)
Post-traumatic stress symptoms (ITQ)						
PTSD total score	16	11.2 (6.0)	14	10.8 (6.0)	15	10.9 (5.0)
Re-experiencing in the here and now	16	2.8 (1.9)	14	1.8 (1.6)	15	3.1 (1.6)
Avoidance	16	4.2 (2.5)	14	4.5 (2.5)	15	4.3 (2.3)
Sense of current threat	16	4.2 (2.7)	14	4.1 (2.5)	15	3.5 (2.2)
Functional impairment – PTSD symptoms	16	0.6 (0.5)	14	0.5 (0.5)	15	0.5 (0.5)
Disturbances in self-organisation total score	16	8.5 (7.1)	14	7.0 (6.5)	15	8.5 (5.4)
Affective dysregulation	16	2.6 (2.0)	14	2.5 (2.1)	15	2.6 (2.1)
Negative self-concept	16	2.6 (2.9)	14	1.9 (2.4)	15	2.7 (2.6)
Disturbances in relationships	16	3.4 (2.7)	14	2.6 (2.4)	15	3.2 (2.4)
Functional impairment – disturbances in self-organisation	16	0.6 (0.5)	14	0.4 (0.5)	15	0.4 (0.5)
Dissociative symptoms (SHUT-D)	16	5.9 (7.3)	13	5.7 (5.9)	13	3.9 (4.0)
Parent-infant relationship (PIR-GAS)	16	37.4 (9.4)	14	42.5 (11.3)	10	46.8 (13.4)
Infant social withdrawal behaviour (ADBB)	15	6.8 (2.0)	14	6.0 (2.0)	9	5.4 (1.7)

The sample size was very small for analyses involving statistical testing. In practical terms, this means the change in outcomes from pre- to post-intervention must be very large to be statistically significant with such a small sample. However, inspection of the mean scores revealed that there were observed decreases in mothers' reports of depressive and dissociative symptoms over time. The clinicians rated an improvement in the quality of the parent–infant relationship over time, and there was an observed decrease in infant social withdrawal behaviour.

In addition to examining the observed means, the proportion of women and infants in the clinical ranges on the outcome measures at each time point were inspected. Table 7 shows that the proportion of mothers reporting elevated symptoms of depression, anxiety and stress in the clinical range on the DASS-21 was similar over time. The proportion of mothers reporting elevated trauma symptoms in the clinical range was observed to decrease slightly at post-intervention, but then increase again at follow-up for some symptoms (see Table 8).

Table 7: Proportion of women in normal and clinical ranges for depressive, anxiety and stress symptoms on the DASS-21 at pre-intervention, post-intervention and 1-month follow-up

	N	Normal *n* (%)	Mild–Moderate *n* (%)	Severe–Extremely severe *n* (%)
Depressive symptoms				
Pre-	16	9 (56.3)	4 (25.0)	3 (18.7)
Post-	13	8 (61.5)	3 (23.1)	2 (15.4)
Follow-up	14	9 (64.3)	4 (28.5)	1 (7.1)
Anxiety symptoms				
Pre-	16	8 (50.0)	4 (25.0)	4 (25.0)
Post-	13	6 (46.2)	3 (23.1)	4 (30.7)
Follow-up	15	6 (40.0)	4 (26.7)	5 (33.3)
Stress symptoms				
Pre-	16	11 (68.8)	2 (12.6)	3 (18.8)
Post-	12	6 (50.0)	4 (33.3)	2 (16.7)
Follow-up	13	6 (46.2)	4 (30.8)	3 (23.0)

Table 8: Proportion of women meeting criteria for post-traumatic stress and complex post-traumatic stress symptom clusters on the ITQ at pre-intervention, post-intervention and 1-month follow-up

	Pre-		Post-		Follow-up	
Symptom clusters	*N*	*n* (%)	*N*	*n* (%)	*N*	*n* (%)
Post-traumatic stress symptom clusters						
Re-experiencing in the here and now	16	12 (75.0)	14	5 (35.7)	15	13 (86.7)
Avoidance	16	14 (87.5)	14	12 (70.6)	15	14 (93.3)
Sense of current threat	16	13 (81.3)	14	11 (78.6)	15	13 (86.7)
Complex post-traumatic stress symptom clusters						
Affective dysregulation	16	10 (62.5)	14	9 (64.3)	15	9 (60.0)
Negative self-concept	16	8 (50.0)	14	6 (42.9)	15	9 (60.0)
Disturbances in relationships	16	12 (75.0)	14	9 (64.3)	15	11 (73.3)
PTSD diagnosis met (but not complex PTSD diagnosis)	16	6 (37.5)	14	4 (28.6)	15	7 (46.7)
Complex PTSD diagnosis met (inclusive of PTSD diagnosis)	16	4 (25.0)	14	1 (7.1)	15	3 (20.0)

With respect to the quality of the mother–infant relationship assessed by the clinician-rated PIR-GAS, the proportions of mothers and infants with scores indicative of a relationship disorder at pre-intervention, post-intervention and 1-month follow-up were 75 per cent, 50 per cent and 16.7 per cent, respectively.

For infant social withdrawal behaviour, the proportion of infants with ADBB scores in the clinical range at pre-, post- and follow-up was 93.3 per cent, 78.6 per cent and 66.7 per cent, respectively. Table 9 shows the proportion of infants with no, mild and clear/severe unusual behaviour on the specific ADBB areas at each time point. The most noticeable decreases in clear or severe unusual behaviour were for facial expressions (e.g. limited expressiveness; face fixed, frozen or sad), vocalisations (e.g. constant crying, whimpering in response to stimulation, absence of vocalisation), and attraction or effort needed by the observer to keep in touch with the infant (e.g. uneasy or disturbing feeling by observer, feeling of being maintained at a distance).

Table 9: Proportion of infants with no, mild or clearly/severe unusual behaviour on the ADBB areas at pre-intervention, post-intervention and 1-month follow-up

	N	No unusual behaviour *n* (%)	Mild unusual behaviour *n* (%)	Clear or severe unusual behaviour *n* (%)
Facial expression				
Pre-	15	2 (13.3)	6 (40.0)	7 (46.7)
Post-	14	2 (14.3)	8 (57.1)	4 (28.6)
Follow-up	9	1 (11.1)	6 (66.7)	2 (22.2)
Eye contact				
Pre-	15	6 (40.0)	5 (33.3)	4 (26.7)
Post-	14	8 (57.1)	4 (28.6)	2 (14.3)
Follow-up	9	7 (77.8)	-	2 (22.2)
General level of activity				
Pre-	15	14 (93.3)	1 (6.7)	-
Post-	14	14 (100.0)	-	-
Follow-up	9	9 (100.0)	-	-
Self-stimulating gestures				
Pre-	15	14 (93.3)	1 (5.9)	-
Post-	14	13 (92.9)	1 (7.1)	
Follow-up	9	8 (88.9)	1 (5.9)	-
Vocalisations				
Pre-	15	5 (33.3)	5 (33.3)	5 (33.3)
Post-	14	5 (35.7)	4 (28.6)	5 (35.7)
Follow-up	9	1 (11.1)	7 (77.8)	1 (11.1)
Response to stimulation				
Pre-	15	11 (73.3)	4 (26.7)	-
Post-	14	11 (78.6)	3 (21.4)	-
Follow-up	9	7 (77.8)	2 (22.2)	
Relationship (with observer)				
Pre-	15	-	10 (66.7)	5 (6.7)
Post-	14	8 (57.1)	5 (35.7)	1 (7.1)
Follow-up	9	1 (11.1)	7 (77.8)	1 (11.1)
Attraction (by observer)				
Pre-	15	-	3 (21.4)	11 (78.6)
Post-	14	1 (7.1)	4 (28.6)	9 (64.3)
Follow-up	9	-	5 (55.6)	4 (44.4)

3.8 Results from qualitative interviews with mothers

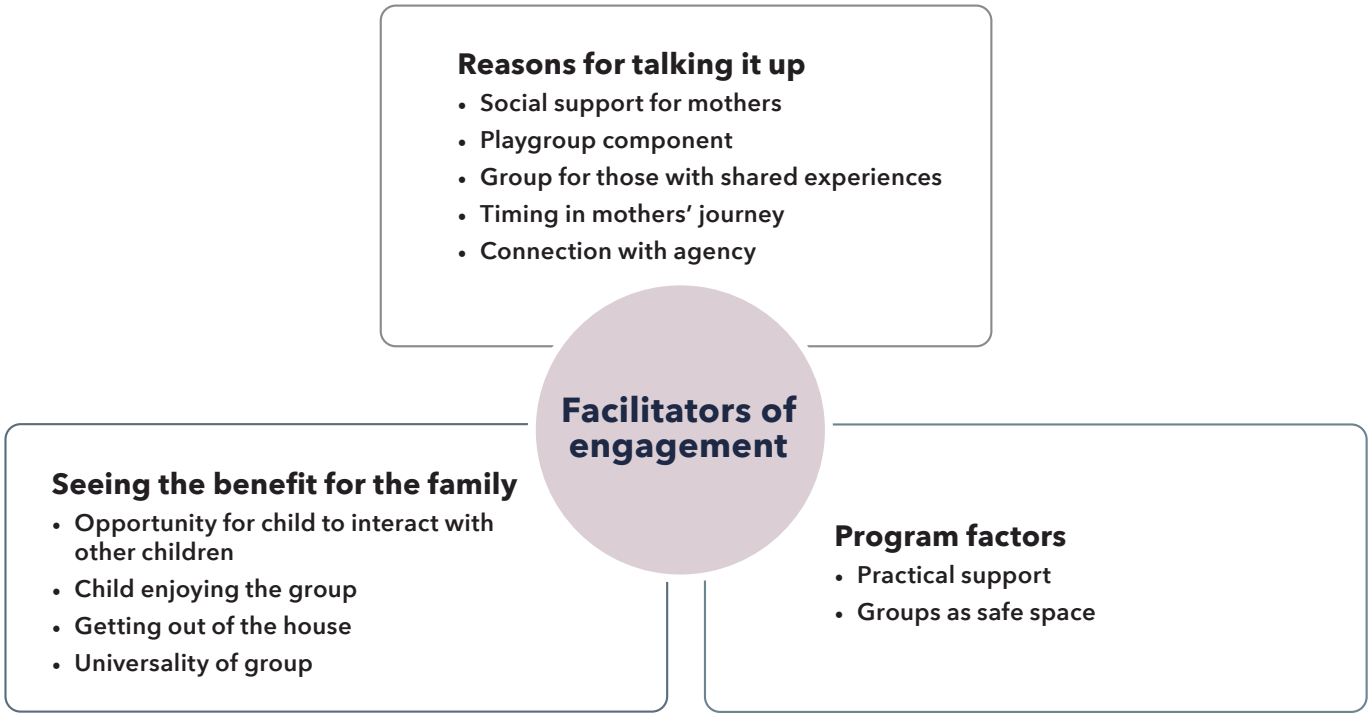
In this section, the results from the qualitative interviews are presented. Of the 17 women who commenced the SNG across the duration of the project, 14 completed the qualitative interviews. One woman dropped out after the first session, another withdrew from further participation in the study prior to the commencement of the qualitative interviews and one was lost to follow-up.

The mean age of women who took part in the interviews was 32.64 years (*SD* = 8.9). Participants had between one and four children, with the mean age of their youngest child (who took part in the SNG program) being 18.6 months (*SD* = 1.14). Half of the women who took part in interviews were born in Australia with the remaining born in Asia (28.57%) or Africa (21.43%). Of the women who were born overseas, the duration of time since migrating to Australia ranged from 4 to 35 years (*M* = 15.3, *SD* = 12.68). Nine women (64.3%) reported that English was the language spoken at home, and most (85.7%) were not in paid employment at the time of the interview. In the following section, the themes and subthemes from the qualitative interviews relating to the experience of taking part in the SNG program are presented.

3.8.1 Facilitators of engagement and participation in the SNG program

Participants described several factors, which facilitated their engagement and attendance in the SNG. Key themes related to facilitators of engagement included: a) reasons for taking up the SNG program; b) seeing the benefit for family; and c) program-related factors. These key themes, subthemes and corresponding quotes are described below and displayed in Figure 2.

Figure 2: Facilitators of engagement in the SNG program



Reasons for agreeing to participate in the SNG

Mothers described their motivations for agreeing to participate in the SNG program. For many, obtaining "social support" through attending a group with mothers was noted as a major facilitator for engagement.

> It's good to meet some other mummies and share our feelings, our thoughts and experience. (Participant 6)

The framing of the group as a "playgroup" was also noted as appealing by mothers. Participant 8 explained how this helped to provide her and her child with an opportunity to get out of the house and to meet others.

> She told me there is a group, anyone who come here, they attend the group there, the kids, and she said it's my choice if I want to attend or not, they're not forcing anybody to say you must go. Then I said that's good because that group is good for the kids and the parents, we just stay home and do nothing and it's good for us to go and learn new things. It's good for her too, to meet with the other kids … She can learn many things there. (Participant 8)

Mothers noted the importance of the group being "specifically for those with experiences of FV". Some described finding it difficult to connect, and to be themselves, in playgroups or mothers' groups in the wider community and that attending a group where everyone had this shared experience was perceived as safer. Participant 4 described how she felt isolated in other mothers' groups due to her experiences.

> I wanted to do something to socialise with him because, I found mother's group a little bit isolating because the other mothers couldn't relate to what I was going through and it's not that I wanted to be sharing that with them and I kind of felt the pressure of them wanting to know a lot about your lives and it's not a space that I wanted to be discussing all that with. (Participant 4)

Mothers discussed the importance of "timing" of the group in their FV journal. The right time to participate in the group differed for each mother with some noting that joining the group shortly after leaving a violent relationship or while staying in a refuge was ideal for them and enabled important support during this stressful time. Participant 15 explained:

> This is really a good time because refuge, especially with my situation, I'm living in a shared house. I am the first one who came here when this refuge opened after the lockdown. It's only me who has a baby. It's hard … Having playgroup, we can go out from the house, we can mingle with other people. It's good. (Participant 15)

Other mothers explained that having time between leaving the violent relationship and commencing the group was beneficial to assist them to feel ready.

> It was probably very good timing. We left home at the end of July, and then we've been in our rental home since October. So, a little bit settled down … that time that has passed since [being] home, I'm able to cope, so yeah it was good timing. (Participant 12)

A small number of mothers reported that having a prior "connection with the agency" through case management and/or staying in refuge facilitated their decision to take part in the SNG program. Mothers explained that this existing connection increased their trust in the group and willingness to take part.

> Emerge is amazing. To have that support from them is very, very important for his wellbeing, for my wellbeing, for recovery. I think if it's offered in refuge, 100 per cent, it is something that is definitely worth the time, worth doing. (Participant 1)

Seeing the benefit for their family

Mothers noted that seeing the benefit of the group for their child and themselves facilitated their attendance and engagement. Specifically, they described observing the benefit of their "children having the opportunity to interact with other children". Participant 3 described the importance of this stimulating environment for her son.

> When I came here and I see everyone here and I see everything very good and my feel better too, and

> [child] in here he happy, he exciting, he like to play with the baby and he like to play the toy and he like to talk with someone in here, and he only happy in here. In my house just only me and [child] and sometime he bored, and he just go around, around, around the house and I can see him very boring. The group very good for baby, very good for [child] now, and for me as well. (Participant 3)

Participant 15 also emphasised the importance of her child's interaction with other children given her child's experience of FV.

> Kids have gone through what the mother had and going through as well in life. Playing with other kids, associating the kids with other kids, it helps them for their social development as well to slowly get back to being playful. (Participant 15)

Most mothers noted that their child enjoyed attending the group and were excited to go each week. Seeing this enjoyment was described as a facilitator of group engagement by mothers. Participant 4 described how seeing the enjoyment of her son motivated her to attend.

