Can we let families speak about domestic violence and abuse (DVA) and respond restoratively?
Exploring family practices and restorative approaches where there is DVA and contact with child protection services.

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Abstract

Domestic violence and abuse (DVA) continues to be a significant factor in referrals to statutory children's social care (CSC) in the UK. While families impacted by DVA have become more visible to CSC little is known of their family practices (FP) or experiences of restorative practices (RP). This thesis foregrounds the voices of families experiencing DVA in a collaborative study in one English city where RP were implemented as innovative practice in response to DVA and child protection (CP) concerns. The application of RP in particular family group conferencing (FGC) is a contested area for DVA practice with limited empirical knowledge of their use in a statutory UK setting.

This qualitative study analyses data using 21 in-depth semi-structured interviews with family participants (15) and practitioners (6), 2 focus groups with practitioners (10) and observations of practice. The findings are discussed in relation to three domains: family practices in the context of DVA; family lived experience of contact with CSC and practitioner experiences of working with families impacted by DVA in a restorative local authority. Through its exploration of FP and RP, this thesis provides new insights that are relevant to social work practice and sociological scholarship on families. Data substantiates complexity in family lived experience and service responses where DVA is present alongside other adversities. Significant histories of abuse, trauma and recurrent intergenerational CSC contact negatively impacted help seeking and trust in services. Individualised CP practice did not consider FP or respond adequately to families' strong desires for resolution involving continued family relationships. While there is evidence of good practice, the aspiration of RP to support family resolution in situations of DVA remain in their infancy; constricted by risk-focused, gendered practice and insufficient practitioner training and support to work restoratively with families and specifically fathers that cause harm.

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Abbreviations

CP	Child protection
CSC	Children's social care
DVA	Domestic violence and abuse
FTP	Failure to protect
FGC	Family group conference
HSHC	High support high challenge
ICPC	Initial child protection conference
MARAC	Multi agency risk assessment conference
RP	Restorative practice
SW	Social worker

Chapter 1: Introduction

> *When we say, 'Let the family speak,' let us acknowledge the potential in these words for a future in which individuals and families are reconnected to decision processes that affect their lives and give them a say* (Burford, 1999, p.359).

Locating the study in family voices

> Yeah … he battered fuck out of me. Jumped me in the street. Broke my ribs. He's done all that. And he's her dad. He … he knows how to look after a baby. Oh! But no! Social says we can't be together! Can't even be in the same child protection meeting together! It's separate meetings. So, how's it gonna get sorted? I can't sort it out. It's all on me! All on me! Keep telling them, we need a big family meeting. We need to sort it out cos I want her to have her dad in her life. I want that. I do. I just don't want to be battered (Rhianna, 22 years old).

> I saw me mum being beaten, he [Dad] was very bad, beat her and stuff, saw all that. There was nothing I could do, got mad with me mum, cos there was nothing she would do. Didn't have no one to talk to, I made trouble and trouble found me [laughs]. No one at school, no one helped like. They all looked at me as bad. So now it's like the same as with me dad [pause] I get very, very angry, can explode. I've hurt people. My mum, Kim [partner], I don't want that to be case, but it's where we are. Now social worker's poking nose in, here we go again. My life all over (Jake, 23 years old).

These quotes are from two of the fifteen individual family participants that shared their story with me as part of this study. Rihanna's narrative speaks of the 'double whammy' that women experience of being responsible for managing DVA and protecting children in the context of abuse. Rhianna states her desired resolution for the abuse to stop and her child to have a continued relationship with her father. For her this means not carrying the burden of this situation and for CSC to support her safety and repair of family relationships. Rhianna's frustration and story are similar to many

women who are caught in the double bind of suffering DVA and scrutiny from CSC (Humphrey and Absler, 2011; Keeling and van Wormer, 2012) with little prospect of resolution through CSC involvement.

Jake's narrative captures both his experiences of abuse as a child and being abusive in his family relationships. He acknowledges his uncontained rage, being labelled as `bad` and lack of support when younger, connecting his behaviour to similarities with his own father. While he articulates wanting change how this will happen is unclear and CSC involvement, due to concerns for the welfare of his child, are a reminder of his own childhood experiences of abuse and previous traumatic state intervention. Jake's narrative is similar to some of the stories of other men in this study where previous unresolved experiences of childhood abuse, cumulative disadvantage and abusive behaviour towards those closest to him continue to be played out from childhood through to adult relationships.

These two quotes serve as a powerful illustration of the lived experiences of DVA, CSC involvement and parental voices seeking change and resolution. They highlight the need to rethink policy and practice in this area to facilitate ` letting the family speak` about violence and abuse (Burford, 1999). This requires services to reimagine their responses to families and foster inclusive decision-making practices that connect with family lived experience.

Background to the study

DVA is the leading factor identified in referrals to Children's Social Care (CSC) in England and Wales (DfE 2022). The traditional CSC response to families affected by DVA has been a one size fits all separation approach. This approach enforces couples to separate in an attempt by CSC to protect children (Humphreys and Absler, 2011; Holt, 2017; Ferguson et al., 2020) and is located in siloed risk orientated, rather than relational, approach to working with families (Hester, 2011; Featherstone et al., 2014).

Separation in the context of DVA is recognised as a dangerous time with empirical evidence asserting the danger and lethality of DVA in the post-separation period (Hester and Radford, 1996; Humphreys and Thiara, 2003) and significant risks for continued post-separation abuse where there are children involved (Katz et al., 2020).

There is recognition of the reluctance of women and couples affected by DVA to separate for a variety of reasons connected to social and economic factors (Stanley and Humphreys, 2017; Philip et al., 2019). There may be cultural pressure for women to remain in DVA relationships and fear of continued violence even when separated particularly where there are children and expectations of ongoing relationships (Mama, 1996; Radford and Hester, 2015; Katz et al., 2020; Thiara and Harrison, 2021). In addition, some women and couples do not want to separate but do want support to address DVA and other difficulties (Fredrick and Lizdas, 2010; Philip et al., 2019). Thus, separation may not be possible or desired for all families, yet separation has been the prevailing state response in situations of DVA and child welfare concerns in the UK.

As such, there is growing recognition of the need for CSC services to innovate and develop more effective and humane responses for working with families (Featherstone et al., 2014), Mason et al., 2017), and Ferguson et al., 2020). Restorative approaches have been imported into UK CSC (Mason et al., 2017; Sen et al., 2018) and provide an alternative to individualised, siloed state responses to DVA, with the potential to challenge mother surveillant practice, give voice to children and engage fathers to develop family inclusive decision-making practice. Family group conferences (FGCs) in particular (Pennell and Burford, 2000; Sen et al., 2018) and `whole family` practices (Stanley and Humphreys, 2017; Rodger, Allan and Elliot 2020) have been piloted within CSC with some positive outcomes for families.

This thesis presents findings from an empirical exploration of family practices, family experiences of DVA, and how the care and protection needs of families are responded to by CSC. This is a collaborative research project between the University of Sheffield and one northern English city (Northford), where CSC service innovation expanded RP, with a specific focus on services for families experiencing DVA.

The title of this thesis is a play on Burford's (1999) paper, *Letting the family speak about violence: Research findings on family group conference use in domestic violence*, referring to empirical evidence on the potential of RP, in particular FGCs to support collaborative decision-making in matters of family violence. The central premise is that by supporting families and communities responsibilities for solving problems that affect them, then sharing power between family, state and community can support social justice and give voice to those that are often marginalised and

unheard. This thesis foregrounds the voices of families with the aim of listening carefully in a bid to support improved policy and practice with families where there is DVA and state intervention.

Clarification of key terms

Domestic violence and abuse

Despite the widespread nature of DVA there is a lack of consensus about the definition, causes and appropriate responses for tackling the problem. Defining DVA is a complex task because the terminology has changed over time and has been socially, culturally, historically and politically located. Terminology is problematic, reflecting the diverse conceptual and theoretical perspectives of this culturally sensitive phenomenon (Radford and Hester, 2006). At different times, DVA has been described as `wife-battery`, `spousal abuse`, `gender-based violence', 'violence against women', 'domestic abuse' and 'coercive control', reflecting a focus beyond physical violence. Other terms are gender neutral ('intimate partner violence' and 'interpersonal violence') and critiqued for their dismissal of the gendered nature of DVA.

The term 'domestic abuse' (DA) is used more widely in legislation, policy and practice than DVA. DA has gained widespread use in recent years, to denote a wider understanding of abuse beyond a conceptualisation of domestic violence being confined to physical acts or incidents of violence (Itzin, 2000). The term DA also recognises that abuse is constituted by the cumulative effect of coercive and controlling behaviour that include a wide range of abuses (Stark 2007; McMahon and McGorrey, 2016).

Early in the research I talked to Northford's Family and Friends Advisory Group (FAFA) (see chapter 3 for further details of the group) who queried the use of the term DA stressing the importance of naming 'violence' to reflect their own interpretation of the problem and lived experiences of DVA. The term DA was rejected for use in the study by the FAFAs as being ambiguous. There was strong feeling that the words `violence and abuse` be included in any publicity and research interviews with family participants. The definition of DVA as understood and agreed by the FAFAs and adopted in this study is amalgamated from the pre-existing cross government

definition (Home Office, 2013) and incorporates the new statutory definition of domestic abuse outlined in the Domestic Abuse Act 2021:

> Any incident or pattern of incidents of controlling, coercive, threatening behaviour and violence, between those aged 16 or over who are personally connected or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to, economical, psychological; physical; sexual and emotional abuse. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group (Home Office 2013; Domestic Abuse Act 2021 c.17).

Therefore, I have used the term DVA in this study to reflect the terminology familiar to those with lived experience of DVA.

Family violence

The term 'family violence' is a broader term that acknowledges abuse within the context of family relationships that can occur between partners or ex-partners, beyond dyads, affect elders and children too. 'Family violence' is potentially a more accurate reflection for what may occur in some families, recognising the possibility of simultaneously being harmed and causing harm, and the co-occurrence of DVA to both mothers and children in families (Pennell and Burford, 2000). As such, this study adopts a broad view of DVA to include intimate partner violence and family violence, and to acknowledge how differing family contexts and relationships are impacted by DVA. However, as the study will focus specifically on families that have had contact with child protection processes, it is likely that families will have been referred to services under the `problem` of DVA that will be conventionally framed as DVA in heterosexual relationships from men to women rather than acknowledging the broader family dynamics and harmful impact of DVA.

Children's Social Care (CSC)

CSC refers to statutory services available for children that include services for children in need, those identified as at risk of neglect and abuse and in need of child protection

services, and services for looked after children. In this study CSC is used interchangeably with child protection (CP) services.

Family and family practices

The concept of `the family` has evolved over time and can be understood in a myriad of ways due to the diversification of family forms (Edwards et al., 2012). However, `the family` remains an ambiguous and contested concept that is used unproblematically in everyday life, political and professional settings yet is the subject of anxiety and political concern, for example, the `crisis of the family` (Weeks et al., 2001, p.9). There has been critique about the use of `the family` as a singular, fixed term and preference for the plural `families` as being more reflective of family diversity (Gittins. 1993). This critique recognises that the idea (and ideal) of `the family` is signified by the `cereal packet image of the family` (Leach. 1967), an idealised heteronormative two parent family with biological children a breadwinner father and homemaker mother. This stereotypical ideal of the normative family is a powerful concept that fails to take account of diverse and marginalised family forms. Despite critiques of `the family` being defined against the idealised norm (Weeks et al., 2001), the heteronormative nuclear family continues to dominate, from which other family forms are judged socially and politically.

Rather than defining `the family` as a fixed object, `family practices` (Morgan 1999; 2011) is a fluid concept that facilitates consideration of the different relationships, interactions and experiences that collectively describe what families `do`. 'Family practices' (Morgan 1999; 2011) provides a conceptual frame for considering the diversity of family 'life' and 'practices' that gives agency, by moving toward a focus on the 'doing' of family; that is, the process of how people construct, display, and perform family, rather than a focus on what people 'are' (Jamieson et al., 2012; Finch, 2011). Morgan (1999; 2011) argues that the concept of 'the family' gives it a 'thing like quality' (Morgan, 2011, p.3), that is both restrictive and elusive as it fails to recognise the many different roles or practices that constitute the way that 'family' can be understood or portrayed. As such, the concept of 'family practices' emphasises the constructed nature of 'family' and the 'performing' of family, as opposed to family being defined as a static category, noun or structure.

In this this thesis ‘family’ refers to both the network of people that can include kin and non-kin members and relationships that are family-like (Morris, 2015), and family practices (Morgan 1999; 2011), the way that family is performed through the `doing` of family life. This definition is not limited to family being defined by household structure and specific types of relationships or as a fixed social entity (McKie et al., 2005). Thus `family` can be defined as having flexible and permeable boundaries (McKie et al., 2005) comprising broader networks, as ‘families of choice’ (Weeks et al., 2001) that are likely to differ from one family network to another. This also facilitates a broader understanding of the family as dynamic, fluid and mediated through relationships, interactions, and experiences at an interpersonal (micro) and structural (macro) level.

Restorative practices

Restorative practices (RP) also referred to as restorative approaches (RA) have their roots in restorative justice (RJ) and social justice theory developed in the 1970s. The International Institute for Restorative Practices (IIRP) defines RP as inclusive participatory processes for learning and decision-making (Wachtel, 2013). A general consensus exists concerning the underlying democratic values of RP that include repairing relationships and harm, community reintegration, forgiveness, participation, shared learning and shared decision-making (Braithwaite, 2000). RP involves bringing relevant people together to support them to understand a problem and to work together to reach a resolution. This process emphasises that people are responsible for their choices and actions and can be supported to come together and be held accountable for their decisions (Restorative Justice Council, 2016). Braithwaite (2000) and Burford and Hudson (2000) argue that supporting families to take responsibility for solving the problems that affect their lives, strengthens their family practices, facilitates sharing power humanely between state, family and community and can promote human rights and social justice by giving voice to those who are often unheard.

People with lived experience of domestic violence and abuse

Violence in relationships is both an interpersonal and structural experience and each term used to describe experiences of DVA carry implications for people who are affected. Within the literature women who have experienced DVA have predominantly been described as ‘victims’, ‘survivors’ and `victim-survivors`. Men who are violent have been described as ‘batterers’, ‘abusers’, `offenders` and ‘perpetrators’ across

legislation, policy, and practice. The binarized positions of victim / perpetrator do not further understanding of the complexity of lived experience and interpersonal relationships. These terms can be used uncritically in professional settings and are problematic because they homogenise lived experience and underscore the power of language to control and stigmatise.

Definitional challenges arise from naming people affected by DVA with dichotomous labels, of victim/perpetrator and victim/survivor, suggesting an 'either/or' positionality (Hester and Radford, 1996). Indeed, this study found that no family participants referred to themselves or family members as either 'victim', 'survivor' or 'perpetrator'. Some practitioners acknowledged the problematic nature of labelling people as victim/ perpetrator because this contributed to people feeling alienated by services; especially men that caused harm. Nonetheless, all practitioners (interviewed and observed) used the terms 'victim/perpetrator', rather than 'survivor' to refer to people with lived experience of DVA. This exemplifies the power of professional discourse to categorise and distil experiences into a narrow definition. However, as this study later shows, lived experiences surfaced of both/and being a victim and perpetrator of DVA and this was also confirmed by practitioner narratives of practice with families.

In order to emphasise a range of DVA experiences I have tried to avoid these terms and have variously adopted 'people with lived experience of DVA/affected by DVA', 'men/fathers that are abusive/causing harm', `those that are harmed and those that cause harm` and 'women/mothers/children experiencing harm'. However, I have used the terms 'victim' and 'perpetrator' at times, recognising that they are default legal and practice labels and shorthand for people with experiences of DVA. I also do this with awareness of the definitional challenges, labelling and reductionism of experience that they suggest.

My journey to this research

I was drawn to this research study for social justice reasons that resonated with my personal and professional values. I was interested in locating and amplifying the voices of families affected by DVA to improve family participative policy and practice in CP provision. Prior to starting my PhD, I had twenty years' experience working with children, young people and families in a range of settings including women's refuges, community development and across CSC organisations. I was working for a national

children's charity, managing a new project for first-time young mothers (aged 14–25 years), when I saw the opportunity to apply for this collaborative PhD studentship.

The collaborative nature of this research between the University of Sheffield and Northford appealed to me because of the potential for exploring new approaches to working with families affected by DVA. In addition, within a city that had received considerable investment to innovate their CSC services. I was in part seeking the opposite experience of the service that I was engaged in at the time which was a research collaboration between a national children's charity, a USA and UK university, and an NHS Foundation Trust. This was a randomised control trial design, and I noted significant ethical issues regarding a lack of choice and control offered to the young women involved. In addition, when mothers shared DVA and other difficulties, the threshold of risk operated by the project led to CSC referrals. Some of these situations could have been contained by the network of support through the project. Needless to say there was high attrition of mothers in the programme, and the study found no benefit for the security of attachment or maternal mental health (Longhi et al., 2019). This experience augmented my interest in this study as I saw an opportunity to explore more humane ways to undertake research with families.

Furthermore, my interest in DVA and family inclusive approaches stems from earlier practice experience within two South Asian women's refuge settings. These were voluntary collective organisations conceptualised by South Asian women, for South Asian women, and founded on Black and South Asian women's activism and scholarship in the UK and USA (Wilson, 1978; Southall Black Sisters, 1991; Anthias and Yuval Davis, 1992; Anitha and Dhaliwal, 2019). These were women only spaces where contact with family members was prohibited and considered to be oppressive and dangerous at the time. Many women returned to live with the families they had fled, as many women struggled to make independent lives for themselves in the community without contact with their family of origin, while some women thrived and made independent lives. Observing the embedded nature of family relationships (Smart, 2007), trying to make sense of family ties when fleeing DVA and the lack of a mechanism for resolving family disruptions, sparked my interest in family-focused practice and the need to 'think family' (Morris, 2017). Thus, my rationale for embarking on this PhD is also driven by the need to contribute to practice in a different way that offers more humane approaches for families .

Research aims and questions

The primary aim of this study is to gain insights from the narratives of family participants and CSC practitioners about family practices and RP, where there are DVA and child welfare concerns, and further academic and applied understandings of families living with adversity.

This study has a dual focus and audience. First, applied expectations of findings for practice development arose from collaboration with Northford's local authority by learning how families experience RP in the context of DVA and how this learning can inform practice and services for families. Second, to inform humane state responses by making an original contribution to knowledge through the rich empirical knowledge gathered from family participants and practitioners. This knowledge is much needed in applied settings, where dominant discourses on children's rights and wishes can compete with maternal and paternal narratives and negate family practices in preference of individualised discourses.

The challenge of this collaboration and dual focus is for applied practice to *listen* and validate family relationships and experiences and for academic audiences to listen and expand the concept of family practices to broaden research and thinking about family practices in the context of familial violence, abuse and adversity.

Giving voice to family participants and practitioner experiences does not remove the challenges of DVA and CP, but at the very least, these stories offer rich insight into attempts to work differently with families in Northford and family reflections on their experiences which are of significance to applied and academic settings.

Research questions

This study has a two-fold focus firstly, on family practices in the context of DVA and contact with CP services. Secondly, on RP in practice with DVA and families, as such, there are three research questions that will explore this two-fold focus.

1. What family practices are described by families in the context of DVA? (How do families 'do' family in the context of DVA?)
2. What are the family narratives of DVA and contact with Children's Social Care (CSC) services?
3. What are the opportunities and limitations of RP to support family resolution in the context of DVA?

Thesis structure

Having outlined the scope of the study, key terms and concepts, I will outline the structure of the thesis. Following on from this introductory chapter, **Chapter 2** will focus on a review of the literature. The chapter will identify the construction of DVA as a social problem and CP concern. I outline CSC service responses to families experiencing DVA and explore evidence on the experiences of families impacted by DVA and contact with CSC. There is a focus on services with men that address their harmful behaviour. Restorative practices and family group conferencing are outlined. The chapter ends with a focus on family practices and the applicability of this theoretical lens for this study.