> His enjoyment is what really drove me and like he said, we got sick and we missed one and the next week he was better and I was still not well, but I was like, we're going, because it's for him and I think that's my driver. (Participant 4)

Some mothers reflected that they had difficulty "getting out of the house" with their children and that the SNG provided an incentive to do this. Participant 12 explained how the group motivated her to take the children out of the house despite finding it challenging.

> I just think doing something good for the kids, and because I struggle to get out of the house and take them places, it was something that was there that I knew was there, and I just knew it would be wrong of me not to take them. I just knew it was good for them, and so there was no question about it. (Participant 12)

Mothers described the importance of connecting and sharing experiences with mothers who had similar experiences. They noted that the "universality" of the group assisted them to feel comfortable, share their experiences and understand that they were not alone. Participant 8 discussed the importance of this support for herself.

> What I loved about it for me, for myself, this is big chance if I learn from them, one day maybe I can get a group, not even I can get a woman and we sit and we discuss something about how we can help other people who don't have anything. We can sit together and discuss, just women to talk and discuss some things you know and learn from them too. That's good. (Participant 8)

> I feel like I've made connections that I could talk to and reach out to that are in a similar position. (Participant 9)

Program factors

Mothers reported program-related factors, which facilitated their engagement in the program. They explained that the "practical support" provided by program clinicians through their participation in the group was extremely helpful. Depending on the family's situation, practical supports may have included baby supplies and/or supermarket vouchers. Mothers also noted that having access to taxi vouchers to enable safe transport to the group each week played a vital role in their attendance. Some mothers noted that without these vouchers, having to drive to an unfamiliar area or having to catch public transport would have been a barrier to attendance. For example, Participants 8 and 15 spoke about the importance of this practical support for them.

> It's very convenient because [facilitator] always booked a cab for us. I don't drive and it's a bit far to walk. They said they're happy to book us a cab whenever we needed to go there. That's how it works. (Participant 15)

> Because I told them I cannot drive, like on the freeway I am not comfortable driving, and they arranged a taxi for me to go to that place. (Participant 8)

Mothers reflected that they perceived the "group to be a safe space" and that this was a considerable facilitator of their engagement. Participants 12 and 14 described how they experienced this sense of safety.

> Because of their experiences growing up, I'm just really very eager to have them around people that are gentle and kind to each other, adults that speak really nicely to each other, and just a nice, warm place, and that's what it was like. It was nice that they followed the kids' lead, and really gave them a lot of respect in the choices that they want and that they're making with their behaviour. It just felt really good to have the kids around nice people. (Participant 12)

> You just feel like yourself. You can have a laugh, you can do anything. You can talk about anything. You end up that comfortable, you can talk about anything … I loved that my son wasn't scared of [clinician] and all them, where he usually doesn't like strangers or anything. (Participant 14)

3.8.2 Barriers to engagement and participation in the SNG program

Mothers described a number of factors, which they perceived impacted their engagement with the groups as well as their attendance. Key themes related to barriers to engagement included: a) individual factors; and b) program factors. These key themes, subthemes and corresponding quotes are described below and displayed in Figure 3.

Individual factors

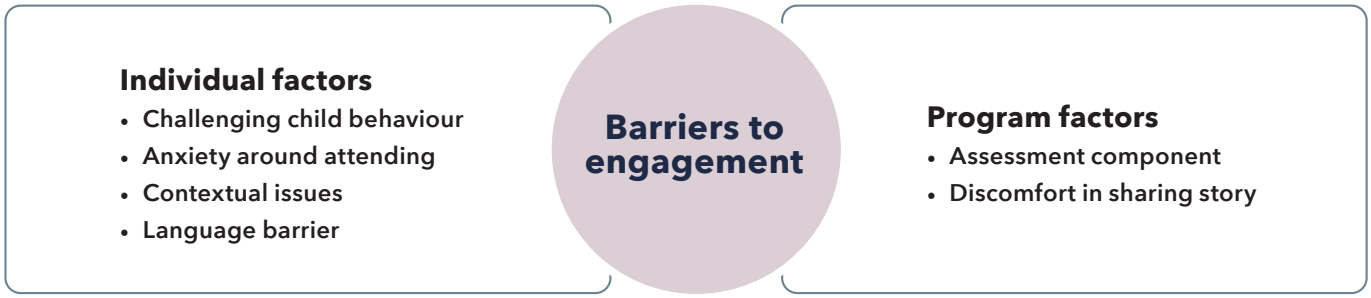
Mothers described several personal and/or circumstantial factors that acted as barriers to engaging in the SNG program, or which had the potential to impact them. A small number noted concerns around "their child's challenging behaviour" within the group, or the behaviour of another child within the group. Participant 17 explained how her child's behaviour made attending difficult.

> I had high anxiety going there every time because we did have some great experiences with [child] probably until the last week. Do I go back? Do I not go back? Once we obviously started laying the ground rules which we parent the same way, we are expecting of whatever happens in the room and the space and that type of thing is for anxiety level, but I thought I felt because [child] was either behavioural or trying to show his emotions and that type of thing. It was quite tough, I faced quite a few challenges myself I think. (Participant 17)

Most mothers described feeling "anxious about attending", reflecting on worries around attending or their child interacting with new people, having to speak about their experiences or not knowing what to expect. Participant 9 described her feelings of anxiety around attending.

> Initially I was just so worried 'cause my son is so active and the initial room was just so echoey and he's just so loud and constantly running around. I was just stressed, do you know what I mean, like oh my god,

Figure 3: Barriers to engagement in the SNG program



> please stop so that we can have a moment to breathe. I guess for me the hardest part was the initial stages and feeling comfortable within the group. It just took some time. (Participant 9)

Mothers described several contextual factors occurring within their lives that made attendance or engagement difficult. These varied across families but included mental health difficulties, mother or child illness, the business of raising young children and fitting the group in within their child's routine. Participant 3 explained how, at times, such contextual factors were difficult for her.

> Just sometime when I sick or I'm not well, or just only me look after [child], sometimes I feel little bit tired, and sometime something happen like little bit trouble, make me feel little bit lonely, little bit miss my family, and little bit more down and little bit tired. (Participant 3)

Many of the mothers attending the SNG spoke English as their second language with a small number noting this language barrier impacted their ability to fully engage with the group. However, it is important to note that these women expressed a preference for attending the group without an interpreter. Participant 6 explained how this was difficult for her.

> It's because – different culture, and I feel like they don't understand me with my English. (Participant 6)

Importantly, these women were also able to reflect on what they needed to manage the language barrier better as stated by Participant 6 below.

> If something like when they reading the book, if there's something I didn't understand they will explain it to me or ask me if I need an interpreter, a Dinka one. I told them, "As long as you guys understand what I'm just saying," I just needed them to break the words down a little bit and I could understand it. If they read it and explain it for me I will understand the meaning of it. (Participant 8)

Program factors

Mothers described several components of the SNG program that acted as barriers to taking part. These included feeling that the assessment, which occurred prior to the group commencing, was anxiety inducing. Participant 1 explained how she found this difficult.

> I guess the camera, I guess the questions. A bit of both. Some of the questions were fine and some of the other questions were difficult, because yeah, it was hard after speaking about things, I guess. Obviously, you go away with that. (Participant 1)

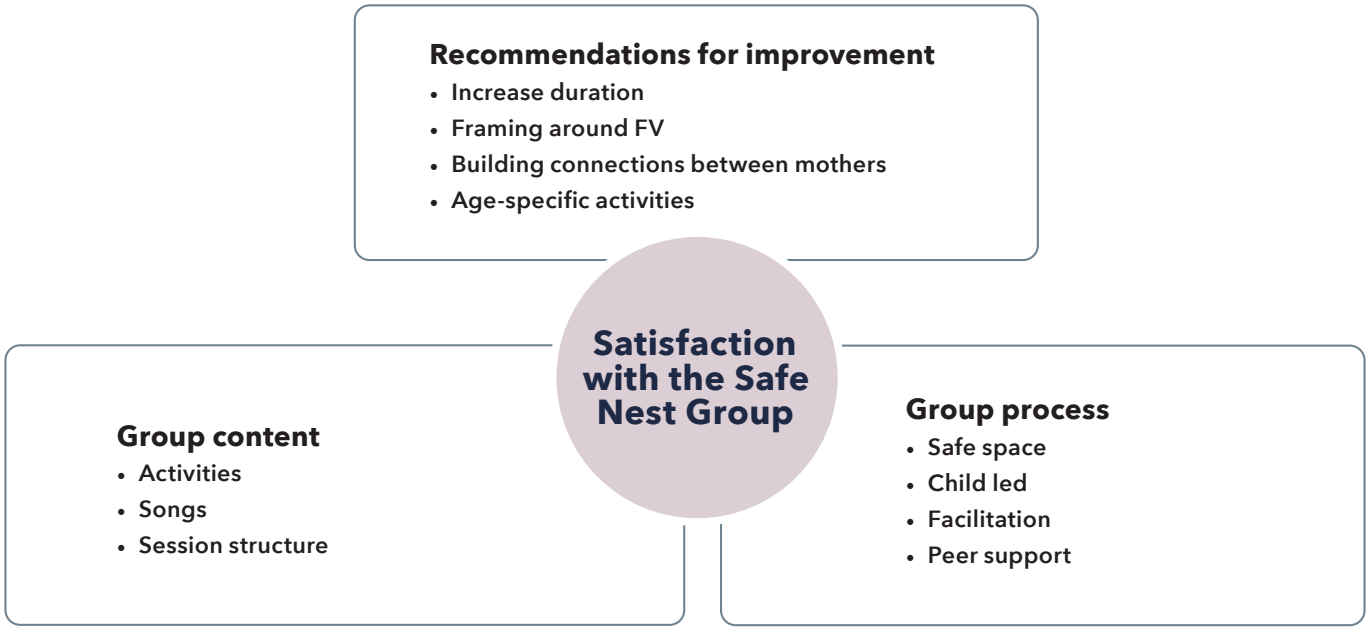
A small number of mothers expressed experiencing discomfort when references to their child's father or experiences of FV were raised. Participant 4 spoke about how a specific activity around the child's father was difficult for her.

> For example, there was activities where we would pick an animal to represent out ex-partners. So, it was very common within the group that there was, you know, the animal that we've picked was sort of unpredictable or loud. So, this resonates between all of us and I think it's awkward to hear that in a way, because you know other people have experienced things, but it's awkward to hear how difficult it is for each person. (Participant 4)

3.8.3 Satisfaction with the SNG

Mothers discussed the acceptability of the SNG for them and their child. A number of areas related to: a) the group process; b) group content; and c) recommendations for improvement. These are discussed below and displayed in Figure 4.

Figure 4: Satisfaction with the SNG



Group process

Mothers described several aspects of the group's process as highly acceptable. They described the group as a "safe space", noting the physical safety which came along with the group's location within a refuge, as well as the group being emotionally and culturally safe. Mothers explained that they perceived the group to be free from judgement and confidential. Many mothers spoke about feeling free to share their experiences, but importantly noted that they did not feel any pressure to do this either. Multiple participants described their sense of safety within the group. These descriptions did not necessarily mention the word safety or feeling safe but rather conveyed a sense of safety for themselves and their children.

> [I] feel very safe, because if I have to do something wrong, I'm not scared because everyone always keep everything the best for me, and everyone not complain, or everyone not make my feel not good. Everyone here I think is good for some mum like me … Sometime in my life something happen, make me feel strange, or sometime I do something not good, and I'm thinking I am not good. But come here and it's okay. I think everything I do good or no good, doesn't matter. In here, everyone just me, everyone believe me, and if I do something wrong I can do again. (Participant 3)

> It's a really lovely, warm place that you'll be treated beautifully, and your kids will be treated beautifully, and it's fun. You'll see your kids smile and interact with other kids, and it's just really good for their development for the kids. It's nice as a woman to be around other lovely, supportive women. (Participant 12)

> It's a secret location, and we would message. I think that was really good for people for domestic violence, and stuff like that, and some people may be still going through that, and scared. Because, domestic family violence isn't all just bashing and stuff. It's also financial, emotional. It doesn't have to be physical. (Participant 2)

Some mothers from culturally diverse backgrounds also noted that they felt accepted and that the group was a place for participants to share their culture.

> Sometimes if I listen to everyone's stories, the different tribes, because there we are different tribes, I feel like when they explain how they do their culture. Culture is very important for me. Yeah. The way they talk to their culture, the way they grow up. Everyone is learning a lot about culture. I like that one. For me, I feel more strong. I feel I can do anything. One day, I will say I can do something by myself. I learn. I learn. (Participant 8)

Mothers noted that the "child-led" nature of the group appealed to them, explaining that it contributed to a relaxed environment and allowed them to observe their children exploring a new environment. Participant 4 reported that this assisted her to relax within the group as well.

> They kind of just let him do what he wanted to do and let him come back when he was ready where I guess I would have been like everybody sitting down, we need to go and sit down, like come on, and then have him crying and kicking. They were just like let him do what

> he wants to do and when he's ready he will come back and join in the group … I feel so much better because now I just kind of go, you know what, he is three, he does want to run around. (Participant 9)

Mothers described the "facilitation" of the group as highly acceptable. They noted that the facilitators were kind and caring and skilled at interacting with children. Participant 10 commented on the skill set of the facilitators.

> They seem a lot more experienced, these girls. They're expert in their field, they're able to tell stories, engage with the children. (Participant 10)

Furthermore, mothers noted that the facilitators were skilled in managing situations where a child within the group was displaying challenging behaviour in a sensitive but effective way. Participant 17 described how the facilitators supported her to manage her son's challenging behaviour within the group.

> He just obviously needs help around trying to regulate himself. Trying to kick the other kids and bite them and pick them up by their hair or throwing things at them and stuff. [The facilitators] were fantastic, obviously trying to help me with that and making sure that I wasn't alone in that scenario. (Participant 17)

Mothers discussed the importance of the group and "peer support" component of the group. Specifically, they explained how this provided them with emotional support and the opportunity to feel more connected and supported by others. Participant 15 described the importance of this during her journey.

> Associating myself to other women having the same experience with me. It's good to see other women that are strong, they are fighting this fight of our situation. It gives me courage as well. If they can do it, I can do it. It gives me motivation. If these women are very strong, I can be as well. (Participant 15)

Group content

Mothers described elements of the group content as highly acceptable. The hands-on "activities", which engaged them and their child in play, were specifically noted as a highlight of the group. Participant 2 reflected on some of the activities, which she thought were engaging for the children.

> Things like pin the tail on the donkey, or just certain things to get those kids more interested. They love the bubbles and stuff like that. So, I think the more active things, they really liked that, because they don't like to sit still very long. (Participant 2)

Similarly, the songs within the group were also noted as an important component and enabled increased connection and interaction between mothers and their children. Participant 18 described the impact which the songs had for her.

> When you're doing Twinkle, Twinkle, and you're lying back, and you have your little baby on you, I think that's a really nice time just to reflect on why you're there as well. Because you're doing the group, and you're part of it, it's all lovely, but then at the end, it's that quiet time when you're singing that you just reflect on why you're actually there and how far you've come to actually get there. That's what I was getting each week, was just that quiet moment of, "Right. We're here." (Participant 18)

Despite describing the group as relaxed, mothers noted the importance of the "session structures", which were in place and consistent across each group. Specifically, they explained how the welcome song and concluding song assisted their child to transition in and out of the sessions creating a predictable routine. Participant 9 described how this structure assisted her child to be more settled within the group as he became familiar with the routine.

> He started to learn that there was a routine when we got there, and it would begin with the welcome song and then we could move onto the next thing and the next activity and then he could go out and play for a little bit and take little breaks when he needed to. I feel like he just felt more comfortable. (Participant 9)

Recommendations to improve the SNG

Despite mothers describing many aspects of the group as highly acceptable, some areas of improvement were noted.