Chapter 3 outlines the research design and rationale for my chosen methodology. I set out the theoretical and epistemological underpinnings of the study with a specific focus on poststructuralist feminist theory. Data production and analysis are described. The chapter also attends to ethical considerations and the challenges I encountered during the research process and how these were addressed.

Chapter 4, 5 and 6 are the findings and discussion chapters. Chapter 4 establishes mothers' and fathers' experiences of DVA. This chapter highlights family practices and experiences of DVA, adversity and state intervention across family participant lives. The binary conceptualisation of 'victim/perpetrator' is challenged by foregrounding family narratives demonstrating the strengthen of family connections and complexity of intergenerational lived experience of DVA and state intervention. These accounts disrupt the conceptualisation of DVA as a singular issue impacting families and evidences how families `do` family in the context of other adversities and experiences of marginalisation.

Chapter 5 builds on the previous chapter by presenting insights from family narratives of CP service provision and the challenges and opportunities for family resolution in

the context of DVA. Data substantiates how the often traumatic experience of earlier contact with CSC imprints subsequent contact. Practice in the context of DVA and CP continues to be disproportionately focused on mothers, and fathers do not experience meaningful or consistent engagement. However, evidence of hopeful, relationship-based practice supports positive experiences of social work contact.

Chapter 6 is the final findings chapter and situates practitioner narratives on working with families where DVA and CP concerns arise. This chapter examines the challenges and opportunities of social workers and family group conference coordinators to respond restoratively with families. While the aspiration of RP has created a practice shift towards relationship-based social work with families, data evidences that RP is constrained by gendered practice, patchy adoption of RP, practitioner fear and a lack of confidence to work effectively with families where there is DVA. This is set against a backdrop of austerity and a lack of clear organisational policy and practice guidance to support RP innovations.

Chapter 7 is the concluding chapter. I revisit the research rationale, aims and research questions. The chapter identifies how the research aims were achieved, key contributions of the thesis re outlined with recommendations for practice, limitations of the study and directions for further research. This chapter draws on the three findings chapters to discuss the implications of the research for expanding our understanding of family practices and experiences of DVA, RP and statutory CSC intervention.

Overall, this thesis contributes to contemporary sociological and social work discussions on families and DVA by giving voice to marginalised families impacted by DVA and practitioners working with them. The study shows how CP practice with families continues to be mother-focused and inconsistent with fathers, even in the context of innovative RP. Additionally, the study shows how families previous experiences of state intervention and cumulative disadvantage impact family practices. Thus, confirming the multidimensional, complex nature of DVA for families where there are child welfare concerns and other adversities.

Chapter 2: Literature review

Introduction

There has been an increase in referrals of families affected by domestic violence and abuse (DVA) to statutory children's services in England and Wales (DfE 2022) with DVA consistently identified as the most prevalent factor recorded for referral and at the end of assessment by CSC in England and Wales (DfE 2022). This trend has also corresponded with an increase in DVA related crime in the UK in recent years (Cowling and Forsyth, 2021; Office of National Statistics, 2020) and recognition of the significance of the problem through the recent Domestic Abuse Act (2021).

The following literature review provides a context for the study and is divided into five sections. The first section locates conceptualisations of DVA within an historical context and considers the limitations of this. The second section considers developments in the differentiation of DVA and broader understandings of the nature of DVA in intimate partner relationships. The third section contextualises DVA as a CP concern and the dominant state response. The fourth section focuses on family experiences of DVA and service responses, including more recent developments in work with men that perpetrate DVA. The fifth section outlines restorative approaches in the context of DVA, in particular the use of FGCs. The final section focuses on family practices as a theoretical lens applied in the study. The literature reviewed highlights research in the context of DVA and recognises the dearth in research on the lived experiences of families in this context.

A complex social problem

DVA is an enduring, complex global social problem and understood as an incident or pattern of behaviour that causes physical, psychological and sexual harm. A recent meta-analysis of 161 countries, covering 90% of the global population of women and girls aged from 15 years old, estimates that 27% of women that were ever-partnered, aged 15-49 years have experienced physical and/or sexual abuse in their intimate partner relationships (Sardinha et al., 2022). Evidence also confirms that DVA is an intersectional gendered act, with more women than men experiencing severe, ongoing and lethal violence and abuse (Garcia-Moreno et al., 2013; Stockl et al., 2013) While the scale of the problem cuts across `race`, age, (dis)ability, ethnicity, sexuality,

religion and cultural boundaries, the interplay of structural inequality and DVA, make it more likely that families who are already structurally marginalised are potentially more likely to be exposed to DVA (Sokoloff and Dupont 2005; Coker 2016). Furthermore, families living with poverty are more vulnerable to DVA (Fahmy et al. 2016) and have a greater likelihood of social work involvement in their lives, yet access to fewer services (Bywaters et al. 2016). This raises moral and ethical concerns for humane state practices (Featherstone et al. 2014) that need to consider family practices and relationships within the specific structural context of families lives.

Feminist activism and the dominant conceptualisation of DVA

Traditional or 'second wave' feminist-led activism and scholarship from the 1970s notably raised public awareness of the physical, sexual and psychological abuse that women experienced. The women's liberation movement included activism specifically against DVA in the UK and other countries and was termed the `battered women's movement` at the time (Lehrner and Allen, 2009). This feminist activism emphasised the commonality of women's experiences of oppression framed by patriarchal power and male privilege within the family and wider society (Dobash and Dobash, 1992; Lehrner and Allen, 2009; Hague, 2021). Grassroots organising of safe housing and support for women experiencing DVA simultaneously revealed the state's reluctance to intervene and acknowledge women's experiences, and successfully challenged state inaction to DVA (Dobash and Dobash, 1987; 1992). Furthermore, the discourses of this activism reconstructed how DVA was understood, shifting it from a private , domestic problem to a public social problem.

As a result of the success of this activism, gender inequality, rooted in patriarchal power and control (Pence and Paymar, 1993), was heralded as the defining explanation for DVA and has had an enduring influence on how the problem of DVA is constructed and who has the power to define the problem (Cunneen, 2008). This has led to the dominant conceptualisation of DVA, a very complex social problem, being narrowly depicted as a universal formula story where women are rigidly perceived as 'pure victims' and abusive men as 'evil villains' (Loseke 2001, p.107) where heterosexual men are abusive to heterosexual women in their intimate relationships (Donovan and Hester, 2014). These definitional discourses influence the

way that DVA is conceptualised, how those impacted by DVA are perceived and the way that services respond.

This formula story of DVA is problematic for several reasons in terms of those that are harmed and those that cause harm. Firstly, some victims' may not identify with the one-dimensional portrayal of DVA as severe abuse as it is not nuanced enough to reflect the nature and accumulation of DVA and coercive control that some people experience (Loseke, 2001; Stark, 2007). Secondly, this view does not consider the role of intersectional inequalities that shape peoples experiences of DVA as mediated through `race`, religion, ethnicity, (dis) ability, sexuality, age and class, presupposing the centrality of DVA in people's lives, where families may be facing a range of difficulties that cause suffering (Crenshaw, 1989; 1991; Sokoloff and Dupont, 2005). Furthermore, the dominant portrayal negates the experiences of DVA within same-sex, non-binary and transgender relationships by focusing on gender inequality as the root cause of DVA (Courvant and Cook Daniels, 1998; Renzetti,1998; Ristock, 2002, Donovan and Hester, 2014).

Intersectionality and DVA

It is the lived experiences of Black and minoritised women (bell hooks, 1981; Lorde, 1985; Jordan, 1995; Crenshaw, 1989; 1991) that provided the most robust critique of the dominant conceptualisation of DVA, by challenging the unified category of `woman` as meaning that all women have a universal experience because of their shared gender. The view that all women were at equal risk and had a shared experience of DVA was rejected by Black feminist scholarship and activism (Crenshaw, 1989; 1991) because it excluded Black and minoritised women's experiences of DVA and the differential impacts of structural and cultural factors on lived experiences (Crenshaw, 1991; Collins, 2002; Mirza, 2015). Black feminist activism highlighted the interlocking nature of women's experiences of 'triple oppression'; sexism, racism and classism and simultaneously challenged the traditional feminist focus on white, Western, heterosexual, middle-class women and the anti-racist movements predominant focus on structural inequality experienced by Black men (Collins, 2002). This analysis of Black women's experiences as rooted in Black women's activism and scholarship was coined `intersectionality` by Crenshaw (1989).

Importantly, intersectional theory has developed beyond a focus on how `race`, gender and class interlock, to understand the interplay between multiple identities, where social categories of gender, `race`, class, sexuality, age, (dis)ability, religion and so on, are identified at a personal and structural level (Crenshaw, 1989; Bryson, 2016). Thus rejecting the idea of static conceptions of inequality to identify '*forms of inequality that are routed through one another, and which cannot be untangled to reveal a single cause*' (Grabham et al. 2009, p.1). Empirical research on DVA has applied intersectionality in different settings to explore Black and minoritised women's experiences (Crenshaw, 1991; Sokoloff and Dupont, 2005; Mirza, 2017; Thiara and Harrison, 2021), lesbian, gay, bisexual, transgender and queer (LGBTQ) experiences (Donovan and Hester, 2010; Rogers, 2021) ethnicity and class (Nixon and Humphreys, 2010), fathering (Heward-Belle, 2016) and mothering and child maltreatment (Damant et al., 2008), which has furthered insights into lived experiences and practitioner understandings of DVA.

Differentiation of DVA

There has been a shift away from traditional feminist understandings of DVA as rooted in men's need for power and control as a singular explanation of DVA and seeking to understand the different experiences of DVA in order to develop more nuanced understandings of how DVA can vary and how best to support those impacted (Johnson, 2005; 2008; Donovan and Hester, 2014; Myhill, 2017). Several typologies of DVA have been identified that are based on the nature and severity of DVA within intimate partner relationships and also the individual characteristics of those that cause harm. It is beyond the scope of this literature review to address these typologies in detail (Gondolf, 1988; Holtzworth-Munroe and Stuart, 1994; Cavanagh and Gelles, 2005). However the development of typologies has helped to facilitate an understanding of DVA beyond a traditional power and control framing and acknowledge that the experience of DVA is multifaceted in impact and perpetration.

As systems for capturing the prevalence of DVA have developed so too have debates about gender symmetry and whether women and men are equally as violent and abusive in their intimate relationships. Research regarding DVA perpetrated against men indicated that that men experience violence and abuse less repeatedly and

severely than women, were less likely to be hospitalised as a result and less likely to experience economic disadvantage when separating from their partner (Straus, 1993; 2010; Tjaden and Thoennes, 2000; Hester, 2009, 2013). Women's violence towards men was used more in self-defence to prevent further violence and women did not use coercive and controlling behaviour in the same way (Swan and Snow, 2003; Hester, 2009, 2013; Myhill, 2017). Prevalence rates and crime statistics across countries indicate that the impact of DVA experienced by women is higher than that of men (Garcia-Moreno et al., 2013; Sardinha et al., 2022) and women's experiences of DVA are more prolonged, severe, repetitive, likely to escalate and cause serious injury requiring medical attention (Johnson and Leone, 2005; Hester, 2009; 2013, Myhill, 2017). Women are also significantly more likely to be victims of domestic homicide across the globe (Stockl et al., 2013) with women from low income, Black and minoritised communities disproportionately more likely to be victims of lethal DVA (Benson and Fox, 2004), thus, evidencing the intersectional gendered nature of DVA.

The need for differentiating DVA has been motivated by efforts to develop more responsive practices to support victims and respond appropriately to those that perpetrate abuse and to contextualise DVA more effectively in intimate partner relationships. Typological approaches for explaining DVA emerged from the dissension between family violence and feminist theorists. Family violence researchers found that violence between couples was an inevitable part of family life and rarely become severe forms of violence (Johnson, 1995) resulting in the claim that women are as violent as men in their intimate relationships (Straus and Gelles, 1986). While feminist researcher asserted gender asymmetry and DVA as unidirectional and rooted in men's privilege and desire to maintain power and control over women (Pence and Paymar, 1993; Stark, 2007). This divergence in the research is attributed to different sample populations, with feminist researchers focusing on women participants in refuges and via police contacts where there is likely to be more severe forms of DVA and family violence researchers using national survey data generated from the general population and identifying less severe forms of DVA and DVA behaviours rather than impacts of these behaviours. These two perspectives were reconciled by identifying types of intimate partner violence that supported both perspectives. Within the research on DVA and gender asymmetry Johnson's (2008) typology is well known and bridges the debate by highlighting the different methodologies, replicating studies with different samples and finding differentiation in

DVA (Johnson 1995, 2005; Johnson and Leone, 2005) that legitimised both perspectives and furthered understanding of the nature of DVA. Johnson's (2008) typology of DVA identifies four main types of intimate partner violence (IPV):

- *Intimate Terrorism*. The most severe type of abuse and consistent with the dominant conceptualisation of DVA. This type of abuse involves a pattern of controlling, psychological abuse and intimidation, with or without physical violence that is used to subjugate women and occurs more frequently than other types of violence. It is more lethal and likely to escalate over time. Johnson claims this is most likely to be gender asymmetrical and perpetrated by men towards women.
- *Violent resistance.* The use of violence to resist or avoid coercive controlling violence being used, characterised by violence used in self-defence and as a response to intimate terrorism. This is identified as most likely being from women to men.
- *Mutual Violent Control* is a situation in which both partners might seek to control the other with the use of physical violence.
- *Situational couple violence.* The most common form of violence categorised. Where both partners are violent or abusive, where there are minor acts of aggression and conflict that can erupt into physical violence and be severe. Johnson (2006) identifies that this is less of an attempt to control the other partner. This sort of violence is categorised as unhealthy, low level, more common, less dangerous that the other categories and men and women are equally likely to perpetrate situational couple violence across relationships.

Stark's (2007) identification of coercive control is broadly similar to Johnson's intimate terrorism typology and argues it is more common than research suggests. Stark defines coercive control as men's use of intimidation, isolation and control to create a `hostage-like` existence for victims (Stark, 2007, p.205). Whereas Johnson (2005) eventually acknowledged gender symmetry in his intimate terrorism typology, changing this type from patriarchal terrorism to intimate terrorism, Stark (2009) maintained that coercive control was rooted in structural gendered inequality, aligning with the dominant heteronormative conceptualisation of DVA.

Mennicke (2019) argues for an interrogation of typologies and expands Johnson's (2008) intimate terrorism category by expanding thinking about the nature of control within relationships. Mennicke (2019) identifies three control related patterns in IPV; unidirectional control – where one partner utilises controlling behaviours, bidirectional control – where both partners utilise controlling behaviours and control resistance, a situation where one partner is violent and controlling, while the other partner is controlling but not violent. In Johnson's (2008) typology this behaviour would be perceived as part of intimate terrorism but identifying it as a separate pattern of harmful behaviours helps to bring greater insight to understanding the use of control in DVA and avoids collapsing all controlling behaviour as intimate terrorism. Transcending the gender debate in DVA can help to disrupt dominant conceptualisations of DVA towards more nuanced understandings of DVA experiences and help build appropriate responses too.

Differentiation of DVA has broadened understanding of DVA, reflecting different lived experiences and supporting more appropriate service responses. While DVA typologies have the potential for developing more responsive support for victims and better assessment of those that cause harm (Kelly and Johnson, 2008; Ali et al., 2016, Myhill 2017), suggesting that DVA is limited to a small number of types and assuming that perpetrators are homogenous in terms of their typology of DVA is too simplistic (Donovan and Hester, 2014; Gadd and Corr, 2017) and the use of typologies to inform practice with those that use DVA behaviours is a contested area. DVA can be unpredictable and triggered by different events and feelings that may have been held for a long time (Leary et al., 2015) that require responses that engage with lived experiences and the meanings that those affected bring to their experiences.

A number of commentators caution against the use of typologies as they can obscure the meanings that those that harm others attribute to their violence and abusive behaviour (Gadd and Corr, 2017; Mennicke, 2019). There are also challenges of translating typologies into practice settings where behaviour may have been categorised at one point in time (Wangmann, 2011) and seeing those that harm others as a binary type. Hence there is caution about rigidly applying typology informed deductive approaches to work with families that potentially homogenise the motives for the use of DVA and the nature and characterisation of DVA.

DVA and child protection

Family experiences of DVA were not adequately recognised by UK social work until they were linked to the impact of DVA on children (Maynard and Hanmer, 1987; Brandon and Lewis, 1996). The risk of harm to children was legally recognised through the Adoption and Children Act 2002 in England and Wales and identified the `impairment suffered from seeing or hearing the ill-treatment of another` as a form of `significant harm` as set out in the Children Act 1989 (s.31). Corresponding guidance made it a requirement for the police to notify CSC of incidences of DVA where children were present (HM Government, 2015). This shift recognised DVA as an issue that affected children, as well as adults. These developments alongside the criminalisation of DVA through the Domestic Violence and Crime and Victims Act 2004 also marked a shift from DVA being conceptualised as a 'private' adult issue, to being constructed as a CP issue (Humphreys and Absler, 2011; Peckover, 2014) and created significant demands on CSC services (Stanley et al., 2011) and greater state intervention into the lives of families affected by DVA.

The mainstreaming of DVA as a CP issue alerted practice to the harms that children are at risk of suffering, however, this has raised concerns about the nature of intervention with families affected by DVA (Featherstone and Trinder, 1997; Featherstone and Fraser, 2012a). In the context of DVA where harm is caused by the father against the mother, the rights and interests of mothers to their own protection from abuse and the need for support and safety has become particularly problematic in a CP context, particularly through state separation focused service responses.

The separation response

Traditional social work responses to families in situations of DVA have been risk focused with reliance on a separation perspective that enforces mothers to separate from their violent partner or risk having their child(ren) removed from their care (Featherstone, 2013; Witt and Diaz, 2019). Separation focused responses take an individualised approach to DVA in families by prioritising a child safety approach, often excluding men from practice and making mothers responsible for protecting their children in the context of abuse that they may be continuing to experience (Ferguson et al., 2020).

CSC dependence on a separation response to DVA fails to meet the diverse needs of families experiencing DVA. This punitive approach makes mothers' separation form their violent partner pivotal to keeping their children and often excludes fathers that are violent from practice (Scourfield, 2006; Lapierre, 2010; Featherstone et al., 2014). Separation focused state responses have failed to acknowledge the diversity of family experiences, where couple's may want support to resolve DVA (Philip et al., 2019), where women want help to end DVA when they seek help, rather than an end to their relationship (Fredrick and Lizdas, 2010; Kelly and Westmarland, 2015; Stanley and Humphreys, 2017). Enforcing separation has produced distrust in services, exacerbating unsafe situations, with families avoiding rather than seeking out support at an earlier stage (Stanley and Humphries, 2017, Robbins and Cook, 2018). While there will undoubtedly be a need for separation to ensure the safety and well-being of family members, it is limited as a one-size-fits-all approach because it ignores the complexity of family relationships and intersectional inequalities.

There can be reluctance to separate for a variety of reasons: a lack of support and economic constraints may prevent women leaving and building independent lives (Goodmark, 2015) there may be religious and cultural pressure to remain (Thiara and Harrison, 2021) and a fear of continued violence even when separated, particularly where there are children and expectations of ongoing relationships. Enforcing separation before there is adequate support in place can create additional needs and vulnerabilities for all family members in the aftermath of DVA (Goodmark, 2015; Philip et al., 2020). Families that are in contact with CSC can lack the social, material and economic resources (Bywaters et al., 2018) to respond to state pressure to separate where there is trauma and mental health difficulties (Philip et al., 2019, 2020; Wild, 2021). Furthermore, separation approaches can increase the risk of lethal post separation violence for women and children (Radford and Hester, 2015) and is a harmful state response to DVA.

The lack of services for working with families simultaneously around DVA are limited by individualised, siloed provision that is focused on children, women or men (Hester, 2011). While there is growing interest in developing alternative approaches (Mason et al., 2017; Stanley and Humphreys, 2017) austerity measures in the UK limit the possibility of resourcing services for victims and perpetrators of DVA and cement separation as a dominant approach.