Many mothers noted that the "6-week duration was too short" and that a "longer length" would enable their child to get more out of the group. Participant 4 explained that it took her child a few sessions to adjust to the group, and just as this was occurring, the group was coming to a close.

> It's kind of like it took maybe the first 3 weeks to sort of ease into it and then after that it starts to develop and then when it's at that developing stage, it's over. (Participant 4)

Although many mothers noted the importance of not feeling pressure to share their experiences of FV, some said that they would have like to see "a greater framing around the shared experience of FV" reflecting that it at times felt unspoken. Participants 17 and 18 explained:

> For me, it would've been nice to be able to discuss bits and pieces of that. I tried to open up. I think it would've been nice to have that space, I think, but it wasn't really offered. (Participant 17)

> I feel like there could have been a little bit more structure around the family violence, why we were there, perhaps if that's targeting a few of the activities just for the mums. (Participant 18)

Despite many mothers noting that the opportunity to connect with other women who had similar experiences facilitated their engagement in the group, some felt that they would have liked to see "a greater focus on fostering connections between mothers". They explained that due to the focus on the children, opportunities to connect with peers on a deeper level and form stronger relationships, which could continue outside of the group, were missed. Participant 3 suggested:

> I think maybe we can make something more activity for with the mum. When some people like mum come here, have plan for mum to do together. (Participant 3)

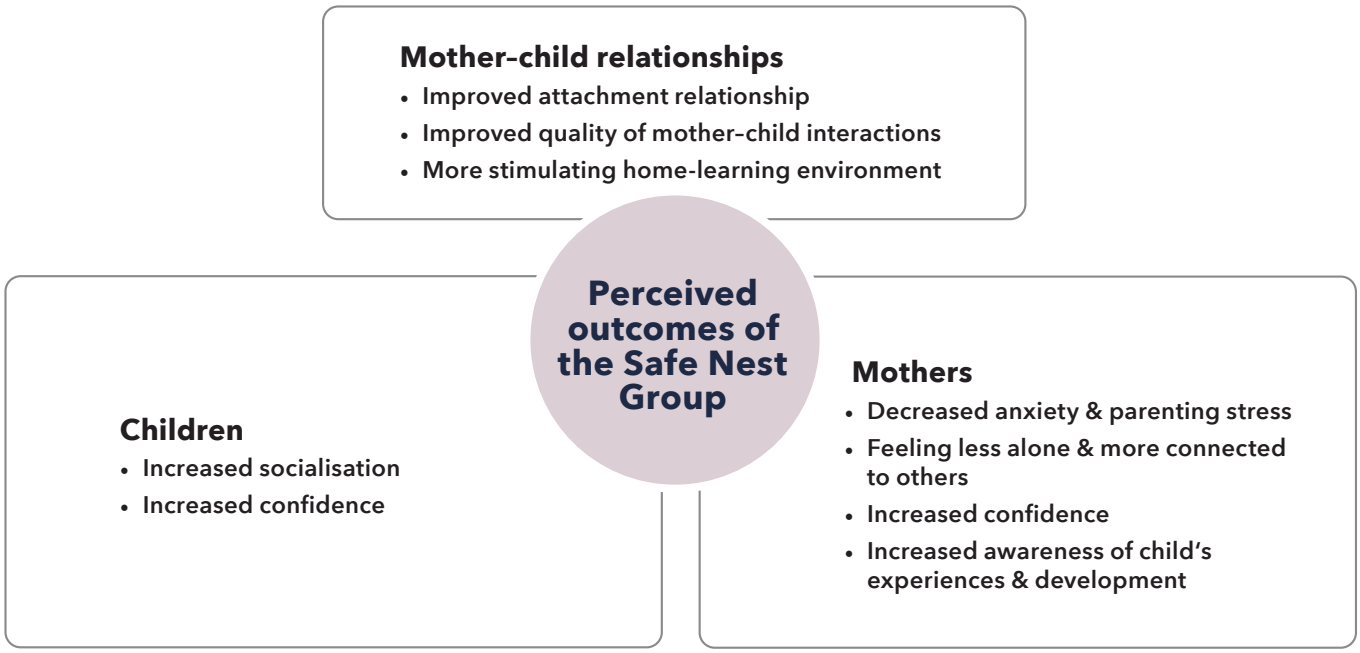
Lastly, a small number of mothers reported that their child was at a different developmental stage to the other children within the group, and that this limited their ability to feel engaged and fully take part in activities. These mothers suggested that limiting the group to one developmental stage might be beneficial. Participant 17 explained how this impacted her experience with the group.

> There was no one really his age appropriate, they were all a lot younger than [child] I guess, harder to keep occupied and that type of thing. When the program started, they didn't actually advise me that there wasn't going to be any older kids, so I didn't really get that choice. (Participant 17)

3.8.4 Perceived outcomes of participation in the SNG

Mothers discussed the perceived outcomes of participating in the SNG for them and their family. Figure 5 displays the key themes and subthemes relating to the perceived outcomes of participating in the SNG for mothers. The key themes related to benefits for: mother–child relationships; children; and mothers.

Figure 5: Outcomes of the SNG as perceived by mothers



Benefits for mother–child relationship

Many mothers described that their child had difficulty separating from them prior to the group and were extremely wary of strangers. Throughout the group, they noticed improvements in "their attachment relationship", noting decreased separation anxiety and "a more secure attachment" both within and outside the group setting. Participant 14 explained how she saw this change in her son across the duration of the group.

> He's always stuck to my hip, like would scream, cry, he'd have to be right next to me, and since going there he's let go of me slowly, slowly, and I was able to leave the room without him even screaming after me or anything. (Participant 14)

Some mothers noted that the SNG helped them to learn new ways of interacting with their child, particularly when their child was upset or displaying challenging behaviour. Mothers explained that they were able to use these skills and noted "improvements in their interactions with their children" as a result. Participant 8 described how the group helped her to reflect on how she interacts with her children when both were experiencing difficult emotions.

> Sometimes when the kid is stressing out, I will stress out too. Not just stress out, if I have things on my head and I'm not in a good mood, that's where I will stress out but I learnt to calm down there … I know I'm a mum but sometimes I'm not happy and the kids are giving me a headache, I will stress out. I still find that but they talk to me and they talk like you need to show the child what to do, you need to follow the child. (Participant 8)

Many mothers reflected that the play-based nature of the group reminded them of the importance of spending quality time with their child. This prompted many mothers to create additional space for play and quality time together, which resulted in a "more stimulating home-learning environment". Participant 18 described how taking part in the group reminded her about the importance of quality time with her son, and that she was able to increase the time she spent being present with him in their everyday life.

> I was aware that I wasn't giving him as much one-on-one time and small plays as I should be. As a busy mum on your own with two little ones at home, it can be really difficult and challenging to do that. I think the group was a really nice reminder to just stop and be present. I find where we're at home, and I'm busy, and I'm doing things, to just stop, and be present, and sit down with him, and play with him, and interact with him, which I try and do as much as I can, but I've noticed since the group, I'm doing that a lot more, which is really nice. (Participant 18)

Benefits for the child

"Improvement in the children's socialisation" was a common perceived outcome for mothers, with many mothers explaining that their child had limited

opportunities to socialise with other children their age. For many mothers this was a driving motivator to take part in the group, and they saw improvement in how their child interacted with other children as the group progressed. Participant 14 described how she observed her son improve in his skills in sharing throughout the group.

> He's less afraid to be with strangers, and he's more talkative, more playful. He's always loved kids, but he's also learned from there to share. He's bad at sharing. But, he's learned so much, he's grown. He's just became an independent little boy now. (Participant 14)

Some mothers believed that this increased exposure and interaction with other children and adults led to an "increased confidence" in their child. Specifically, mothers noticed that their child was more talkative and playful with others and that they had increased confidence to explore the immediate surroundings. Mothers described observing this increased confidence both inside and outside of the group context. Participant 18 reflected on noticing the changes in her son across the duration of the group.

> It was really nice each week to see how far he had come as well. To watch him gain in that confidence in the space as well was really lovely. (Participant 18)

Benefit for mothers

Some mothers reported that they experienced a "decrease in their overall anxiety and parenting-related stress" following participation in the group. For example, Participant 2 described the changes which she saw in her own mental health.

> I feel like I'm more calm. So, I was really nervous, and anxious, and stuff before, but I feel really more calm. (Participant 2)

Moreover, Participant 17 noted that she perceived taking her child out to be less stressful following participation in the group.

> Look, that things can be okay. That I know that I can handle [child] out within the groups and that type of thing. (Participant 17)

Although the extent to which specific experiences of FV were shared within the group differed, some mothers described that being part of a group with other women who had similar experiences assisted them to "feel less alone and more connected to others". This was particularly important for some women who reported feeling isolated and had difficulty connecting with other mothers who didn't share these experiences. Participant 18 described the benefit of connecting with other mothers who had been through similar experiences.

> Being a part of the group and knowing that I'm not the only one out there, and there are people my age that have been through it, there are people older, younger. I'm not the only one. Just knowing that there are so many other women out there that have gone through this, far worse than me or not as bad. Everyone has a story. You can come out of it. You can move on from it. (Participant 18)

Participant 9 explained how the group helped her feel more connected to others.

> I guess I feel more at ease with my situation. I feel like I've made connections that I could talk to and reach out to that are in a similar position. (Participant 9)

Building on this connection to others, mothers noted a general "increase in confidence" about themselves and their parenting and hope for the future. Some mothers explained that the group provided a safe space to build this confidence through interactions with other mothers and the facilitators. Participant 12 described how important this was for her after her experiences of FV.

> I guess I developed just confidence. Because my relationship was so controlling, doing most things for myself are a big deal. I think just confidence, I just felt proud I guess that I was taking them somewhere good and positive. It doesn't sound like much but having that feeling of pride is really a big deal to me. That's what I got most out of it, I guess. (Participant 12)

Some mothers described how the group assisted them to "better understand their child's development and experiences" of the world in their own right. For some

mothers, this included reflecting on how their child had been impacted by experiences of FV. Participant 15 spoke about what her child had experienced.

> I don't want [child] to experience like this because me, myself, I didn't grow up in an abusive family. I feel we are not rich, but I have a decent family. I didn't grow up with my dad or my mum abuse their child. No. I feel sad for [child] that she's going through this. I don't think my daughter deserve like this … she experienced yelling inside the house and that's … why I said to myself I need to get out because I am the primary carer. I am the mum, and I don't want my daughter to feel and to think that abuse is okay, because abuse is never okay. Never. (Participant 15)

Some mothers also discussed how the group provided space to understand their child's reactions to situations within the context of their experiences of FV. For example, Participant 4 reflected on her child's attempt to find safety when some aggression was shown between two other children within the group.

> Sometimes you might not have the time to actually appreciate that response from a child, made you kind of think, okay, kind of understand why they're responding that way, whereas in normal circumstances, you wouldn't even think twice … (Participant 4)

4. Case studies

In this section, four case studies are presented to bring to life the experiences of mothers and their infants who participated in the SNG. The case studies draw upon data from the assessment measures completed by women, qualitative interview data from women and clinical observations by the SNG clinicians. The cases were chosen to highlight differences in women's cultural backgrounds and social context, as well as their experiences in the SNG and perceived outcomes for the mother–child dyads. Purposefully, some cases we selected are representative of women who did not attend every SNG session and/or had limited change in the completed outcome assessments. Please note, all identifying information has been removed from each case study, some details have been changed, and pseudonyms have been used throughout. Participants provided their consent for the case study material to be used.

The first case study presented is for Jemina and her son Martin and how they found safety after a long history of FV and multiple experiences of being made homeless due to FV. The second case study is for Mina and Joe. Here, we illustrate how this dyad discovered support from others after their experience of severe FV and isolation. The third case study is for Shari and Eden. It describes how this mother and her son reconnected with each other after FV. Consistent with the focus of the group being infant led, the final case study is written with the infant's experiences as the primary focus. Here, we provide a more in-depth presentation of a mother–infant dyad who participated in the group.

4.1 Case study 1 – Jemina and Martin – finding safety and support after a long history of FV

Jemina was born in Australia after her parents migrated from a non-English speaking country before she was born. She had accessed several different FV services for serious and life-threatening FV that twice forced her family into homelessness and refuge and negatively impacted their psychological functioning. She had experienced physical violence from an intimate partner prior to commencing the SNG. Although Jemina had a limited support network, she was engaged with FV services as well as health and mental health support services for herself and her children. She presented with a previous diagnosis of PTSD.

Jemina and her son, Martin, participated in the SNG. This was her first experience of being offered dyadic therapeutic support, and she acknowledged the impact of FV on their relationship and her sense of identity as a mother. Observations during the psychosocial assessment suggested that Martin was a happy and curious boy. He seemed to show interest in a range of activities and was observed to engage in independent play. He stayed close to his mother throughout the assessment session. Jemina was observed to respond appropriately and sensitively to Martin's initiated interactions. He appeared to have some motor coordination difficulties (e.g. toe walking) and repetitive play. He showed limited engagement with the clinicians (e.g. no eye contact) including when they talked directly to him. Jemina reported that Martin experienced nocturnal and diurnal sleep difficulties. She reported feeling exhausted, and her self-report baseline indicated that she was experiencing mental health difficulties, including symptoms of depression, anxiety, stress, PTSD and dissociation.

Participation in the SNG

Jemina acknowledged that participating in the SNG was the first time that she had sought support for herself and Martin. She talked about her stays in refuges as being difficult and how important it was to receive support during this time. Jemina and Martin were able to attend the group with the help of taxi vouchers provided as part of the research project. They were often the first to arrive and the last to leave the group, attending five of the six sessions. They missed one session because it conflicted with another appointment. Jemina presented as initially shy and seemed to feel more comfortable observing the interactions between others in the group. However, she appeared to always be ready and willing to participate in the different group activities. Despite her apparent shyness and reported anxiety, Jemina formed friendships with two other mothers in her group.

Following the SNG

In the qualitative interview, Jemina noted that the SNG was helpful. However, she described feeling very anxious about it at the start.

> A bit nervous, for a start. I guess with anything that you go to – and plus I've got high anxiety and PTSD, so everything's triggering for me. My anxiety. Really challenging. So, for me to make it to every group, which I did, but it was challenging.

She specifically noted that the taxi voucher assisted her to overcome the transport barrier to attending the group.

> I do say that the taxi voucher was very helpful in getting me here. Yeah, my anxiety holds me back from a lot of things, from doing just normal things, so I think having that support would be helpful.

Jemina also noted that she felt safe in the SNG and that she was not being judged. She viewed the infant-led nature of the sessions positively.

> That we weren't judged by our kids' behaviour. They could roam around and use the Textas how they wanted to. We were led by them, which was really good. It wasn't a structured-type thing, like, "We're going to do this." It was like, "Okay, the kids are hungry now. Okay, the kids want to play this." Yeah, so I think that was good.

Jemina talked about her son enjoying the SNG and that it provided him with important opportunities to interact with others.

> I liked that [child] was enjoying it. I liked that he looked forward to coming here. He knew as soon as we got in the taxi, as soon as we got here, straight away he knew. He's never been in childcare or anything, so I felt it was really, really good for him to interact with other kids, yeah, and also see me interacting with other adults, and me a bit more relaxed and sitting down with him and singing songs … He enjoyed the song at the start. He'd come and sit and start patting and he'd be ready for it. So, yeah, even at home now, when Twinkle, Twinkle comes on, he lies down on the mattress.

She also noted that the social support was also important for her.

> Getting to know the other mums as well, yeah, just having that support. I think having support is really important, especially when you're in the situation and you get isolated and stuff like that. Yeah, you don't want to feel like you're left behind.