Family experiences of DVA and service responses

This section is focused on family experiences of DVA in the context of child welfare concerns. There is a dearth of empirical research that focuses on everyday family life and family relationships and wider family networks in situations of DVA. The dominant focus in the literature on family relationships in the context of DVA is on dyadic relationships, in particular the mother-child relationship with less focus on father-child relationship in these circumstances. This mirrors the preoccupation in practice more generally with mothers as the focus of practice and neglect of the role of men as fathers (Scourfield, 2006; Featherstone and Peckover, 2007; Lapierre, 2008; Haworth and Sobo-Allen, 2020). An exception is the emergence of literature evaluating 'whole family' interventions (Stanley and Humphreys, 2017) and FGCs with families affected by DVA (Pennell and Burford, 2000; Mason et al., 2017; Sen et al., 2018) (which are considered later in the section on restorative practices). What follows is a focus on family members experiences of DVA. Due to the lack of family-focused research, the literature on children's, mothering and fathering experiences of DVA is considered respectively, with recognition that they are not separate entities but relationally bound, with individual and relational, family experiences of DVA.

Children's experiences of DVA

The research evidence of children's experiences of DVA is varied and complex. However there is consistency concerning the detrimental impact of DVA on children's lives. Notably, there are two strands in the literature: one focusing on the uncontested negative impact of DVA and interventions to address these impacts, and the other an emerging focus on children and young people's agency and resilience in situations of DVA. The conceptualisations of children as perpetual victims of their experiences are challenged by more recent studies that provide accounts of how children and young people's agency and coping strategies when living with DVA.

The prevalence of children's experiences of DVA are difficult to know because of the hidden nature of DVA, the different ages and limited ways that children can self-report abuse. Research evidences significant experiences and prevalence in the UK with one largescale survey of 6,195 children and young people in the UK estimating 15% of children had witnessed some form of DVA within a one year period, with 3.8% of children surveyed witnessing severe abuse of a parent (kicking, beating up, choking) suggesting that one in four children in the UK will experience DVA by the time they are

18 years old (Radford et al. 2011). However, a study into domestic homicide reviews (DHR) in England and Wales between 2011-2016, identified that there were children involved in 55 of the 142 DHR, indicating a high number which were found to have witnessed the homicide and called for help in the aftermath (Chantler et al., 2020). There is evidence that young people are victims of DVA from their peers (Bracewell, et al., 2020) and those aged 16-17 years old continue to be the group most likely to suffer DVA from a partner in the same age group (CSEW, 2019) with two thirds of 16 to 17-year olds who have been in a relationship indicating that they had at least one experience of DVA (CSEW, 2019). Teenage mothers are most vulnerable to DVA in this age group, and specifically in the immediate period after giving birth (Harrykisson et al., 2002; Agarwal et al., 2014). Furthermore, a UK study with young people revealed that the young women and men perceived violence as acceptable between intimate partners in certain situations (Lombard, 2016), highlighting the need for further research into how young people make sense of their experiences of DVA in intimate relationships.

There is substantial research demonstrating children's experiences of DVA can have a detrimental impact on their physical, social, emotional, mental health and development (Edwards et al., 2003; Meltzer et al., 2009). Research with children identifies that cumulative exposure to DVA will have a longer-term impact (Kitzman et al., 2003; Farmer, 2006; Humphreys and Stanley, 2006). Additionally, intersectional inequalities and family circumstances of parental mental health, parental substance use and poverty further compound children's experiences of violence and abuse (Cleaver et al., 2011; Thiara and Harrison, 2016).

Children have varied experiences and responses to DVA that will be dependent on their developmental stage, age, gender and the severity of exposure to DVA (Stanley et al., 2011). This can range from direct injury to witnessing or overhearing DVA of a parent or carer. Children's accounts include descriptions of being threatened, forced by fathers to be violent to their mothers, having their access to school, family members and friendships controlled and everyday experiences of fear and anxiety due to the anticipation of violence (Houghton, 2015; Lombard, 2016; Thiara and Humphreys, 2015). These impacts are manifested through physical and emotional distress, illness, depression, anger and aggression, anxiety and self-harm (Buckley et al., 2007; Houghton, 2015), evidencing the enduring nature of children's experiences of DVA..

Children's experiences of DVA have also been conceptualised as being part of an intergenerational cycle of violence and abuse. For instance, Ehrensafet et al., (2003) claim that children who experience DVA learn to use violence and control as a strategy within their own relationships and are at greater risk of repeating this behaviour in their relationships across the life course. While not detracting from this likelihood for some children and families, not all children that experience DVA in childhood go on to repeat abuse in their adult relationships (Moore, et al., 2013). The negative impact of DVA is not contested here; however, representing children that have experienced DVA only as victims is problematic, as it homogenises children's experiences and prevents seeking out broader understandings of how children cope in their everyday lives and relationships and how this can inform effective support.

More recent research evidencing children's agency and resilience in the context of DVA challenges the one-dimensional representation of children as passive victims (Katz, 2015; Callaghan et al., 2017; 2019). In the largest qualitative study to explore children's experience of DVA, 110 young people were interviewed across four European countries (Callaghan, et al., 2017). The study demonstrated children and young people's capacity to articulate the complexity of living with DVA through coping strategies that reflected their agency and resistance through everyday practices that included maintaining contact with friends and significant family members, protecting younger siblings and mothers and using imaginary play and music to distract themselves. Furthermore, young people reported an increased sense of empowerment and self-worth through their involvement in the research project (Callaghan et al., 2017, 2019), evidencing the importance of participative research methods in 'sensitive' research areas with children.

Limited services are provided for children affected by DVA and the evidence base specifically regarding children's and parental experiences of these services is underdeveloped. In a systematic review of qualitative studies by Howarth et al., (2016), controlled trials of interventions and consultations with children, parents and service providers (involving 1,345 children across the USA, the Netherlands, Israel and the UK) noted that the limited availability of services for children affected by DVA was significant. Most interventions were psychotherapeutic and focused on mental health outcomes with psychoeducational group-based interventions delivered with the mother and child reported as being the most acceptable by participants. However, the

UK had the least available evidence of services for children with little service evaluations, few qualitative studies and no UK-based trials. Therapeutic group-based provision for mothers and children was most evident but patchy and located within the non-statutory sector. Furthermore, austerity and funding cuts to the DVA sector were identified as significantly undermining the development of appropriate services for children affected by DVA in the UK. Therefore, there is a need for service that are responsive to all family members impacted by DVA. This study foregrounds the voices of family participants with experiences of DVA and can contribute to insights on adult sense-making of childhood experiences of DVA to support the evidence base on lived experiences and the kind of support that would have been helpful in their earlier lives.

Mothering in the context of DVA and contact with CSC

In the UK and other countries, women experiencing DVA are often responsibilised for protecting children by child welfare systems that are designed to support them. This is related to gendered discourse on mothers within social work practice which reinforces mother-blaming in situations of DVA (Strega et al., 2008). Indeed, the literature on children's experiences of DVA is more often concerned with the role of mothers rather than fathers, as having responsibility for the protection of children (Levendosky et al,. 2003; Lapierre, 2008). Maternal parenting in the context of DVA tends only to be understood through a CP lens of 'adequate or not' (Lapierre, 2008; 2010), with limited attention on how lived experience and intersectional inequalities impact on mothering. It is women's deficiencies as mothers and not their capabilities that become the focus of practice (Lapierre, 2010) and they can be perceived to be failing to mother because the context of their parenting prevents professionals from seeing the ways in which they provide `good enough` mothering (Mullender et al., 2002). Encountering blame and shame by service providers in this context can impede mothering capacities for help-seeking and compromise the safety and protection of women and children.

The evidence on maternal parenting and impact on children in contexts of DVA identifies tensions, with some studies finding that DVA has a negative impact on mothering that can result in women being more likely to significantly harm their children (Levondosky and Graham-Berman 2000). Some women's accounts of parenting in the context of DVA include physical and emotional abuse and exhaustion, impacting on their ability to consistently attend to the needs of their children (Radford and Hester,

2006; Humphreys et al., 2011; Keeling and van Wormer, 2012). This can include being abused in front of their children, physically assaulted, criticised, humiliated and having their parenting undermined (Mullender et al., 2002; Humphreys et al., 2011). It is unsurprising in these contexts, for mothers to articulate feeling defeated and disconnected from their lives, resulting in mental health difficulties and a loss of control over their parenting at times (Lapierre, 2010). Contrasting evidence suggests that while DVA, understandably, has a negative impact on parenting, some women can compensate for adverse environments at times and care adequately for their children and are no more likely to inflict harm than other mothers (Mullender et al. 2002).

Interest in understanding the process of mothering in situations of DVA has led to research focused specifically on maternal protectiveness; the steps that women take in their everyday lives to protect their children from DVA. Studies exploring mother-child relationships and protection in the USA, Australia and the UK (Haight et al., 2007; Kelly, 2009; Lapierre, 2010; Humphreys et al., 2011; Buchanan et al., 2014; 2015; Wendt et al., 2015) evidence a myriad of maternal protective practices. This includes being more attentive to DVA and using strategies in the moment to protect and prevent violence in front of children, avoiding arguments, appeasing partners, making arrangements in advance so that children will be away when women sense DVA is likely, physically getting between children and their partner, calling for third party help and limiting telling children the full extent of the abuse when they ask in the aftermath (Haight et al., 2007; Kelly, 2009; Lapierre, 2010; Humphreys et al., 2011; Buchanan et al., 2014; 2015; Wendt et al., 2015). Additionally, mothers in an Australian study found that thinking proactively about how to protect their children was a *constant* process (Wendt et al., 2015), highlighting the pervasiveness of experiences of abuse on mothering practices.

Mothering in the context of DVA is informed by discourses that carry high gendered expectations that make women responsible for their children and are reinforced by state interventions (Keeling and van Wormer, 2012). The use of attachment theory (Bowlby, 1979) to assess parenting is firmly embedded within social work practice and informs women's expectations, with little regard for the context of parenting in adverse situations. Attachment theory asserts that the primary carer (usually the mother) is instrumental in establishing a relationship with the child through a pattern of secure or insecure behaviour (Bowlby, 1979). The extent to which the attachment is secure or

‘good enough’ is judged by professionals and academics to be dependent on the primary carer’s capacity to parent. However, other factors such as the reciprocity in responsiveness in the mother-child relationship and how the temperament of the child also contributes to the attachment relationship is minimised in practice (Gopfert et al., 2010). This can lead to a sense of failure in their own mothering and reinforces service assessments of not being a good enough parent. As such, women can be viewed as failing to protect their children and their deficiencies become magnified, detracting from the ability to see the ways in which women provide good enough mothering (Mullender et al., 2002; Lapierre, 2010; Buchanan et al., 2014) and the ways in which they resist DVA in their everyday lives.

Women’s accounts of social work intervention identify both positive and oppressive practices (Lapierre, 2008; Keeling and van Wormer, 2012). Where women had clearly decided to leave their abusive partner, women spoke of positive practical and emotional support from their social worker, without which they would not have been able to leave. However, there were also direct threats and ultimatums, such as, `he has to go, or the children go’ to women that were undecided and felt powerless to make a decision (Keeling and van Wormer, 2012). This points to punitive practice that fails to acknowledge the lived experiences of women (Featherstone et al., 2014) and ultimately places the burden of protecting children on women.

Post-separation is a time of risk as women have stated it is harder to predict their partners’ behaviour when they are not living with them, which often leads to increased fear and distress (Hester and Radford, 1996; Humphreys and Thiara, 2003; Keeling and van Wormer, 2012). Separation does not necessarily mean an end to DVA either, as child contact arrangements can expose women and children to continued abuse (Radford and Hester, 2015) and increased risk of violence and DVA homicide in the period immediately after separation (Radford and Hester, 2015).

Fathering in the context of DVA and contact with CSC

Like mothering, the role of fathering is sensitive to the context in which it is ‘done’ (Perel and Peled, 2008). Changes in family structures and gender roles, from women’s greater participation in work, childcare responsibilities, rise in lone parent fathers and non-resident fathers have led to changes in the way that fathering is conceptualised. It is argued that there has been a move away from enduring definitions of fathering,

such as the breadwinner role to contemporary expectations and responsibilities of more involved, intimate and 'good' fathering (Featherstone, 2009; Miller, 2011). These changes bring tensions and contradictions because social expectations to provide financially still endure (Williams, 2004). However, structural inequalities and intersecting identities, for example, differential experiences of unemployment, can put the role of stable provider out of reach for many men and limit fulfilling societal expectations of being a responsible father and partner (Pennell et al., 2013). The changing role of fathers has seen an increased interest in fathering and fatherhood (Featherstone et al., 2007; Lamb, 2010; Featherstone, 2013) and highlighted the importance of the father-child relationship to a child's emotional and social development.

Research on fathers that perpetuate DVA has been `slower to emerge' (Smith and Humphreys, 2019: p.156), with DVA literature focusing on men as abusive partners and largely neglecting men's fathering role, while literature on fatherhood has largely neglected a focus on men who are violent and abusive (Heward-Belle, 2016). Mainstream DVA scholarship has 'othered' men by focusing on their hegemonic masculinity, agency and use of abusive behaviours, dismissing other aspects of their identities and adopting a `one dimensional` conceptualisation of men that are abusive (Featherstone, 2013). There is a gap in the literature and social work practice on men's lived experiences of fathering in the context of DVA with dominance on binarized conceptualisations of men as either `risk` or `resource` (Scourfield, 2006; Featherstone, 2013; Philip et al., 2019). The call for father inclusive practice in this area (Zanoni et al., 2013) requires an understanding of men's motivations and preoccupation with the use of DVA to seek appropriate responses that can keep women and children safe and help men to seek to change their abusive behaviour. This requires a consideration of men's lived experiences, not as excuses for DVA behaviour but to understand men's use of DVA in their intimate relationships and seek to develop appropriate interventions that support men to be accountable for their behaviours and ensure the safety of women and children.

The varied and complex factors that contribute to men's use of DVA are starting to emerge in the literature that link men's adverse childhood experiences with dominant masculinity (Augusta-Scott and Maerz, 2017) and trauma and mental health difficulties (Philip et al., 2019; 2020). Hegemonic or dominant masculinity is the concept of a

culturally idealised representation of manhood that acts as a reference point for men (and others) to judge themselves against (Connell and Messerschmidt, 2005). In Western societies, dominant masculinity is regarded as white, heterosexual and defined by personal, economic and institutional power(Connell and Messerschmidt, 2005) and brings expectations of how to behave, be in control and what emotions to show and what to hold back (Augusta-Scott and Maerz, 2017). The literature connecting dominant masculinity to DVA and men's experiences of abuse and trauma open up opportunities for connecting with men's multiple identities and challenge the rigidity of the `perpetrator` category.

Pence and Paymar (1993) argue that men that have experienced abuse and perpetuate DVA can often blame their own circumstances, their partners, children, mental health and substance use to mitigate their abusive behaviour. This can lead to some men developing narratives that identify them as victims and prevent them from taking responsibility for their DVA behaviour or seeking safer behaviour (Augusta-Scott and Maerz, (2017). Those that have engaged in research with men who have varied experiences of being harmed and harming others call for greater awareness of the role of intersectional inequalities in the dynamic of DVA (Heward-Belle, 2015; Gadd and Corr, 2017; Augusta-Scott and Maerz, 2017, Philip et al., 2019; 2020). This links to the stance adopted in this thesis, to gain further insight into the lived experiences of fathers, fathering practices and the meanings men attribute to DVA and resolution.

Fathers that perpetuate DVA in the literature are regarded as a homogenous group and characterised by the risks they pose to women and children (Perel and Peled, 2008; Heward- Belle, 2016). They are often described as fixed categories: abusive and neglecting (Harne, 2011), controlling and authoritarian (Bancroft et al. 2012), lacking interest in fathering (Lapierre, 2010), perceiving their parenting as better than their partner's (Radford and Hester, 2011) and not accepting of the impact of their abuse on their children (Salisbury et al., 2009).

A more recent qualitative study with seventeen fathers from diverse backgrounds (Heward-Belle, 2016), adopted an intersectional approach to consider men's lived experiences and impact on fathering. The findings confirmed previous research outlined above, that fathers perpetuating DVA place children at significant risk of harm.

However, differential harms were identified in this study that resulted from the interplay of personal and structural factors that shaped men's fathering practices. A typology was developed identifying a continuum of high to low identification with hegemonic masculinity, and a high to low loss of control. For example, the risks posed to women and children by men in the study from privileged socioeconomic groups that identified with hegemonic masculinity and low level of control over their use of DVA was significantly different to men who identified with lower hegemonic masculinity and low level of control. Heward-Belle (2016) concluded that children of fathers from the former group were more likely to be at risk of physical, sexual and emotional abuse, and children of men in the latter group were particularly at risk of emotional abuse and neglect. These findings are limited without corresponding research with women and children in these contexts, yet the study has demonstrated that an intersectional focus on men's lives can bring insights into the diversity of fathering practices in the context of DVA that further thinking about the safety of women and children too.

There have been calls to develop more holistic understandings of fathers that perpetuate DVA to develop insight into the issues facing men in their everyday lives and how this manifests through family life (Maxwell et al. 2012; Heward-Belle, 2016; Gadd and Corr, 2017). By its very nature research with men that are abusive to family members can reinforce a focus on men's abusive behaviour towards women and parenting deficiencies (Perel and Peled, 2008). However, a simplistic focus on single-axis explanations, for example, gender, `race` or class, constrains our understanding about men's lived experience and the meanings that men ascribe to DVA. This situation restricts the ability to explore how change could happen and ultimately how women and children can be protected from DVA. The family practices frame adopted in this study supports an exploration of fathering practices and consideration of men's multiple identities to further understanding of the parenting capabilities of fathers that are abusive.

Services for men that perpetrate DVA

There has been growing interest in UK CSC for appropriate services that engage fathers that perpetuate DVA and facilitate the safety of children and mothers as victims of DVA. This section will first consider the historically dominant Duluth model (Pence and Paymar, 1993) and then outline some of the programmes and interventions that

have evidenced hopeful practice for achieving positive outcomes for families and reducing men's DVA behaviour.

The dominant conceptualisation of DVA has been extremely influential in domestic violence perpetrator programmes (DVPPs) in criminal justice responses in the U.K. and across English-speaking countries (Barocas et al., 2016). DVPPs emerged in the 1980s in the U.K. as part of Co-ordinated Community Responses (CCR) to implementing services that could support change and accountability for harmful DVA behaviour. The historically dominant model in the U.K. and internationally is the Duluth Model (Pence and Paymar, 1993). This is a multi-agency intervention with perpetrators of DVA framed by a gendered analysis of DVA, emphasising the ways in which patriarchal power and control manifests in DVA against women and girls. A key tool of this model is the `Power and Control Wheel`, a visual tool that identifies DVA as part of a pattern of abusive behaviours used by men as a means of exercising their privilege and control and seeks to change this destructive behaviour through identifying behaviours from the `Equality Wheel`, which forms the basis of more egalitarian relationships (Pence and Paymar, 1993). These tools are used extensively beyond perpetrator group based activities and feature in social work practice to support victims and perpetrators to make sense of their experiences and to recognise the range of ways in which DVA is perpetrated.

There have been criticisms of the Duluth model as a heteronormative model that homogenises women's experiences of violence and male violence and proposes a reductive format that lacks the sophistication to deal with the complexities of DVA in different relationships by highlighting the negative impact of DVA on partners and children but not on parenting skills (Dutton, 2006; Featherstone, 2009; Rivett, 2010). The model focuses on men's responsibility and attributions of blame, denial and minimisation of abuse and its impact is experienced as punitive rather than reparative, resulting in high dropout rates on DVPPs (Mills, 1998; Babcock et al., 2004; Akoensi et al., 2013; Richards et al., 2019). While the Duluth Model is widely accepted as the gold standard for DVPPs across the world, research evidences that DVPPs based on the model have limited success. A meta-analysis review of twenty -two studies (evidenced that DVPPs based on the Duluth Model had limited effectiveness, with 40% of participants being non-violent following the programme compared with 35% of participants being non-violent without attending the programme, with minimal impact

on reducing recidivism beyond the effect of being arrested (Babcock, et al., 2004). Despite this elements of the model continue to be used in DVPPs in the UK and elsewhere.