Jemina shared that the main change following the SNG was for her son. She had noticed that he had less separation anxiety with her.

> … before this group wouldn't stay with somebody on his own. Even with [clinician] and that, I would quickly run to the toilet and he'd be screaming, so I had to take him to the toilet with me. So, now he's a lot better. He's not doing that.

The clinicians observed a similar change in Martin, which was reflected in the PIR-GAS score at the post- and 1-month follow-up. He seemed to become more confident, exploring the fullness of the therapeutic space and developing friendships with the other infants. Other than with his siblings, Martin had not had any opportunity to interact with his peers in social settings. Over the weeks, he was observed to seek out other children at the beginning of the group and initiate parallel play while also enjoying joint play with the clinicians. He seemed less preoccupied with his mother and needing to be close to her and/or where she was, tolerating brief absences and demonstrating an increased ability to form additional meaningful connections and relationships.

With respect to Jemina's self-reported surveys of her mental health symptoms, there were decreases in her anxiety and stress symptoms from pre-intervention to 1-month follow-up (see Figure 6). This decrease was most noticeable for depressive symptoms, which were no longer in the clinically elevated range at follow-up. There was also a small reduction in her PTSD symptoms and disturbances of self-organisation (e.g. affective dysregulation, negative self-concept and disturbances in relationships; see Figure 7).

Figure 6: Pre- to post-scores on the Depression, Anxiety and Stress Scales for Jemina

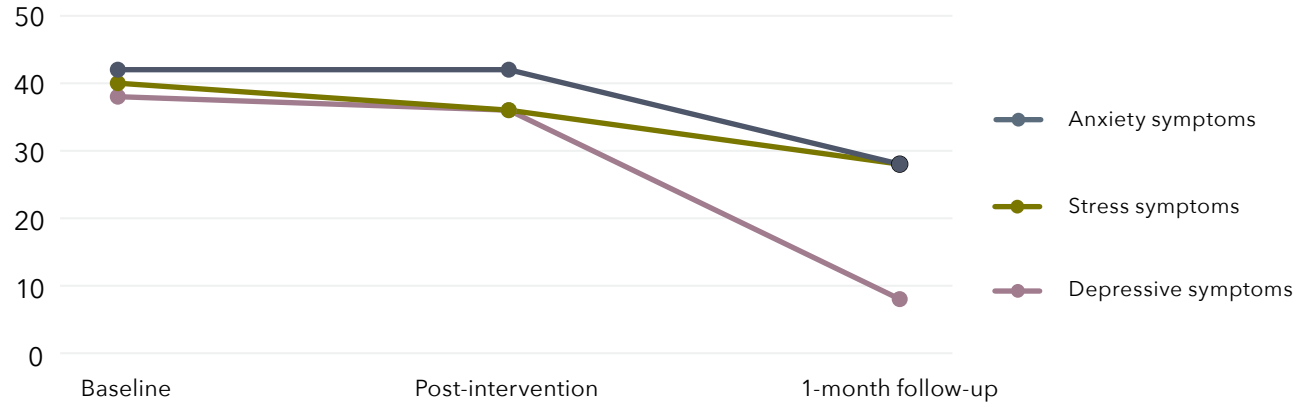
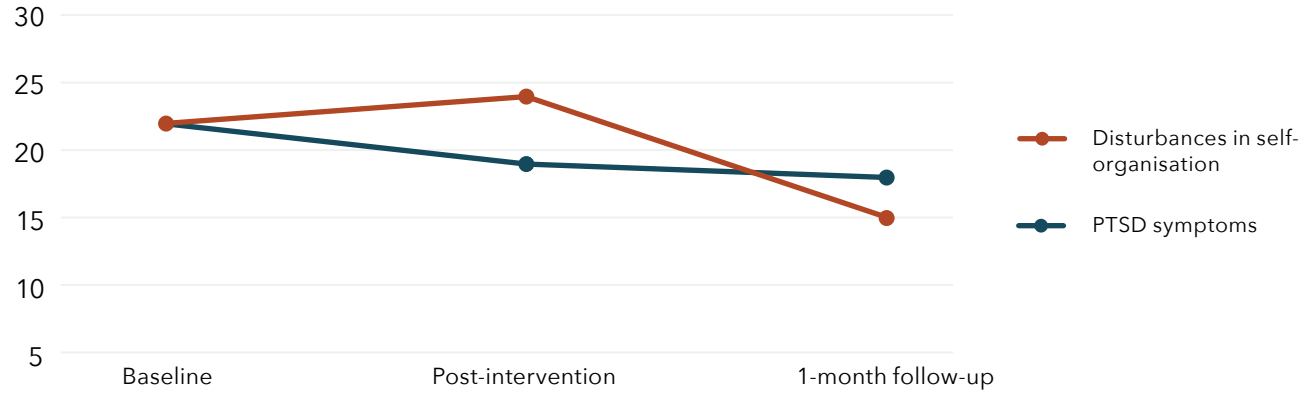


Figure 7: Pre- to post-scores on the International Trauma Questionnaire (ITQ) for Jemina



Jemina also noted that participating in the SNG gave her an opportunity to reflect on her relationship with her son and the importance of taking the time to strengthen their relationship.

> I realise that [child] is going to grow up quicker and he's already grown since the first session and changed so much that I need to take out that time sometimes and be more present with him, even if it is 10 minutes, just take that time with him.

4.2 Case study 2 – Mina and Joe – discovering support from others after experiencing severe FV and isolation

Mina migrated to Australia several years earlier. Her proficiency in speaking and understanding English was low but she was able to engage in simple conversations with confidence. Prior to staying in refuges, Mina had limited contact with people other than her ex-husband and his family. She also reported experiencing significant housing instability and homelessness. Her goal for the referral to the SNG was for her son, Joe, to make friends. This was the first time she and Joe had participated in any mother–baby activity. It was also the first time that she had accessed therapeutic support around FV. Despite feeling anxious about meeting new people, Mina expressed an interest in attending the group. She reported a recent history of violence from her intimate partner as well as other family members. Based on Mina's self-report and clinician observations, she struggled with emotional regulation, ability to relate to others and persistent dissociative symptoms. For example, she would become distressed when attempting to contain Joe's behaviour or set firm boundaries. Further, there were sudden shifts in her mood or demeanour that were not explained by a change in external factors. Mina had no family or other social supports. She had recently attended a community service to receive assistance for sleep, settling and parenting. Joe attended childcare once a week.

During the psychosocial assessment, Joe appeared to explore his environment with high energy. He looked at, and played with, a range of toys. He was observed to be gaze avoidant with the clinicians, but he attempted

to interact by throwing balls to get their attention. He would briefly express curiosity towards the clinicians and allow them to come near him to show him toys, albeit briefly. Joe was also observed to avoid Mina, particularly when she attempted to interact or engage with him to contain his behaviour. Despite this avoidance, Joe did check in with her periodically and looked for her if she left the room. Mina was not observed to actively engage in play with her son. At times, she seemed to find it hard to answer questions relating to his experiences, thoughts and feelings.

Participation in the SNG

Unfortunately, due to ongoing difficulties with concentration and memory that impacted her psychological functioning and ability to maintain routine, Mina and Joe only attended two sessions. Despite this limited participation, she still attended the 1-month follow-up assessments. Mina expressed how important it was to be able to contribute to the research project and her story was chosen to honour her desire to have her voice heard.

Mina often indicated via SMS that they would be coming only to not arrive at all, or they would arrive late to the group creating considerable disruption, particularly by Joe who struggled to settle in or join his peers in play/activities. However, when in attendance, Mina seemed to enjoy connecting with the other women and formed a close friendship with another mother.

Despite Mina's difficulties with English, she was keen to share her experiences of the SNG in a qualitative interview. She was offered an interpreter but declined. Mina's reflections about the group were positive.

> When I came here and I see everyone here and I see everything very good and my [child] feel better too, and [child] in here he happy, he exciting, he like to play with the baby and he like to play the toy and he like to talk with someone in here, and he only happy in here. In my house just only me and [child] and sometime he bored, and he just go around, around, around the house and I can see him very boring.

Although often fearful and reluctant to leave home, Mina shared that she felt comfortable and safe attending the SNG.

> I still little bit scared, I don't want to go outside too much. I don't want to see some people. I'm new with me, so here I can come here and see everyone with myself. I'm not scared. I don't know how to say it so you understand. I feel comfortable when I come here to see everyone, because I think everyone here only make everything the best for me and for my son. I don't want to see more people when I'm not here like this, because I don't know they believe me or they don't believe me, or they good with me or they no good with me, and they thinking about me good or thinking about me no good.

Mina spoke about her relationship with her son and getting out of the house. Although Mina only attended two sessions, she reflected on how the group had enabled more positive interactions with her son and with other people.

> Every mum in the world all loving the kids. And sometime if I'm not take him to go outside, just only me and him, sometime he make me angry, or I can learn him something. Sometime I can't understand. Yes, sometime we miss, I can't always give him the hug, and I can't all the time talking gentle with him. Sometime he make me angry, and he too, he feel it too … But, when take him to go outside, or join in the group, he can see some people and he can feel more about. [Child] really like playing with the kids, with the baby, and he like to talking with the people.

Finally, Mina experienced some language barriers, as reflected in her quote below.

> Maybe sometimes when I talking, they not understanding and sometimes I don't understand what they say. That's a reason why little bit hard.

Following the SNG

Although Mina only attended two sessions, she was keen to complete the follow-up assessment. She required assistance from the clinicians to complete the self-report

surveys about her mental health at pre-intervention and follow-up. Her scores on the DASS-21 indicated low symptoms of depression, anxiety and stress in the normal range from pre-intervention to the 1-month follow-up. On the ITQ, Mina had persistent scores of PTSD and disturbances of self-organisation over time but did not meet the clinical cut point for potential diagnosis of PTSD or complex PTSD. Despite limited participation in the SNG, the most notable change in mental health symptoms was for dissociative symptoms on the SHUT-D. Mina's scores remained similar from pre- to post-intervention in the clinical range, but at the 1-month follow-up her score was in the normal range.

During the qualitative interview, Mina's main reflection was that she felt less alone following participation in the SNG despite only attending two sessions.

> … before I come here I feel just only me. I feel very lonely. But, now I think I got [clinicians]. I think many people in the world believe me, like me, and are happy whenever they always are ready to share with me. Is happy too much when I'm feel someone believe me. Yes, it's very, very, very, very, good.

4.3 Case study 3 – Shari and Eden – reconnecting with each other after FV

Shari migrated to Australia with her family. She reported experiencing recent physical and emotional abuse and coercive control from her husband in the year prior to referral to the SNG program. The FV began soon after her son, Eden, was born. Eden was reported to have witnessed intense displays of anger and aggression from his father. Shari separated from her husband prior to the referral to the SNG. She reported that she had good family support, with Eden often staying with extended family. Social and formal supports were limited. Her husband was reported to have prevented her from accessing maternal and child health programs and other early parenting services. Shari was reluctant to attend group programs with other mums, as she felt pressure to talk about her family, her situation and experiences.

Observations in the psychosocial assessment session suggested that Eden was slow to warm up to explore the environment and toys. Although he stayed close to his mother and ran back to her when he ventured too far or for too long, he did interact with the facilitators during play. He showed a range of facial expressions, which seemed to express sadness, worry, happiness and enjoyment. These were all congruent with the context and interactions with his mother and facilitators. At one point, Eden seemed to be preoccupied with the sound of other people in the next room and communicated worry by pulling the hand of the facilitator to the window or door indicating he wanted to know who was there or what was happening. Shari described Eden as being quiet at home and easy to calm and settle when distressed. During the assessment session, she kept a close eye on her son, redirecting his behaviour when required. Her responses to interactions with Eden were muted at times, and she was observed to have a moderate flat affect. Eden often looked uncertain in interactions with his mother, as if waiting for her encouragement or permission.

Participation in the SNG

Shari and Eden attended five of the six sessions. They missed one due to being unwell. They would often arrive 30 minutes early. Most weeks, Shari reported that Eden had been clapping in the car seat and singing the welcome song on the way. Although Shari was often open in sharing her worries and the impact of these on her self-confidence, she seemed to easily develop rapport and a connection with the facilitators and other mothers. Initially, Eden seemed to be shy and withdrawn and uncertain about how to join in with the group. However, as the group progressed, he appeared to become more confident in initiating play and games with others. He was also observed to help other babies when they were upset.

Following the SNG

With respect to the clinician's rating of the parent–child relationship using the PIR-GAS there was a very slight improvement from pre-intervention to the follow-up. With regard to the self-report surveys, there was a slight decrease in depressive and anxiety symptoms for

Shari over time; however, these symptoms were still in the elevated clinical ranges. With respect to PTSD and dissociative symptoms, there was limited change from pre-intervention to follow-up.

In the qualitative interview, Shari identified several ways the SNG program helped her and her son. She reflected on the importance of being part of a group with mothers who had similar experiences to her own.

> … when you're in a mothers' group, their lives are all seeming perfect and your life is crumbling kind of thing, so when you're with people that are in similar experiences you feel less pressure on yourself to have this perfect life.

She noted some changes in her own thoughts and feelings about her experiences of FV. In particular, Shari shared that she felt less ashamed.

> I think I'm more relaxed about speaking about what's happened, not as ashamed maybe. I think maybe a lot of people would feel that and it's more accepting of what's happened.

Importantly, Shari shared that she had a better understanding of Eden's experience of FV.

> … from my last session there was a little bit of a push and shove with two little ones and [he] kind of saw it and grabbed my hand and pulled me into the tent. It was quite interesting to see how when he saw that confrontation that he grabbed my hand and just pulled me away from that and just wanted to be in a little bit more of a safer space which he felt was the tent.

She also stated that she better understood Eden's experience, his needs and wants.

> Seeing him be himself gives me more of an understanding of what he's liking and what he's not liking and what he wants to do, so when we're at home you can incorporate that at home as well. Just understanding his personality more.

The SNG provided Shari with the important opportunity to connect with her son and notice new things about him and his personality.

> … it's that space to have a bit of time out … the time out to see your child in a different light, to see their development, to see their personality and to know that they're safe in that space to have that freedom.

She described feeling anxious about joining the group in the beginning and that Eden also became more comfortable after a few sessions.

> Very anxious for myself and I think even for [child], he initially was a little quiet but towards the end of it he was a lot more vocal and really comfortable with the space.

Meeting with the facilitators before the group commenced helped ease some of Shari's anxiety. She explained:

> … [the clinicians] both were very approachable, very patient and explained things very well, so very welcoming. So, it helped, and I think the initial meeting with them before the group started was really good, because then it eased us in, it didn't feel like coming somewhere brand new to a whole group of people.

Shari shared that she had separated from her partner and participating in the group so soon afterwards helped her adjust.

> … it was a good time because a lot had happened in that space and when this had started, but it sort of gave me a little bit of grounding as well, some routine which was not happening so much.

She noted the importance of the relaxed and child-led set-up of the group for both her and her son.

> … it's almost like it came into a space where we let the babies just play and enjoy themselves and I think [clinicians] were both, because I'm quite particular about him getting messy, and in here, I sort of relaxed about that as well and just let him enjoy himself. So, by relaxing and letting go, he was able to just experience more as well.

Shari also reflected on the importance of her son's freedom to play and explore. She explained there was a contrast between how comfortable she felt to let him do this at home compared to in the group.

> At home, I'm always like don't touch that, don't do this, no, don't climb that, so in here I was able to just sit and go and I can let him do what he wants to do and just enjoy watching him play.

She noted how Eden's behaviour had changed across the duration of the program as he felt more comfortable.

> … his vocalisation. Like, initially, he just didn't say anything really. He would just be doing things and not speaking so much, but towards the end he was blah, blah, blah, all over the place and quite confident in speaking and doing what he wanted to do.