The lack of evidence on the effectiveness of DVPPs in the UK prompted researchers to examine DVPPs and identify measures for effective change in DVA relationships. Project Mirabal was a multi-site, longitudinal research project in the UK (2009-2015) that evaluated the effectiveness of DVPPs in reducing men's violence and abuse and increasing positive outcomes for women and children (Kelly and Westmarland, 2015). Project Mirabal focused on evaluating long standing group work programmes that were established on the premise that men were consciously behaving in harmful behaviours to establish power and control over family members.

The project looked at six measures of success to address change among men on DVPPs and noted improvement on all measures. There was not only a focus on the cessation of violent behaviour but also addressed outcome measures for coercive controlling behaviour that women and children experienced. The evaluation demonstrated that change was possible through improvements in all six areas that focused on respectful communication, expanding `space for action`(Kelly, 2003), where women and children having more freedom and less anxiety both within and outside of the home. There was significant improvement in women and children feeling safer with freedom from violence and abuse and some improvement for safe, shared and positive parenting, with increased engagement by some fathers and awareness of their children's fears and anxieties. There was also improvement in some men's understanding of the impact of their DVA behaviour on their partner and children, with a reduction noted in men making excuses for their abusive behaviour and a small number making themselves accountable to wider family and friends by admitting their abusive behaviour and how they thought this had impacted their family.

The final measure focused on healthier childhoods and all indicators showed improvement particularly in the decrease of children worrying about the safety of their mothers and some children stating that they felt less frightened of their father after he had completed the programme. Importantly, these shifts were not always attributed directly to changes in men's behaviour but changes that the women and children had also made. The significance of Project Mirabal is the insights it provide across the six

outcome measures on how change happens for men who are abusive, their partners and children. Change in men's behaviour, through understanding and reflecting on their behaviour and translating this into change behaviour was understood as a non-linear process over a period of time.

Another initiative in the UK has aimed to consider men's experiences more holistically. The Drive project is a multi-agency service for perpetrators of DVA that works specifically with high risk, high harm offenders of DVA. This initiative was piloted in England and Wales (2016-2019) and is a partnership of non-statutory and statutory agencies, that include the police, health services and CSC and works with perpetrators to reduce the harm caused to victims and reduce repeat and serial harm by intervening early to safeguard families living with high-risk, high-harm DVA (Hester et al., 2017; Wild, 2021). The focus on intervention is more holistic than earlier DVPPs predicated on power and control, with a focus on mental health issues and trauma informed practice. An evaluation of the project (Hester et al., 2019) identified reduction in risk of DVA in three quarters of the cases over the intervention period and success was noted in reducing abusive behaviour, increased safety for victims and increased decision making that included victims seeking help to leave partners.

Alternative responses to thinking about men's use of violence and abuse in their intimate relationships has started to address men's experiences of trauma and abuse and their use of abusive behaviours. Psychosocial approaches have been effective in challenging men's use of violence and abuse through trauma-informed approaches. In one Canadian service, advances in practice with men support changes in DVA behaviour, Augusta-Scott and Maerz (2017) highlighted the importance of services attending to men's experiences of victimisation and dominant masculinity through narrative therapy approaches that enabled men to take greater responsibility for their abusive behaviour and attended to their experiences of victimisation. Through collaborative therapeutic practice men were supported to deconstruct their "victim-only" narratives and recognise the role of power and powerlessness in their relationships. This approach acknowledges men's experiences of victimisation and challenges the influence of dominant masculinity by facilitating recognition of multiple identities and stories that simultaneously position them as abusive and abused and still responsible for their choices.

Fathering programmes developed in Canada, Caring Dads, (Scott and Crooks, 2004; Scott and Lishak, 2012) and the USA, Strong Fathers, (Pennell et al., 2013) have been imported into UK service provision and offer community-based provision that utilise strengths based approaches (Saleebey, 1996). Independent evaluation of Caring Dads (McConnell et al., 2017) and Strong Fathers (Nulu et al., 2021) have shown positive outcomes for father- child and wider family relationships. They are established as programmes that work to motivate fathers to reflect on their relationships with their children, with the aim of changing their abusive behaviours with children and by association, their partners. linked to the concept of generativity and motivating men's desires to be safe and respectful fathers and by association, partners too. Generativity is a concept developed by Erikson (1964) as part of his theory of the eight stages of human development. The generative stage (seventh stage) involves the capacity to care about the next generation with a focus on shaping the world, beyond a focus on self. Generativity has been identified as an important aspect of fathering identity that is enhanced when thinking about men's legacy and their relationships with their children (Fleming et al., 2015). While Caring Dads and Strong Fathers were originally developed as parenting programmes to motivate healthy relationship strategies for fathers, they are established as part of the range of programmes that support restorative approaches to DVA too.

The Safe and Together Model (Safe and Together Institute 2018) disrupts mother-focused interventions in situations of DVA and emphasises the engagement of fathers to hold them accountable for their harmful behaviour. The model has three key principles: supporting the non-offending parent to keep children in their care as the default position; partnering with the non-offending partner as a default position and focusing intervention on the offending partner to reduce the risk of harm to children (Bocioaga, 2019). There is a focus on the abusive partners behaviour, the efforts of the parent that is harmed, the impact of abuse on the child and the wider impact of factors such as substance use (Bocioaga, 2019). Findings from the implementation report in Scotland identified that practitioners found it difficult to continue using the model without corresponding support from supervisors and managers, highlighting the importance of wider cultural change in organisations to support implementation of innovative interventions (Bocioaga, 2019; Scott, 2019).

There is evidence of approaches that seek to work with families that evidence innovation in DVA practice with families. The Hertfordshire Family Safeguarding model (Rodger, Allan and Elliot, 2020) is a whole family and whole system approach to CP services that aim to keep children safe within their families. The model brings together multi-disciplinary teams of adult and children social care practitioners from DVA, mental health and substance use services to deliver short term and longer term interventions with families. Practitioners work with a family as one team and use motivational and RP to support working with families. Evaluation of the project demonstrated that families were able to make positive, lasting changes to their lives. The model shows that DVA can effectively be responded to holistically in ways that challenge both the traditional separation approach and split between children's and adults social care provision.

The literature reviewed in this section advocates the need to develop more nuanced understandings of men who are abusive and to attend to their multiple identities in the context of their everyday family lives. There has been a move away from not working with men who perpetrate DVA to thinking about how to work with men that are abusive and the programmes above show innovation, evidencing that change is possible for men, women and children.

Restorative Practices

Restorative practice (RP) and approaches have their roots in restorative justice (RJ). In its contemporary form, RJ came to prominence in the 1970s as a social movement that sought to change the way society responds to crime by challenging punitive, retributive criminal justice responses and replacing them with more democratising community-based reparation (Braithwaite, 2000). This approach focuses on repairing harm done to people and relationships rather than focusing only on punishing those that have caused harm (Zehr, 1990). RJ is an omnibus term used to describe various practices that can vary widely and include victim offender mediation, FGCs, family group decision-making (FGDM), sentencing circles and peace-making circles (Rossner, 2017). The commonality of these practices is on participatory processes to address harm through repairing and building relationships that in turn can strengthen communities.

The use of restorative approaches in DVA is a highly contentious area of practice and debate (Strang and Braithwaite, 2002; Stubbs, 2007; Ptacek, 2010). This is because RJ was developed for one-off discrete incidents involving strangers rather than use for intimate partner violence which is often a repeated escalating harm that can be subtle or overt, between couples in ongoing relationships, and therefore seen as inappropriate (Stubbs, 2002; Stubbs, and Daly, 2006). Consequently, the use of RJ in cases of DVA in certain areas has previously been prohibited in law (Ptacek, 2010; Restorative Justice Council, 2016). However, there is a distinction between RJ and the use of restorative approaches (RA) and family participative decision-making in the form of FGCs.

The use of FGCs in situations of DVA have also been contested, with much of the debate focusing on the use of RJ with DVA and located within the field of criminology and law (Stubbs, 2002; Goodmark, 2009). These debates present significant valid concerns about the appropriateness of the use of RP with DVA in child welfare settings. These concerns have been predicated on concerns about their use where there are ongoing relationships and connections and relating this to the safety of victims, the potential for victimisation through the reproduction of abusive power relationships (Stubbs, 2002), violent partners potentially dominating restorative meetings (Kohn, 2010) and restorative processes not holding men sufficiently accountable for their violence.

Empirical evidence addresses these concerns with the use of FGCs in child welfare settings to facilitate repair and resolution for families affected by DVA. In their influential Canadian study, Pennell and Burford (2000), compared outcomes for children's and adults welfare and safety through the use of family group decision-making (FGDM) conferences with traditional child welfare responses over a one-year period. The findings demonstrated a significant decrease in incidences of child maltreatment and DVA in the FGDM group of families, compared to the traditional child-protection-process family groups, where a significant increase of DVA incidences occurred over the year. Families stated that FGDM processes had helped to strengthen family relationships, children's and adult safety and had helped them to deal with further family difficulties. Women in the study stated that they felt empowered by the process and preferred it to traditional CP responses. While there has been

limited research on the use of FGCs with DVA there has been research and evaluation of a UK based initiative.

Recent significant developments have occurred in the use of FGCs with DVA from a UK evaluation (Sen et al., 2018), where an established FGC service in a statutory setting was funded to expand its provision specifically for families affected by DVA. Findings from this evaluation have been used to develop a typology of FGCs. Sen et al., (2018) identified; Pragmatic, Resolution-focused and Restorative FGCs as outlined below:

- *Pragmatic* – where there is a focus on children's safety with the involvement of maternal networks and no involvement by the father/father figure or paternal network. This type can be helpful for practical support and validation of DVA experiences post separation for mothers.
- *Resolution focused* – this type can be helpful for resolving disagreements between partners and acknowledging paternal involvement in the child's life. This type can help restore communication and practical childcare issues. This type of FGC was used post-separation and involved maternal and paternal networks.
- *Restorative* – this type engages paternal and maternal networks, mothers and partners/fathers where it was safe to do so. The focus is on the safety and well-being of mother and provide an opportunity for the perpetrator to acknowledge DVA behaviour with plans put in place for the father.