4.4 Case study 4 – Jasmine and Doris – an infant-led intervention

Infants have their own voice, and it is important we find ways to attune to it and to understand what they can tell us about their lived experience (Paul & Thomson-Salo, 1997). This is especially important for infants who have witnessed FV. The following case study was included to deliberately and meaningfully elevate the voice of one infant who participated in the SNG and highlights some of her affective and sensory experiences and relational encounters during the group. Very young and non-ambulant babies can employ early developmental coping strategies to manage the often very stressful impacts of FV (Jordan, 2014). They are also reliant on adults to respond to their need for urgent safety and protection. This case study was co-written by the lead SNG facilitators who were able to directly observe the infant over several sessions and wonder about what she was communicating. Careful attention has been taken in writing a case study that applies the principles of infant observation, privileging information that emerged in the context of the group and described by her mother as the primary carer. It is important to explain that infant observation offers a different way of knowing and that interpretations are used to form a picture to enable deeper insights into the experiences of the infant. The lead facilitator (EvD) was trained and experienced in infant observation.

Jasmine was one of the youngest infants to participate in the SNG. She and her mother, Doris, had resided in multiple refuges. Doris reported fleeing FV perpetrated by Jasmine's father when she was in the late stages of her pregnancy with Jasmine. However, she said that she returned to him soon afterwards when he "promised to look after her and the baby".

Doris came to Australia a few years ago and met Jasmine's father soon afterwards. She moved geographical areas to be closer to him and then moved in with him when she fell pregnant. Doris did not have any connections to her community or extended family in Australia or overseas.

Jasmine was born prematurely following a complicated birth, delivery and postnatal period. According to Doris, these complications resulted from the alleged physical abuse and psychological stress that she experienced during the pregnancy. The father was not present at the birth but was at home when Jasmine came out of hospital. Doris said that the father was "a good dad who cares for Jasmine" but described him as using substances, controlling the finances and not letting her hold Jasmine when she was crying/hungry/distressed. According to Doris, the FV continued to escalate and when Jasmine was a few months old, Doris left the home with Jasmine and what she could pack into one bag. Jasmine had not seen her father since.

Presentation

On first meeting Jasmine, she presented as wide awake and alert, facing outwards in her pram. She made eye contact with everyone, taking time to study the new faces, although her facial expression did not seem to change. Doris took her out of the pram and positioned her on the floor for tummy time. The lead facilitators noticed that Jasmine was not yet able to push herself up off the ground or hold her head up. Her movements seemed to be jerky, and her head flopped forward suddenly. Jasmine seemed to become overwhelmed by all the new people and objects,

sharing her distress quickly and loudly. As her distress increased, we noticed Jasmine's body stiffen and she arched her back. We could feel her distress and wondered what would help her to feel safer in this new environment. Doris prepared her daughter a bottle of milk and then lay her on the ground explaining that Jasmine was tired and this is how she preferred to self-soothe.

The facilitators wondered whether, at times, the stress was too great for Jasmine, which triggered dissociative responses to help her cope. For example, it was observed that she stopped crying and fell silent. Her facial expression was very still, and we noticed the muscle tone in her limbs had become limp. We watched Jasmine hold the teat of the bottle in her mouth not sucking, and her eye gaze was unfixed. Noticing her daughter's lack of interest in the bottle, Doris moved her to the pram to sleep, covering it with a blanket and rocking the pram back and forth.

Jasmine stirred after approximately 10 minutes, and Doris got her out of the pram. This time, Jasmine seemed to be less surprised to see the facilitators, and she engaged with them when they offered her balls to play with. Although she still seemed shy, she did reach for the ball a few times and attempted to roll it back, but overall, it was hard to get her interest and she could not sustain eye contact. Her mother talked with us about her hopes for a new life for them both. Jasmine seemed to tire after about 10 minutes, and her mood changed again, seemingly becoming upset by something and rolling onto her back. Jasmine's crying intensified. Her arms and legs became stiff, and she started to make a gagging sound. The facilitator picked up Jasmine to offer her some comfort, but she seemed to be too upset to receive this comfort. Doris took Jasmine from the facilitator and placed her back in the pram indicating it was time to go. Jasmine quickly quietened, and we noticed her staring gaze.

Relational observations

Doris appeared to engage openly with the facilitators and expressed her interest in joining the SNG. This would be the first mother-baby activity that she had done. The COVID-19 restrictions had prevented them from regular playgroup activities in the community. Doris shared her deep love for Jasmine, describing her desire for her daughter to have more social connections and to be safe. She expressed her gratitude to everyone who had helped the family to leave her ex-partner.

Doris reflected on not having her own family to help her to learn how to care for Jasmine. She told us that everything was "fine" and re-expressed her gratitude for all the help that she had received. She told us that Jasmine was a content baby, and she had no concerns. She described the basics of Jasmine's routine and how much she enjoyed being a mother.

We wondered about the impact of the FV on the parent–infant relationship and how both might be presenting in survival mode following the number of traumatic experiences. Doris always kept her daughter close to her but, at times, seemed to struggle to correctly label her feelings, often commenting that Jasmine was "enjoying" something when she seemed to us to be showing signs of distress. Jasmine seemed to manage these interactions with her mother in several different ways. The facilitators noticed that as her arousal increased, she would exhibit heightened emotional dysregulation. She quickly moved past her threshold and into a shutdown response. Her gaze became unfixed and her affect blunted, whereas, at other times, she appeared hypervigilant with a fixed and intense gaze on the adults. This vacillation between shutting down and relational withdrawal was reflected in the baseline score of 8 on the ADBB (Guedeney, 2016). This score suggests a clinically significant level of relational withdrawal present in an infant.

Group engagement and observed changes

Jasmine and Doris attended three of the five group sessions, initially missing the first and second group due to health appointments. It seemed that beginning the group might have been difficult for Doris. When they finally were able to join the group, Jasmine spent most of the time in her pram sleeping, waking and joining the group for 15 minutes to 30 minutes.

During the moments when Jasmine was physically present, we noticed she took her time to warm up. She observed the group silently, watching from the floor close to her mother. Each time she was awake, another non-ambulant baby would roll a ball in her direction signalling he wanted to play. One of the older children, a toddler, would come over to her and show his interest in her too. We could see Jasmine was taking in what was happening around her but needed some time to figure everything and everyone out. We were mindful that this was the first time Jasmine had met so many people at the one time.

Doris seemed to hold Jasmine in mind even when she was asleep, talking about her and sharing stories of the week. She joined in the mother–baby activities as best as she could without her daughter when she could have opted out. As the weeks went on, Doris was gently encouraged to use these activities to interact with Jasmine. By having fun and playing together, we noticed more synergy in how they physically came together, with Jasmine being held by her mother during the group in a ventral-to-ventral position instead of lying on the floor. We used the discussions about FV, including its impact on the children and the mother–child relationship, as well as the experience of homelessness, to wonder about Jasmine's subjective experience and how she coped.

Although Jasmine was not able to join all the group sessions, we observed distinct changes in her social-emotional development, which was reflected in the post-ADBB score of 5. This score placed her at the cusp of moving within a normal range of 0 to 5 (Guedeney, 2016). She started to vocalise more, communicating her preferences, interests and feelings. There were some tentative smiles, and she seemed more confident in initiating ball rolling games. Her gaze seemed to soften, and her body was more relaxed, suggesting that she was less hyper-vigilant and feeling more comfortable in the group. Doris also seemed more confident to hold her daughter, and we witnessed her holding her protectively when the older children got boisterous, moving her away from harm.

Final reflections

The impact of the multiple lockdowns on the continuity of the group was significant. These created several unanticipated pauses between weeks and ultimately meant that the final group had to be reduced from 6 weeks to 5 weeks. We remained in contact with Doris and Jasmine offering them both support where we could on the weeks we could not come together. In the 1-month follow-up assessment via Zoom, we were greeted with the image of Jasmine's face who welcomed us virtually into their new apartment. Doris was holding her up to us proudly, which was a change from her being hidden away. We saw Jasmine's face change in recognition of us, albeit through the screen, and we saw her play with some toys on the mat with her legs kicking back and forth in the air. She was still quiet, and her face was less expressive than we might have expected, but she was engaged and engaging us.

5. Discussion

The overall aim of this pilot study was to gather preliminary evidence about the outcomes for women and children participating in the SNG. The study included women and children who left a relationship where FV had occurred and who were living in refuges or other transitional housing. We examined pre- to post-intervention changes in: maternal depression, stress and anxiety, trauma symptoms experienced by the mothers, relational withdrawal behaviours in the infant and the quality of the mother–infant relationship. The second aim was to explore the mothers' subjective experiences of the SNG, including their satisfaction with the content and delivery of the program. The strengths of the study will be highlighted as well as its limitations and directions for future research. The implications of the findings for clinical practice and policymakers will then be discussed followed by some concluding remarks.

5.1 Pre- to post-intervention changes in mother and child symptoms and relational behaviours

The first aim of this pilot project focused on gathering preliminary evidence about the psychological and relational outcomes for women and children participating in the SNG. Due to the overall low sample size, it was not possible to conduct rigorous parametric tests because of the limited statistical power to detect any meaningful differences. Nonetheless, there were some observed changes in mean scores for mothers' depressive and dissociative symptoms from pre- to post-intervention. This finding suggested that there were shifts in these symptoms for mothers, which now requires further validation using a larger sample size. Mothers also reported fewer trauma symptoms from pre- to post-intervention. While very preliminary, these results are consistent with previous research demonstrating intervention effects for reducing the experience of trauma for mothers (e.g. Lieberman et al., 2006). We are aware that such changes for mothers in the short and longer term might have been due to factors other than the group intervention as part of the natural healing process that can happen after leaving a violent relationship. However, the current findings do highlight the ongoing need for intervention research to continue to incorporate evaluation measures that focus on specific areas of functioning (e.g. depression, trauma) that are known to impact the mother's overall quality of life as well as her relationship with her children.

Information from the group facilitators indicated changes in the quality of the mother–infant relationship from pre- to post-intervention. That is, findings from the clinician-rated PIR-GAS showed a reduction in the proportion of mothers and infants with scores indicative of a challenging relationship from pre- to post-intervention and 1-month follow-up. With regard to infant social withdrawal behaviour, the proportion of infants with ADBB scores in the clinical range also decreased from pre- to post-intervention and follow-up. The most noticeable decreases in clear or severe unusual behaviour were for facial expressions (e.g. limited expressiveness; face fixed, frozen or sad), vocalisations (e.g. constant crying, whimpering in response to stimulation, absence of vocalisation) and attraction or effort needed by the observer to keep in touch with the infant (e.g. uneasy or disturbing feeling by observer, feeling of being maintained at a distance). An increased ability to reflect on the needs of the infants was evident for most of the mother–infant dyads. Being able to consider the thoughts, feelings and experiences of a child, especially young children, supports the child's affect regulation, secure attachment and resilience (Rexwinkel & Verheugt-Pleiter, 2008; Slade, 2005). For example, infants who were observed to be more relationally withdrawn would seek out their mother to play games or when they needed comforting instead of avoiding them. In turn, the mothers of these infants seemed to wonder more about the needs that were being communicated by their child through their behaviour and affect. They also seemed to be more curious and empathic in their responses to their infants. This positive feedback loop is likely to strengthen the mother–child relationship with each additional experience and contribute to deepening the mother's understanding of her child. However, again the lack of statistical power meant that the program's effect on the mother–child relationship was not able to be substantiated statistically.

5.2 Exploration of mothers' subjective experience of the SNG program

The qualitative interviews with the majority of the mothers provided a rich insight into their experiences of the SNG program for themselves, their children and the dyadic relationship. The findings from these interviews will be discussed, drawing together the different themes and subthemes as presented in the results section above.

Overall, the women reported finding the SNG program very useful for a range of reasons. Some reported that they experienced the group as culturally safe and felt comfortable sharing aspects of their lives. The group seemed to provide an experience of universality – an experience which Yalom (1995) recognised as an important factor for therapeutic change. Many of the women also likened the group to a playgroup rather than a therapy group. Experiencing the group in this way was possibly less stigmatising for the women and more sensitive to their cultural needs. According to the IPV Stigmatisation Model (Overstreet & Quinn, 2013), the potential for stigma can be feared; women hold the belief that they will be judged by others in their network if they discuss their experiences of FV. This can serve as a significant barrier to accessing support and intervention (Murray et al., 2016). In this context, the current program might have alleviated some of this fear by it being likened to a playgroup. The reference to a playgroup is also consistent with the emphasis on the program being infant led and giving voice to the mother and child. It also possibly resonated with the mothers because it is familiar to them and created some normalisation of their experience.

Consistent with the trends from the self-report outcome measures, the mothers reported that they experienced an overall reduction in their anxiety and parenting-related stress following participation in the SNG. This finding holds significance in the context of previous research showing that mothers' experiences of psychological and traumatic stress can impact their parenting because they feel less available for their children and more stressed in the parenting role (Meijer et al., 2019). The current results suggested that the SNG helped mothers to feel stronger emotionally and more confident overall. These shifts are likely to translate directly to their parenting experience, which, in turn, could impact positively on their child's development and attachment over time.

Women in this pilot study also noted that they had greater insight into the impact of FV on their children following participation in the group, even though this seemed to be difficult for some mothers to think about. The mothers came into the group knowing that FV is not acceptable, while acknowledging that they did not want their children growing up in a house where it was occurring. However, participating in the SNG possibly helped them to better understand that FV impacts children regardless of their age and whether or not they directly witness it. This finding highlights the ongoing need to support women to support their children in the context of FV and to find a narrative that helps to give meaning and significance to their experience over time. Importantly, some of the women acknowledged that they would have liked more structure and support around the sharing of FV experiences during the group program. Further work is required to determine how this would best be done to ensure a safe and contained environment that does not trigger the women in unhelpful ways and disrupt the therapeutic process between them and their infants. It would also require an assessment of their level of readiness to discuss violence during the psychosocial assessment prior to the commencement of the group. Careful consideration would also need to be given to whether or not the infants should be present or resources available for infants to be cared for in another room while women have time to more fully discuss their experiences.

The women also reported better understanding of the developmental needs of their children during the course of the group. Despite the group being a brief intervention, infants have a significant capacity for change and psychological growth (Bunston, 2008). The observations provided by the mothers were also consistent with those of the facilitators who noticed developmental improvements in the children as reflected in the case study of Jasmine and Doris. Overall, the children showed an increased capacity to regulate their emotions, while

also seeming to benefit from the structure of the group. This structure, as well as the consistent presence of the facilitators, possibly helped the mothers to translate more routine and predictability to the home environment.

The women also reflected that the group reminded them of the importance of engaging in play with their children. They noted that they were often preoccupied with their internal and/or external pressures, which were barriers to being in the moment with their children. Becoming more aware of the importance of play, and having shared time, has the potential to further benefit the mother–child relationship as well as the child's development (Nijhofa et al., 2018). Research has shown the importance of unstructured play for developing independence, emotional/behavioural self-regulation and social skills (Gibson et al., 2017; Pellis & Pellis, 2007). Childhood play is also "the most natural medium of self-expression" (Kaduson, 2006, p. 10). The more that children have the opportunity to play, which was modelled and supported during the SNG, the more likely they are to communicate their internal experiences, including those associated with the trauma of being exposed to FV (Kaduson, 2006).

The positive changes described for the children, their mothers and the mother–child relationship, are consistent with the emerging evidence supporting brief interventions for women and children impacted by FV (Fogarty et al., 2022). Considering the unpredictability of the lives of most of the families in the group due to living in transitional housing, a brief program fits well with the post-crisis landscape they are adjusting to and helps to promote a re-adjustment to living.

5.3 Strengths of the SNG

There are several clear strengths in implementing the SNG program with this cohort of vulnerable women and their children who have experienced housing insecurity. The program was manualised, and as such, the session structure was the same for all groups. However, there was flexibility in the activities and approaches within each session so that it could be tailored to the specific and evolving needs of the mothers and their infants.

Delivering a program that is not prescriptive meant that the facilitators could respond to the changing social-emotional needs of infants, as well as the emerging themes of the group in the here and now. The group process allowed for the program to move organically, unfolding in a heterogeneous manner. The psychodynamic structure of the program allowed the group to act as a container to hold and "contain the *actual* as well as the *psychic* mess and pain brought by mothers and the children" (Paul & Thomson-Salo, 1997, p. 233). This is especially important when considering the varying degrees of trauma and traumatisation the participants reported. The group existed as an intimate space developed around the shared experience of mothering in the context of FV. An example of the "holding" effects of this group was seen with the women consistently communicating when they were unable to attend and asking for this information to be shared with the other participants cognisant that their absence might trigger concern or some disruption. Although this phenomenon needs to be better understood, it parallels the function of keeping the baby in mind and being held in mind (Slade, 2005, 2007).

There are currently very few Australian studies that have delivered therapeutic programs for mother–children dyads from CALD backgrounds. While the SNG program was not designed exclusively for CALD participants, it promotes diversity, inclusion and cultural safety that supports the recommendation for specialist FV services to eliminate barriers for women and children from CALD backgrounds in accessing help for FV (State of Victoria, 2016a). Of the women who participated in the group program, 8 of the 17 were born overseas and spoke a language other than English at home. The facilitators adopted a cultural and historical trauma lens to better understand the intersections between cultural identity, race, ethnicity, gender, religious beliefs, socio-economic status, sexual orientation and ability (Ghosh Ippen, 2009). Guided by the diversity-informed tenets for infant mental health practice (Ghosh Ippen, 2012), conversations about different cultural practices of parenting, including those of the facilitators, were interwoven with wondering about the infant's experience rather than "teaching" mothers how to parent differently. In delivering an infant-led program that is not prescriptive, facilitators were able to

strengthen the quality of the mother–child relationship (Ghosh Ippen, 2012) by taking time to better understand the family's story, its culture and history, and how this shapes their experiences of FV.

5.4 Study strengths and limitations and directions for future research

The current pilot study begins to address a critical gap in the literature on interventions for women and infants who are living in a refuge or transitional housing following FV. The findings highlighted that it is possible to engage this hard-to-reach and culturally diverse sample of women and infants in a group-based intervention targeting their mental health and relationships. Despite the multitude of disruptions, including delivery during the COVID-19 pandemic, only a small number of women dropped out of the intervention and the research study. FV research with hard-to-reach populations typically reports high rates of attrition (Meijer et al., 2019), but the rate of attrition in the current study was relatively low (10.5%). This is likely due to the specialist clinicians' strong engagement and focus on building relationships and trust with the women throughout the referral and psychosocial assessment process. The clinicians also focused their efforts on understanding and overcoming potential barriers to the women's attendance in the assessment and intervention sessions. It is also likely that careful attention to tailoring each SNG session to the women's and infants' needs helped them to feel safe and supported in the group and with each other. That is, while the program was manualised many of the women also reflected that their children felt a sense of belonging, which helped them to stay connected to the group.

The multi-methods approach was a particular strength of this pilot study. A rich understanding of women's experience of the SNG program and outcomes for them and their infants was made possible by the comprehensive psychosocial assessment methods incorporating: a) maternal self-report surveys; b) clinical observations of infants and their interactions with their mother; and c) qualitative interviews with women. The program gives voice to the lived experience of those women and children who have been exposed to FV. While some mothers reported finding the assessment challenging, it did provide a rich insight into the complexity of their lives and the multiple impacts of FV. It would be important, nonetheless, to continue to refine the assessment protocol so as not to be a potential barrier to engagement.

Despite the strengths of the study, some limitations must also be acknowledged. The small sample size was limiting. The number of women and children able to participate in the project was limited for practical reasons related to the number of dyads who could be recruited for each group. It was not possible to have more than six dyads in any one group at a time due to the importance of holding the space for the participants and to optimise the therapeutic effects. Although this might sound like a small group size, when the two facilitators and a trainee/student are included, the group size can be as large as 15 people. Capping the number of dyads per group was important for clinical reasons because it allows each mother and infant to be more than adequately supported by the facilitators, which is essential when working with vulnerable populations. While capping created a practical limitation to the number of dyads who could be recruited for each group, there were also other contextual variables that further impacted recruitment.

The most significant of these contextual variables was COVID-19 and the associated lockdowns. These lockdowns and related stress made it hard to recruit participants because there was uncertainty regarding whether or not the groups would go ahead and in what capacity. We experienced unexpected and unforeseen events due to COVID-19 that impacted upon the implementation of the pilot project (e.g. lockdowns effecting timely follow-up assessments, illness of the ADBB trainer, illness of participants). It is also possible that COVID-19 impacted on the mental health data at the post- and follow-up stages because of its more general impact on wellbeing and motivation. Finally, although a longer-term follow-up beyond 1 month would have enabled us to determine whether changes in mental health and relationships became more apparent in the long term or whether improvements were maintained over time, this was not conducted for practical reasons (e.g. a minimising

of study drop-out due to a highly transient cohort moving from refuge and transitional housing to more stable housing).

A further limitation of this pilot project was that we conducted all assessments and group activities in English. While we offered some participants the use of an interpreter when indicated, mothers did not want to use this service possibly because of privacy concerns. Therefore, given that English was a second language for some participants, it is possible that this acted as a barrier to being able to fully access the group materials.

There are a number of important directions for future research, including the need for more rigorous evaluations of the SNG program with larger cohorts of women and children using an RCT design with a long-term follow-up. This would help to better understand the effectiveness of the program over time. Further understanding the experiences of women from a range of diverse cultural backgrounds would help to further elucidate the needs of these women and children and how to best create cultural safety for them. Similarly, areas for future research are to consider the appropriateness of the SNG for Aboriginal and Torres Strait Islander families, women with a disability and LGBTQ+ families. Finally, continuing to develop a trauma-informed assessment protocol that lends itself to the observation of trauma symptoms in infants and children would also be beneficial, as well as delivering the SNG program to groups of women and children in different community settings. This might also increase the reach and accessibility of the program.

5.5 Implications of the current findings for clinical practice and policy

The RCFV (State of Victoria, 2016a) identified a small number of services within Victoria that provided therapeutic support to children. However, a strong evidence base for these interventions was lacking. The current pilot study goes some way to addressing this gap by implementing an intervention that is grounded in theory and which gives voice to mothers and their children. This intervention, while relatively small in scope, highlights the importance of engaging women through creating a safe and welcoming space that is specifically focused on their needs as well as the needs of their children. Running a therapeutic program in an environment that is familiar to the women and their children is also important because it supports initial engagement and completion. Such an environment serves to provide a "safe haven" for the women and their children when the family home has not always provided such a haven (Meijer et al., 2019). This reinforces the importance of providing trauma-informed care in the FV sector to ensure safety and to minimise the risk of re-traumatisation. It is imperative that service providers receive appropriate and ongoing funding to support the training of their staff in this care model.

The women in the current pilot study reported that they wanted greater access to services and/or support following the SNG and/or for the group to continue. Efforts were made by the Emerge practitioners to link women and infants into additional specialist services following the group, if needed and/or requested. This included referrals to the infant team at CYMHS/CAMHS to provide multidisciplinary clinical assessment of infants thought to have developmental delays and/or signs of poor mental health. Mothers who wanted to learn more about how to build stronger emotional communication and connection with their infant were linked to child-focused programs such as Tuning in to Kids (Havighurst & Kehoe, 2021) or Circle of Security (Cooper et al., 2005). It is important to note that during the period of the research project, infant mental health options for dyads who had experienced FV were frequently limited or unavailable due to prohibitive factors such as location and cost. This finding reinforces the need for long-term therapeutic as well as practical support and a wraparound service model that is not only integrated but also meets the women where they are at (Hegarty et al., 2016). In this context, policymakers need to ensure that funding models recognise the ongoing and often changing needs of women and families who have experienced FV, increase accessibility to services and ensure that there is continuity of care over time. This is in line with the Department of Human Services's (now

Department of Families, Fairness and Housing [DFFH]) *Practice Guidelines: Women and Children's Family Violence Counselling and Support Programs* (see Grealy et al., 2008). The success of a wraparound model also relies on training service providers in collaborative care. That is, providers need to understand the importance of professional liaison across services to ensure that women do not have to continue to repeat their story. Collaborative care is also containing for these women; they feel held by the services working with them, which can translate to them feeling more settled in their personal lives. A wraparound model would help to address the typical pattern of services/professionals working in silos without consistent/regular communication (Mason et al., 2017; Vlais et al., 2014).

It is also critical for professionals/agencies working in the FV space to recognise some of the barriers to engaging in services. The women who participated in the current study identified some of these barriers as their own mental health issues, as well as illness in their child or other contextual factors such as appointment clashes and transport. It is imperative for service providers to identify these barriers early and work closely with the women to support them to facilitate engagement in treatment. Some women might need to receive support for their mental health issues prior to engaging in dyadic work (Fogarty et al., 2021). As was found in the current study, practical support in the form of taxi vouchers and reminder texts might also help to engage women in treatment.

The current findings highlight the sense of connection and community that group programs can provide to women who have experienced FV. Previous research funded by ANROWS has also emphasised the importance of harnessing the leadership and support that is provided by community members. For example, Vaughan et al. (2015) found that many members of the local CALD communities were providing important but more informal support for women impacted by FV. The women in the current study also emphasised how important it was for them to feel supported by members of the SNG and how they wanted to remain in touch after the group to continue receiving this informal support that helped to provide an experience of universality. Community members can provide valuable local knowledge that policymakers can harness to develop targeted programs both in the intervention and prevention space (Vaughan et al., 2015).

Our findings reinforce the important role that therapeutic programs play in supporting the parent–child relationship and child development following experiences of FV. Women in the current study reflected that they came to better understand the developmental needs of their children by observing other children in the group while also observing the facilitators. This is consistent with previous research showing that dyadic child–parent interventions that are based on trauma and attachment theory are effective for improving the mother–child relationship, which is critical in the recovery from FV (Buchanan, 2013; Hegarty et al., 2016). Specialist clinicians working with women impacted by FV need to recognise their capacity to develop skills in mentalisation and to provide opportunities to foster this skill. This could be done by referring them to a suitable program or engaging the women and their children in dyadic work. In dyadic work, the clinician can support mothers to see how their children's behavior is a representation of their thoughts and feelings, while interactions during the session can provide opportunities for emotion coaching (Gottman & DeClaire, 1998; Kaduson, 2006).

Violence against women is now considered one of the most significant human rights and public health problems in Australia and worldwide (Marcus & Braaf, 2007). While the Australian public are showing an increased understanding of violence against women (Webster et al., 2018), there is still more work to be done in improving women's understanding of how to recover from violence. Policymakers and specialist clinicians need to articulate pathways for women who have experienced violence to reclaim a sense of safety and autonomy in their lives. Working with these women to find a sense of purpose while supporting them to re-engage with the community *may help them to feel a sense of self-efficacy.* However, this requires a consistent focus from professionals working with these women to scaffold what a more autonomous existence would look like. For example, they could start by encouraging the women to imagine what a different

future might look like and what they see themselves doing with support.

Policymakers need to ensure that women have choice and autonomy around the services that they access. Currently, women face many barriers in accessing support for their children following FV. Increasing the accessibility and availability of services is likely to increase the sense of parenting self-efficacy and empowerment experienced by these women.

Funding evidence-based infant mental health interventions for mother–infant dyads who have experienced FV is an important prevention strategy for the mental health and wellbeing of children and might interrupt intergenerational cycles of trauma and FV. The research tells us that infants simply cannot afford to wait to receive therapeutic intervention following FV (Bunston et al., 2021). An infant's development and future depend on early intervention either remediating the harm caused or promoting resilience. Thus, a specialised workforce is needed. A priority area of Victoria's FV reform was to develop an expert workforce of diverse professionals who have specialist knowledge of FV policy, practice and responses. While the needs of children are clearly identified in this reform, there is an ongoing need to provide specialised/specialist training in infant mental health within the FV sector. This will increase the confidence and competence of FV practitioners to support young children and women, as well as increase accessibility to early intervention services.

5.6 Concluding remarks

A range of counselling, group work and play-based therapeutic interventions exist for children exposed to FV. However, very few programs have a specific focus on a dyadic approach to the healing process for mothers and children exposed to abuse (Rizo et al., 2011). The current pilot project helped to fill this gap by evaluating an infant-led intervention for women and their children who had left FV and who had experienced housing instability. The focus was on giving voice to the infants and their mothers because the research is clear in telling us that both need to be heard. The partnership between Swinburne University, Emerge and Murdoch Children's Research Institute (MCRI) helped to ensure methodological rigor with findings that have direct application for clinical practice and policymakers.

While the small sample size did not lend itself to significance testing to assess change in mental health and trauma symptoms experienced by mothers and their infants across time, the results from the qualitative interviews and case studies captured the more nuanced experiences and potential benefits of the SNG for women. The mental health of some women in the program improved, and the program seemed to help them to better understand the needs of their children while also appreciating the importance of play and engagement. The group also provided many of the women with a sense of security and safety to start to share their story of FV, to connect with others and to experience a sense of autonomy. There were also reported benefits to the children, including greater capacity for regulation and a positive response to the structure and routine of the group. The benefits of the program can provide an important platform from which the women and their children can continue to grow and develop through the process of recovery.

This pilot project, while relatively small in scale, highlights the need for future evaluation research of the SNG program and has direct and significant implications for professional practice and policy. The project aligns closely with the Luke Batty Foundation Legacy and addresses key knowledge gaps identified by the RCFV by giving an important voice to women and their children and helping them on their road to recovery from FV.

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APPENDIX A

Table: Key characteristics of the reviewed interventions

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
Mother–child dyadic interventions									
Jouriles et al., 2009, 2001; McDonald et al., 2006	Project Support	To reduce conduct problems among children exposed to IPV through reducing harsh and inconstant parenting practices	4–19 years	Parenting strategies (e.g. listening to your child, praising, reprimanding), safety, emotional support	Child development theory	Skill development, role plays, psychosocial support	Mother–child sessions	Not reported	8 months (mean of 20 sessions, range of 2–40)
Lieberman et al., 2005, 2006	Child–parent psychotherapy	To improve the child's emotional, cognitive, and social functioning through a focus on safety, affect regulation, the joint construction of a trauma narrative and engagement in developmentally appropriate goals and activities	3–5 years	Play, sensorimotor disorganisation and disruption of biological rhythms, fearfulness, recklessness, self-endangering and accident-prone behaviour, aggression, punitive and critical parenting, the relationship with IPV perpetrator, treatment termination	Psychodynamic, attachment, trauma, cognitive behavioural, and social learning theories	Dyadic psychotherapy and play therapy	Mother–child sessions	60 minutes	50 weeks

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
Waldman-Levi & Weintraub, 2015	Family Intervention for Improving Occupational Performance (FI-OP)	To improve mother–child interaction and children's play functioning	13–72 months	Mother–child interaction, reciprocity, playfulness, play skills	Attachment theory Social learning theory and social-cognitive theory	Therapists the following methods of delivery: mediation, modelling, consultation, environmental organisation and adaption, reframing, enabling and reflection	Mother–child sessions	30 minutes	8 sessions
Timmer et al., 2010	Parent–child interaction therapy (PCIT)	Aims to enhance the parent–child relationship, improve child compliance and promote positive parenting practices	2–7 years	Two phases: 1) child-directed interaction, which coaches parents to follow their child's lead in play, describe their activities, reflect their verbalisations and praise positive behaviour; 2) parent-directed interaction, which coaches parents to provide clear and direct instruction for maximise compliance and use time out methods for non-compliance	Social learning theory and attachment theory	Didactic training	Mother–child sessions	1-hour plus observational coaching	14–20 weeks

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
Herschell et al., 2017	Parent–child interaction therapy (PCIT)	Aims to enhance the parent–child relationship, improve child compliance and promote positive parenting practices	2.5–7 years	Two phases as per Timmer et al. (2010)	Social learning theory Attachment theory	Didactic training	Mother–child sessions	1-hour plus observational coaching	14–20 weeks
Bunston et al., 2016	Peek-a-Boo Club™	To repair relational ruptures and attachment difficulties arising following exposure to IPV	0–4 years	Weeks 1–3 – engagement, safety, ritual development (e.g. hello and goodbye songs), needs of infants. Week 4–6 – talking about fathers, family of origin, limit setting, the "watch, wait and wonder" approach. Weeks 7–8 – group directed, group closure	Object relations theory, attachment theory and social justice practices	Infant-led practice and play therapy	Mother–child group sessions	2 hours	11 sessions
Concurrent mother and child interventions									
Overbeek et al., 2013	"It's my turn now!"	Child: to process inter-parental violence experiences, to learn how to differentiate and express emotions, and to learn to cope with feelings and problems in a different (non-violent way). Parent: To increase knowledge about the impact of IPV on children and to improve parenting and disciplinary skills	6–12 years	Child group: affect modulation, emotion regulation, coping, social skills, and enhancing future safety and development. Parent group: psychoeducation, parenting and discipline skills, interpretation of children's emotions and actions, and parent's own emotional adjustment	Trauma theory	Psychoeducation/not reported	Mother and child groups	1.5 hours	9 weeks

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
Graham-Bermann et al., 2007	The Kids Club and Mom's Empowerment Program	The Kids Club program aimed to increase children's knowledge of IPV, address attitudes and beliefs and families and IPV, enhance emotional adjustment and social behaviour The Mom's Empowerment Program aims to increase parenting capacity, social connection and provide a safe place to discuss concerns	6–12 years	The Kids Club group: establish safety, develop a therapeutic relationship and assist in developing a common language to express emotions and experiences of violence The Mom's Empowerment Program: psychoeducation of the impact of IPV on child development, skill development (discipline and parenting skills)	Social-cognitive theory, social learning theory and trauma theory	Not reported	Mother and child groups	Not reported	10 weeks
Graham-Bermann et al., 2015	The Preschool Kids Club and Mom's Empowerment Program	As above	4–6 years	As above	As above	Not reported	Mother and child groups		5 weeks
Basu et al., 2013	The Kids Club group and Mom's Empowerment Program	Child group: to decrease experiences of shame and increase emotional expression, and their sense of mastery over social behaviour	3–12 years	Child group: Parent group: parenting (e.g. empathy, discipline, and communication), emotional and practical support (e.g. safety, child custody, and legal proceedings)	Social-cognitive theory, social learning theory and trauma theory	Psychoeducation	Mother and child groups	1.5 hours	10 weeks

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
Becker et al., 2008	Haupoa Family Component	Child group: aimed to provide a safe setting for children to learn about IPV, explore their attitudes and beliefs around violence and promote positive coping strategies. Parent group: to assist parents to support their children cope with exposure to IPV and increase their parenting skills	3–17 years	Child: safety skills, trust building, self-awareness, understanding and expressing emotions, communication, "naming domestic violence", empathy, non-violent conflict resolution, self-esteem, self-blame, and gender stereotypes. Parent group: paralleled child group with parent's own adjustment, self-esteem and mental wellbeing	N/A	Psychoeducation, experiential activities (e.g. role plays, play, topic appropriate stories) and cultural emphasis on symbolism	Non-offending parents/ guardians and child groups	90 minutes	12 weeks
Grip et al., 2012	Child Are People Too (CAP)	To reduce children's general behavioural problems and social impairment	4–19 years	Education about violence, safety planning, feelings, defences, risk and choices and parent–child communication	Not reported	Play therapy, art therapy psychoeducation and "talk therapy"	Mother and child groups	1.5 hours	15 weeks

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
Pernebo et al., 2018, 2019	Child and Adolescent Mental Health Services Intervention (CAMHSI) – Psychotherapeutic	To decrease children's psychiatric symptoms, to help children express and understand their emotions, thoughts and experiences and reduce feelings of shame and alienation. Parent group aimed to increase parenting knowledge and skills, reduce feeling of shame and alienation and strengthen to parent–child relationship	4–13 years	Violence within the family, separation, visitations, fears, grief, and conflicts in daily life	Trauma theory, attachment theory and psychodynamic theory	Trauma focused play, free play, dialogue, exercises	Mother and child groups	1.5 hours	12–15 weeks
Pernebo et al., 2018, 2019	Community-based intervention (CBI) – Psychoeducative	Based on the Children Are People Too Program the intervention aimed to improve children's coping, increase their understanding of their emotions, thoughts and experiences and decrease feelings of alienation and shame. The aim of the parent group was to increase parenting knowledge and skills; reduce parent's feelings of alienation and shame	4–13 years	Education of violence, safety planning, reaction to IPV, family relationships and communication	Not reported	Play therapy, art therapy and psychoeducation	Mother and child groups	1.5 hours	12–15 weeks

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
Carter et al., 2003		Child group: 1) to build safety planning skills, self-esteem, emotional expression, pro-social skills and identify and strengthen support systems; 2) to provide a safe space conducive to self-disclosure and therapeutic intervention to health trauma responses Parent group: 1) to assist parents to encourage their children to be non-violent, express emotions, and feel safe at home; 2) to provide support for parents and their families	4–18 years	Safety planning, emotion regulation, violence education, communication	N/A	Psycho-education and play therapy	Parent and children groups*	1.5 hours	11–12 weeks
Macmillan & Harpur, 2003		The child group aims to address trauma symptoms through the creation of a safety and trusting therapeutic space for children to express their thoughts, feelings and experiences. The parent group aims to improve the parent child relationship through increasing the parents' understanding of their child's experience and to promote positive discipline practices	6–12 years	Identifying and expressing emotions, safety planning, problem solving, education about all forms of IPV, relaxation	Trauma theory	Psycho-education, experiential exercises	Mother and child groups	1.5 hours	10 weeks

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
Combined dyadic and concurrent mother–child interventions									
Cohen et al., 2011	Trauma-focused cognitive behavioural therapy (TF-CBT)	To improve PTSD symptoms and psychopathology in children exposed to IPV	7–14 years	Psychoeducation about trauma, relaxation skills, cognitive coping skills, correcting maladaptive cognitions about trauma. In the joint parent–child sessions children are encouraged to share IPV experiences with their mother	Trauma theory	Trauma focused CBT	6 concurrent individual sessions for children and parents and two joint parent–child sessions	45 minutes	8 sessions
McWhirter, 2011	Emotion-focused intervention	To decrease relational based non-adaptive coping (e.g. isolation) and family conflict and increase family bonding	6–12 years	Child: identifying feelings associated with family transitions, understanding, expressing and integrating these feelings, understanding behaviours of self and others, learning and recognising abuse, keeping safe in abusive situations. Exploring personal belief systems, understanding different forms of abuse, understanding and expressing feelings, recognising healthy relationships, and finding healthy ways to cope with stress	Trauma theory	CBT and gestalt therapy	Concurrent separate mother and child groups followed by joint mother and child therapy group	1-hour group for mothers; 45-minute group for children and 1-hour joint session	6 weeks

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
McWhirter, 2011	Goal-oriented intervention	Child group aimed to empower children to realise that they have the choice to change aspects of their life Mother group aimed to increase internally guided change and decrease maladaptive coping	6–12 years	Adaptive and non-adaptive coping mechanism, identification of goals, conceptualising steps to reach goals	Trauma theory; Transtheoretical Model	CBT, motivational interviewing and art therapy (child group)	Concurrent separate mother and child groups followed by joint mother and child therapy group	1-hour group for mothers; 45-minute group for children and 1-hour joint session	6 weeks
Sullivan et al., 2004		To increase parenting skills, increase coping skills and safety planning of mothers and children, and decrease the impact of post-violence stress	M Age = 8 years	Child group: development of safe space, safety planning, resolutions of trauma symptoms, self-blame, conflict resolution skills. Parent group: developing safety planning, parenting skills and provision of social support	Feminist theory	CBT & systemic intervention approaches	Concurrent mother and child groups followed by a joint mother child group		9 weeks

Author	Intervention	Aims	Age range	Topics covered	Theory	Modality	Format	Session duration	Intervention length
Smith et al., 2015	Domestic Abuse, Recovering Together (DART)	Strengthen the mother–child relationship, reduce child emotional-behavioural difficulties, increase mothers' and children's self-esteem, increase parenting confidence	7–11 years	Not reported	Attachment theory		Concurrent separate mother and child groups of 5 sessions and joint mother–child groups for remaining 5 sessions	2–2.5 hours	10 weeks
Woollett et al., 2020	Art and play therapy	To reduce child depressive and PTSD symptomology	5–14 years	Child group: creating a safe space, relaxation and emotion regulation skills, cognitive coping skills, trauma narrative and cognitive processing of trauma, psychoeducation. Parent Group: parenting skills, psychoeducation on trauma and impact on development and parenting	Trauma-theory	Trauma-informed CBT, play therapy, art therapy, client-led	Child only groups for 9 sessions, conjoint mother–child groups for 3 sessions	1–2 hours	12 weeks

Note: * Parents consisted of 52 non-offending parents, 8 offending parents who had completed a family violence treatment program, and 4 non-offending partners.

APPENDIX B

Table: Key characteristics and findings from included studies

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
Mother-child dyadic interventions									
Jouriles et al., 2001	USA	36 mothers and children	Recruited from domestic violence shelters	RCT	Monthly phone calls	CBCL Direct observation of mothers' child management skills SCL-90 R IES	11 African America, 10 Caucasian, 12 Latino, 1 Asian American and 2 classified as other	Pre-, post- & follow-up	• Compared to families in the control group, children who participated in Project Support demonstrated significant faster reduction in externalising problems over time • Mothers within the treatment condition reported a significantly faster increase in maternal child management skills • Significant reductions also reported in maternal psychopathology symptoms. However, these did not differ significantly from the control group
Jouriles et al., 2009	USA	66 mothers and children	Recruited from domestic violence shelters	RCT	Monthly phone calls	CBCL ECBI PDI CTS-R parent-child SCL-90 R IES	38.2% Black, not of Hispanic origin; 20.6% Hispanic; 41.2% White	Pre-, post- & follow-up	• Compared to families in the control group, children who completed Project Support reported a significantly more rapid reduction in externalising behaviours at post-treatment • At the follow-up assessment, only children from the treatment group experienced a further reduction in externalising behaviours • Mothers in the treatment group reported more rapid reductions in inconsistent and harsh parenting than those in the control group • Although maternal psychiatric symptoms decreased for both groups from pre- to post-, continued significant reduction at the follow-up assessment were observed for the treatment group only

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
McDonald et al., 2006	USA	30 families	Transition from domestic violence refuge to home	Quasi-experimental	Monthly phone calls	CBCL DSM-IV structured interview CTS-R parent–child	9 Caucasian, 1 African American, 8 Latino, 1 Asian American, 1 other	Pre-, post-, 2-year follow-up	• Compared to children in the control group, those in the treatment group displayed significantly lower levels of externalising behaviour and higher levels of happiness and social support at follow-up • At the time of the follow-up, mothers in the treatment group were less likely to use aggressive discipline strategies towards their child and less likely to return to their partner
Lieberman et al., 2006	USA	75 mother and children	Community	RCT	Case management and individual psychotherapy	CBCL Semi-structured Interview for Diagnostic Classification SCL-90-R CAPS	38.7% mixed ethnicity (predominately Latino/white, 28% Latino, 14.7% African American, 9.3% White, 6.7% Asian, 2.6% Other	6-month follow-up	• At 6 months following the treatment conclusion, both mothers and children were experiencing significantly fewer trauma symptoms than those in the control group

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
Lieberman et al., 2005	USA	75 children and mothers	Community	RCT	Case management and individual psychotherapy	CBCL Semi-structured Interview for Diagnostic Classification SCL-90-R CAPS	38.7% mixed ethnicity (predominately Latino/White, 28% Latino, 14.7% African American, 9.3% White, 6.7% Asian, 2.6% other	Pre- post-	• In comparison to those receiving case management, significant reductions were identified in children's behavioural and trauma symptoms and mothers' avoidance symptoms
Waldman-Levi & Weintraub, 2015	Israel	37 mother child dyads	Domestic violence refuge	Quasi-experimental	Play group	R-KPPS ToP CIB	35% Asia, 30% Europe, 30% Africa, 5% North America	Pre-, post-	• Improvements in overall mother–child interactions, sensitively and limit setting compared to families in the control group • Children in the FI-OP group demonstrated significantly improved play skills compared to those in the comparison group
Timmer et al., 2010	USA	129 mother–child dyads	Community/ home based	Quasi-experimental	Children not exposed to IPV	CBCL ECBI PSI SCL-90R	63% White/ non-Hispanic, 9% African America, 22% Latino	Pre-, post-	• Children exposed to IPV who completed PCIT with their caregiver demonstrated significant and large reductions of child externalising and Internalising behaviour • Parents reported a significant reduction in psychological symptoms but not parenting stress

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
Herschell et al., 2017	USA	21 parent–child dyads	Domestic violence refuge	Non-randomised intervention	Nil	The Life Stressors Checklist revised ECBI APQ SCL-90-R PLOC	52.4% White, 47.6% Black or African American, 4.8% American Indian or Alaska native	Pre-, post-	• Significant reduction in children's behavioural problems • Significantly improved parental discipline and perceptions of parenting control • Significant reduction in parents mental health symptoms
Bunston et al., 2016	Australia	105 mothers and 133 infants	Child & Adolescent Mental Health Services	Non-randomised intervention	Nil	BITSEA PIR-GAS MPAS	62.5% Australian, 8.5% African, 3.9% Asian, 3.9 % other, 21.2% not disclosed	Pre-, post-	• Post-intervention, mothers rated their children as significantly more social and to display less behavioural problems • Improvements in the mother–child relationship were demonstrated on both the PIRGAS and the MPAS
Concurrent mother and child interventions									
Overbeek et al., 2013	The Netherlands	155 mother–child dyads	Community	RCT	Group program that did not target specific factors	CBCL, TSCYC, CTS2, Child parent conflict tactics scale	43% Dutch, 18.7% Turkish/Moroccan, 20% Antilles/ Suriname, 18.1% other countries	Pre-, post-, follow-up	• Both treatment conditions displayed significant reductions in children's internalising, externalising and trauma symptoms at post-treatment and these were maintained at follow-up • No significant differences found between the groups

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
Graham-Bermann et al., 2007	USA	181 children and their mothers	Community	Quasi-experimental design	Wait-list control	CBCL AAFV	52% Caucasian, 34 % African American, 9.5% biracial, 4.5% other	Pre-, post-, 8-month follow-up	• Compared to children allocated to a control group, or the child only group, those whose mothers also participated in the parenting group demonstrated significantly larger decreases in externalising-behaviour problems from baseline to post-treatment. Moreover, this significant treatment effect was maintained at 8-month post-treatment completion
Graham-Bermann et al., 2015	USA	120 mother–child dyads	Community	Quasi-experimental design	Wait-list control	CBCL	38% Caucasian, 37% African American, 8% Biracial, 6% Latino/a 1% other	Pre-, post-, 8-month follow-up	• Compared to children allocated to the control group, children who took part in the intervention demonstrated a significantly larger reduction to internalising symptoms at post-treatment • Female children who participated in the intervention has significantly larger decreases in internalising symptoms from baseline to follow-up
Basu et al., 2013	USA	36 mothers, 20 children	Recruited from community agencies and domestic violence shelters	Quasi-experimental design	Wait-list control	BSI BDI TSCL Harter's Pictorial Scale of Perceived Competence and Social Acceptance for young children	50% African America, 30% European American, 15% multiracial, 5% Latino	Pre-, post-, 6-month follow-up	• No significant differences for maternal depression or anxiety • Children in the control group demonstrated a decrease in anxiety and depressive symptoms compared to the intervention group • A trend in decrease in anxiety and depressive symptoms was observed in the intervention group

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
Becker et al., 2008	USA	106 mother–child dyads	Community	Non-randomised intervention	Nil	CBCL Clinician rated scales on child's domestic violence knowledge, strengths and pro-social skills. Clinician rated item of parent's domestic violence knowledge and skills and parenting practices	52.8% identified as multi-ethnic (predominately reporting Caucasian, Chinese, Hawaiian, Japanese and Filipino background). Of those reporting sole ethnicity 30% identified as Hawaiian and 10.4% Caucasian	Pre-, post-	• At post-intervention, both children and mothers were reported to have increased DV related skills and children were reported to experience a reduction in externalising and internalising problems • At post-intervention, parents were also reported to have an increase in parenting skills
Grip et al., 2012	Sweden	51 mothers, 70 children	Community	Non-randomised intervention	Nil	SDQ IES Self-report trauma rating	47% born in Sweden, 27% born in Europe, 26% born outside of Europe	Pre-, post-, 1-year follow-up	• Children displayed significant improvements in SDQ scores from pre- to post-intervention; however, these were not maintained at 1-year follow-up

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
Pernebo et al., 2019	Sweden	50 mother–child dyads	Child & Adolescent Mental Health Services	Quasi-experimental design	Psychoeducation group	SDQ TSCYC EQ-P BSI	CBI group- 61% born in Sweden, CAMHSI group – 74% born in Sweden	Pre-, post-, 6-month and 12-month follow-up	• Both intervention types demonstrated significant decreases in SDQ, TSCYC and EQ-P from pre intervention to 6 months follow-up. All sustained for psychotherapeutic group at 12-month follow-up. • Comparison- Psychotherapeutic group reported a large effect size in comparison to a small to medium reported by psychoeducation group • Maternal mental health was found to moderate change on children's SDQ and TSCYC
Pernebo et al., 2018	Sweden	50 mother–child dyads	Child & Adolescent Mental Health Services	Quasi-experimental design	Psychoeducation group	SDQ TSCYC EQ-P BSI	CBI group- 61% born in Sweden, CAMHSI group – 74% born in Sweden	Pre-, post-	• Children in CBI group showed improvement in emotional problems (SDQ) and total TSCYC scores with mothers reporting improvements in trauma symptoms and general mental health • Children in the CAMHSI group showed improvements in total SDQ score, emotionality (EQ-P) and trauma symptoms and mothers reported a decrease in trauma symptoms • Compared to those in the CBI group, families in the CAMHSI group reported larger improvements in children's pro-social behaviour, emotion regulation, depression and dissociation

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
Carter et al., 2003	USA	192 children and 64 parents	Community	Non-randomised intervention	Nil	YOQ SSRS PSI TSCC-A FWS Piers-Harris Children's Self-Concept Scale	75% White, 18% Hispanic, 3% African American, 3% Native American, and 1% Pacific Islander	Pre-, post-	• At post-intervention, significant children displayed improvements in distress, somatic symptoms, social problems, interpersonal relations & emotional expression • Parents reported a reduction in parenting stress following treatment completion
Macmillan & Harpur, 2003	Canada	47 parent–child dyads	Family violence community centre	Non-randomised intervention	Nil	CBCL PSI CDI RCMAS ACTS	Not reported	Pre-, post-	– At post-intervention, children displayed significantly lower levels of internalising and externalising behaviours – At post-intervention parents reported significantly reduced levels of parenting stress
Combined dyadic and concurrent mother–child interventions									
Cohen et al., 2011	USA	124 mother and their children	Community	RCT	Usual care-child centred therapy	K-SADS-PL UCLA PTSD RI SCARED CDI KBIT CBCL	Not reported	Pre-, post-	– Children in the treatment group reported significantly greater improvements in overall psychopathology symptoms, trauma, and anxiety symptoms than children in the comparison group

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
McWhirter, 2011	USA	46 mothers, 48 children	Domestic violence refuge	RCT	Goal focused treatment	Family attachment scale of the student survey of risk and protective factors. Quality of Social Support Scale. CESD GSC Readiness to Change Ruler Child Emotional Barometer, single item on peer conflict, family conflict, and self-esteem	47% White, 20% Latino, 16% African American 11% Native America, 2% Asian American	Pre-, post-	• In both groups, mothers demonstrated significant improvements in depression, family bonding, readiness to decrease violence, readiness for therapeutic change • In both groups, children's displayed improvements in emotional wellbeing and self-esteem • Families in the goal directed group did also displayed significant decreases in family conflict • Families in emotion focused reported increases in social support
Sullivan et al., 2004	USA	46 mothers and 79 children	Not reported	Non-randomised intervention	Nil	CBCL TSCC PSI children's perceptions of interpersonal conflict	Not reported	Pre-, post-	• At post-intervention, significant improvements in children's externalising and internalising symptoms and anger related trauma were reported • Significant improvements were also observed for overall trauma symptoms but only for those children scoring in the clinical range • Parents reported significant decreases in parenting stress

Author	Location	Sample size	Setting	Study design	Control group	Outcome measures	Cultures serviced	Time points assessed	Key findings
Smith et al., 2015	Wales	95 mothers, 92 children	Domestic violence refuge	Quasi-experimental	Play therapy group	PLOC PARQ SDQ	Not reported	Pre-, post- & 6-month follow-up	• At post-intervention, mothers demonstrated improvements in self-esteem, perceived parenting efficacy and influence over child's behaviour. These changes were maintained at 6-month post-intervention • Children reported decreased behavioural problems which was maintained at 6-month follow-up • Children rated their mothers as having increased affection and reduced aggressive or rejecting behaviour • In comparison to the control group, children who participated in the DART group had significantly reduced total difficulties and conduct problems at post-intervention
Woollett et al., 2020	USA & South Africa	11 mother–child dyads	Domestic violence refuge	Non-randomised intervention	Nil	CDI UCLA PTSD-RI	54% American, 46% South Africa	Pre-, post-	• At post-intervention, significant improvements in child depressive symptoms were reported • Improvements in child PTSD symptoms observed but did not reach statistical significance

Notes: Attitudes About Family Violence = AAFV; The Angie/Andy Cartoon Trauma Scales = ACTS; Alabama Parenting Questionnaire = APQ; Beck's Depression Inventory = BDI; Brief Infant-Toddler Social and Emotional Assessment = BITSEA; Brief Symptom Inventory = BSI; Clinician Administered PTSD Scale = CAPS; Child Behaviour Checklist = CBCL; Children's Depression Inventory = CDI; Centre for Epidemiological Studies Depression Scale = CESD; The Coding Interactive Behaviour = CIB; Revised Conflict Tactic Scale -Parent–Child, CTS-R; Eyberg Child Behaviour Inventory = ECBI; Emotion Questionnaire for Parents = EQ-P; Family Worries Scale = FWS; The Generalised Self Efficacy Scale CHILD = GSC; Impact of Events Scale = IES; Kaufman Brief Intelligence Test = KBIT; Kiddie Schedule for Affective Disorders and Schizophrenia Present and Lifetime Version = K-SADS-PL; Maternal Postnatal Attachment Scale = MPAS; Parental Acceptance and Rejection Questionnaire (PARQ); Parenting Dimensions Inventory = PDI; Parent–Infant Relationship Global Assessment = PIR-GAS; Parental Locus of Control Scale = PLOC; Parenting Stress Index = PSI; The Revised Children's Manifest Anxiety Scale = RCMAS; The Revised Knox Preschool Play Scale = R-KPPS; Screen for Child Anxiety Related Emotional Disorders = SCARED; Symptom Checklist-90-Revised = SCL-90R; Strengths and Difficulties Questionnaire = SDQ; Social Skills Rating System = SSRS; The Test of Playfulness = ToP; Trauma Symptom Checklist for Children = TSCC-A; Trauma Symptom Checklist for Young Children = TSCYC; University of California at Los Angles PTSD Reaction Index = UCLA PTSD RI; Youth Outcome Questionnaire = YOQ.

APPENDIX C

Table: Summary of interventions currently implemented within Victoria

Intervention	Organisation	Aims	Age range	Therapy type	Format	Intervention length
Restoring Childhood	Berry Street	• To minimise the impact of the family violence on children and young people and prevent the development of chronic post-traumatic stress disorder • To improve the relationship between child/ren and non-offending parent	0–17 years	• CPP • Eye Movement Desensitization and Reprocessing therapy (older children in medium term)	Mother–child dyadic therapy or concurrent mother child therapy for older children involved in medium term	Short term – 4 weeks Medium term – up to 6 months
Peek-a-Boo Club™	The Salvation Army/Emerge	• To provide a supportive and safe setting to strengthen the mother–child relationship	0–3 years	Infant-led practice Play therapy	Mother–child group	8 weeks
Safe Nest	Emerge	• Guided by attachment and trauma theory with the aim to decrease infant trauma symptoms, improve the mother–infant relationship and decrease women's psychological distress	0–4 years	Infant-led practice Arts therapy	Mother–infant group	8 weeks
Beyond the Violence	Anglicare	• To help mothers understand the impact of past violence on themselves and their children • To gain strategies for building resilience and reshaping life pathways • Explore ways to build trust with the family • Take steps to re-establish appropriate parent/child relationships • Develop strategies to handle children's behaviours and emotions	Children (unspecified)		Concurrent mother and child groups which end with joint sharing time	8 weeks

Intervention	Organisation	Aims	Age range	Therapy type	Format	Intervention length
Fun Buddies	Uniting	• To strengthen mother–child attachment	Toddlers		Mother and child group	8 weeks
Children and Mothers in Mind	Kids First (western metropolitan) , Anglicare Victoria (Gippsland), Sexual Assault and Family Violence Centre (Barwon), Family Life (Shepparton)	• To strengthen mothers' self-care, self-compassion and stress management skills in relation to parenting. • To support the mother–child relationship through enhancing mothers' sensitivity and responsiveness to her child and strengthening feelings of parenting self-efficacy	0–4 years	• Psychoeducation • Playgroup-based therapy • One-to-one counselling and case support	• 8 weeks of concurrent mother and child groups for mothers to address own trauma • 10-week playgroup for mothers and children • One-to-one support throughout the program	22 weeks
Safe Place for Arts, Sharing and Learning (SPLASH)	Women's Health West	• To assist children to identify and express emotions through art making, play and talking • To build relationships with peers and practice social skills • To connect with other children who have also experienced violence • To have opportunities to strengthen their relationship with their mother or carer	8–12 years	• Art therapy	Mother and child group	8 weeks
Strength-2Strength	Family Life	• To assist mothers and children to process past experiences • To empower mothers and their children • To support children's development • To nurture ongoing family connection	0–12 years	• Child focused • Trauma informed	Mother–child dyadic sessions and group sessions	To be determined by practitioner
Popping Bubbles Program	Australian Childhood Foundation & Eastern Domestic Violence Outreach Service	• To strengthen the mother–child relationship	6 months, 2.5 years, 5 years	• Play based, infant/child focused	Mother–child group sessions	Information not available

APPENDIX D

Promotion flyer for the Safe Nest Group

safe nest

A safe place for mums and bubs who have experienced family violence

The Safe Nest Group is a 6 week program designed for mothers and their infants aged 0 - 3 years old who have survived family violence.

It is a safe place for mums and bubs to come and have fun with play and creativity while exploring behaviours and emotions.

The program aims to help mothers better understand their child's experience of family violence, helps strengthen their relationship and promotes wellbeing of both mother and baby.

Details

Time:
Dates:
Venue:
Cost: Free of charge, morning tea provided
Bookings: Please call Emma at Emerge on 03 8657 8622 or email cp@emergesupport.org.au

The Safe Nest Group Program is being run as a research project by Swinburne University of Technology in collaboration with Emerge Women & Children's Support Network and the Murdoch Children's Research Institute. We gratefully acknowledge the financial support we have received from Australia's National Research Organisation for Women's Safety (ANROWS) towards this research and, through it, the Luke Batty Foundation.

emerge women & children's support network

SWINBURNE UNIVERSITY OF TECHNOLOGY

murdoch children's research institute

safe nest

APPENDIX E

Semi-structured interview schedule

Qualitative interview schedule

Safe Nest Group Program

Getting Started with Safe Nest

- How did you find out about the Safe Nest Group (SNG) program
- What made you decide to join?
- What was it like getting started with SNG?
  - What was the timing like for you?
  - What things made it easy or hard to get started?
- Thinking back to the first meeting with your SNG clinician, what comes to mind about what that was like for you?

Experience of specific aspects of the Safe Nest Group

- Thinking back to the SNG, what comes to mind about what it was like for you?
- What were some of the things that you did in the group?
  - What did you like/didn't like
  - What was helpful/not helpful?
- What are your thoughts on the length of SNG? Were the number of sessions the right amount?
- How could the Safe Nest Group program be improved for other women and children?
- What was the best thing about coming to SNG?/What was the worst thing about coming to SNG?

Facilitators to engagement and participation

- What kept you coming back to the group?
- What do mothers need to help them to join a program, and get the most out of a program like SNG?
- What are your thoughts on the best way to tell mothers about the SNG or other programs like this?

Barriers and challenges to engagement and participation

- Was there anything that made it hard for you to get involved or get the most out of the group?
  - What would have helped you with these things so that they didn't get in the way?

Perceived benefits of the Safe Nest Group

- What did you get out of the SNG?
  - For your wellbeing? Parenting knowledge about child development? Confidence in parenting? Relationship with child? Supporting child?
  - Have you noticed any changes in yourself since doing the program?
  - What do you think would be different if you had not done SNG?
- What things didn't SNG help with? For you? Your child?

- Would you recommend SNG to other women?
  - What would you say to them about how it could help?

Experiences of the group for your baby

- What do you believe your baby gained from the group? How did your baby let you know this? What changes have you noticed in your baby over the past 6 weeks in coming to SNG?
- If your baby could tell us about his/her experience of coming to the group, what do you think they would tell us?
- What would we tell other mothers about what the main benefits are for you? Your baby? And your relationship? That would encourage them to participate.
- In what ways do you think your relationship with your baby has improved?
  - How has coming to SNG helped your baby?
- In what ways have your thoughts and feelings changed since coming to SNG?
- What have you learned about your baby's experiences of family violence?

Any last thoughts or things you would like to share about your experience with the Safe Nest Group Program?

Thank you for your time today.

APPENDIX F

Fidelity checklist

SNG weekly checklist

Group: SNG

Name of Facilitators:

Term:

Themes:

Session: Theme:

Item	Task	Activity #	Time	Complete
1.	Set up space with rugs, cushions, and protocol toys			
2.	Welcome song. Practice. Welcome and closing song			
3.	Infant-led play			
4.	Create group rules			
5.	Mid-session snack			
6.	Infant-led play			
7.	Bird's Nest Drawing (session 1 and 6 only)			
8.	Infant-led play			
9.	Closed with Twinkle, Twinkle song			
10.	Implemented dyad-focused interventions (e.g. bubble blowing, songs)			
11.	Implemented emotional (co) regulation strategies (e.g. pairing a song with rhythmic movement)			
12.	Facilitators modelled watch, wait, and wonder principles (i.e. infant led)			
13.	Implemented group-based intervention (e.g. walk and stop activity)			
14.	Group ran for 120 minutes duration			

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to Reduce Violence against Women & their Children