Sen et al., (2018) found that pragmatic FGCs were the most common with resolution focussed being used less and restorative FGCs rarely featuring in their data. This was attributed to the influence of three factors: FGC Co-ordinator confidence to work with DVA; mother-focussed practice and the prevalence of a separation approach in social work practice.

The empirical evidence indicates that FGCs can be used in the aftermath of DVA with careful preparation and support for family members; in particular, with attention to the safety of mothers and children (Pennell and Burford, 2000; Sen et al., 2018). FGCs

are not going to be appropriate or accepted by all families in situations of DVA, however, Sen et al., (2018) typology expands opportunities for understanding both the possibilities and limitations of practice and family lived experience in the context of DVA and CSC contact.

Family Group Conferences in child welfare settings

Family group conferences (FGCs) will be the focus of this section of the literature review. The growing recognition of the inadequacies of provision for families affected by DVA and the parallel cost to the public purse, has provided a driver for innovation in CSC and the development of alternative approaches by the UK Government to tackle DVA (DfE 2014). This has included restorative approaches following DVA that utilise FGCs (Mason et al., 2017; Sen et al., 2018) that engage a wider family network.

FGCs are a strengths-based, family-led, decision-making approach that facilitates families to come together with professionals to discuss and agree plans for the care and protection of their child(ren) (Ashley and Nixon, 2007). FGCs originated in New Zealand in the 1980s and were established as part of social work practice with families through the Children and Young People Family Act (1989). FGCs were introduced in this way as a RJ mechanism to address structural racism in the child welfare and criminal justice system, with significant numbers of Māori children and young people removed from their families into state care and who were overrepresented in the criminal justice system (Ptacek, 2010). The New Zealand Children and Young People Family Act (1989) sought to shift this practice by making it a legal requirement to proactively involve families through an FGC meeting in decision-making for children and young people that incorporated Māori community led problem-solving customs through the use of family and community networks to seek resolution for family difficulties (Marsh and Crow, 1998). The use of FGCs in these settings was emulated in other countries, including CSC as a family engagement practice rather than an RJ concept.

FGCs have been adopted by other countries and developed differently across national, legislative, policy and practice contexts and not all are conceptualised as family-led processes (Burford and Hudson, 2000). FGCs were adopted in the 1990s in the U.K., outside of mainstream social work provision, primarily championed by advocates of family-led participative practice with families but also by services looking

to reduce numbers of children being brought into state care (Morris and Burford, 2009; Morris and Connolly, 2012). Consequently, FGC adoption and practice has developed differently in terms of geography and when they were first introduced.

FGCs consist of a family network meeting who come together with an independent facilitator to discuss issues relating to the welfare of a child or young person. There are three key stages to an FGC meeting:

- Preparation. The independent facilitator prepares carefully for the meeting by working with the family and professionals to include a wide family network, provide support to enable those involved to feel safe to participate and ensure the family are involved in the practicalities of the meeting to reflect their choice of venue, food, etc.
- The Meeting has two stages, the first stage is where professionals and family members come together, and the professionals share information about their concerns about the child's welfare. The second stage is private family time. Professionals leave the room and the family have time for discussion and to make a family plan that identifies how concerns will be met and arrangements for monitoring the plan.
- The Family Plan is shared at the meeting, with professionals re-joining and resources discussed, with the Family Plan agreed in principle or the plan is circulated following the meeting. There can be a singular FGC or follow up meetings can be arranged (Morris and Burford, 2009, p.122).

International evidence supports the positive outcomes that FGCs can achieve for families where there are child welfare concerns (Burford and Hudson 2000; Holland et al., 2005; Nixon et al., 2005; Frost et al., 2014b; Dijkstra et al., 2016). Families report high levels of satisfaction with the process and are more engaged in developing plans for their children in comparison to engagement with traditional CP processes, with fewer removals of children into state care (Pennell and Burford, 2000; Nixon et al., 2005; Dijkstra et al., 2016). While there is also evidence of inconclusive effect of FGC practice in comparison to CP processes in some studies too (Sundell and Vinnerljung, 2001; 2004; Frost et al., 2014a). However, there is consistency about FGCs enabling opportunities for family participation in decisions about their children (March and

Crow, 1998, Pennell and Burford, 2000; Holland et al., 2014) and supporting family engagement with CP services.

The inconsistency around outcomes in studies on FGC practice in child welfare settings raises a number of issues. Firstly, the focus on outcomes is difficult to define in relation to FGCs as outcomes will differ depending on family circumstances and are also dependent on whose outcomes are privileged: the organisations, practitioners or family members and which family member? (Mitchel, 2020). Secondly, the extent to which FGCs can facilitate family-led decision-making in a dominant child-safety, risk averse organisational culture is questionable (Sundell and Vinnerljung, 2004). Much of the empirical evidence on FGCs has focused on the FGC process and outcome, with little focus on family narratives about how families come to make decisions and exercise their ethic of care through and beyond the FGC process (Laird et al., 2017). This study addresses this gap by exploring family experiences of the use of FGCs and restorative approaches through CP interventions in the context of child welfare concerns where there is DVA.

The implementation of RP for families where there is DVA, provides a unique development for families and services to engage in participatory processes to support families to be actively involved in decisions about their lives. This also provides significant learning for social work practice and policy in the UK and internationally.

While restorative approaches in situations of DVA have been contested in the literature, they have evolved alongside practice and need empirical inquiry to develop theoretical understandings. A criticism of restorative approaches with DVA is the lack of empirical evidence on the benefits or harms that might result from such processes (Stubbs, 2010). Further understanding is needed into how experiences of restorative approaches can support the safety and wellbeing of those impacted. This study will contribute to this knowledge gap by exploring family experiences of RP and FGC and consider the experiences of families impacted by DVA and involved in CP processes.

Family practices

While there has been academic interest in family life in the context of ‘family troubles’ (Ribbens McCarthy et al., 2011) and poverty (Daly and Kelly, 2015), there is a lack of empirical enquiry on how families ‘do’ family life in the context of DVA (McKie, 2006;

Morgan, 2011; Hearn, 2013). The study of DVA in relationships and families has historically been located within the sphere of gender and family scholarship and revealed the interiority of family life along gendered power relations (Smart, 2005; Marx Ferree, 2010). While significant, the focus on `the family` as a rigid frame of analysis has limited the development of theoretical pluralism in this area to inform alternative perspectives in research (Eagleton, 2003; McKie, 2006), policy and practice.

The move away from conceptualisations of 'the family' as a fixed institution, towards a diverse and fluid concept of family life, relationships, interactions and activities, can be understood through Morgan's influential work on 'family practices' (Morgan 1996, 2011). Family practices are what families 'do' together; the multiple, interdependent, habitual elements of personal life (Smart, 2007, Shove et al., 2012), intimacy (Jamieson, 2005) and performativity (Finch, 2007). Theorising family as practices shifted the focus on the family as a fixed entity, to a focus on the 'interiority' of family life and family relationships (Smart and Neale, 1999). This linked changing family structures to human agency; the ability of individuals to negotiate and define their own family relationships and networks, regardless of biology, residence, marriage or location (Jones and Hackett, 2012), and shifted the focus from what families 'are' to what families 'do'; the way that families live their everyday lives, through activities and routine (Williams, 2004). This shift in scholarship towards the `doing` of family also reflected a move away from institutionalised understandings of the family, towards a focus on family relationships and personal lives.

A family practices frame invites a broader conceptualisation of `family`, away from the traditional narrow formation often practiced within social work (Morris et al., 2015), to consider how family networks practice their ethic of care (Williams, 2004) in circumstances of DVA and other adversities. Family practices provides an important conceptual lens for the study of families affected by DVA, because it facilitates a focus on everyday life rather than individualising family difficulties as individual deficits of family members.

Additionally, family practices provide a focus on relationships, and together with an intersectional perspective can facilitate an understanding about how structural inequalities impact people in different ways and can produce and reproduce DVA in

families (Montesanti and Thurston, 2015). For example, through this lens we can see how women's experiences of DVA are reinforced through cuts to refuge and welfare provision, how women's lack of access to material and legal resources also force some women to remain in situations of violence or lead to poverty when separating from abusive partners (Fahmy et al., 2016). The lack of attention to how structural inequalities impact the everyday lives of families affected by DVA explains, in part, why DVA continues to be patterned by gender, poverty and age – with younger people affected more than older adults – and why those that are structurally marginalised can find it harder to leave DVA relationships (Montesanti and Thurston, 2015; Fahmy et al., 2016; Gadd and Corr, 2017). Therefore, family practices brings a much-needed perspective in the scholarship on how families 'do' family in these situations and the complex exchanges involved in family relationships, within the context of other relationships through CSC involvement. This study is located in thinking about family in this broader more nuanced way and will contribute to scholarship about families working out family life in the context of DVA and state intervention.

The dominant conceptualisation of DVA has perpetuated a single story of severe DVA that limits exploration of the interplay between DVA and structural inequality. How families 'do' family in these contexts has received little attention. Consequently, theoretical contribution to inform effective social work practice remains limited. The social work field needs research that connects with family experiences through the exploration of family practices and contextualised practices as they intersect with the structural reality of family lives. As families continue to be referred to CSC in increasing numbers, this study will help to develop an understanding of family practices in the context of DVA to support practice and policy in this area.

Conclusion

This chapter has highlighted the contemporary issues in relation to DVA, CP service responses and family experiences of CSC provision in the context of DVA. Restorative practice and FGCs have been outlined. The literature demonstrates the impact of DVA and service responses for children and mothers and highlights a lack of evidence on the fathering practices of men that perpetrate DVA. Service responses are siloed and, predicated on the risks posed to children in situations of DVA and the exclusion of fathers from services. This impacts most heavily on mothers, who become the recipients of services through the continuation of a separation model making them

responsible for children's welfare and safety in the context of suffering abuse. Little attention has been paid to the family practices of families impacted by DVA and in contact with child welfare agencies. The literature reviewed in this chapter provides both a context for this study and also emphasises the need for nuanced approaches to DVA and CP that engage with the stories of those affected by DVA. This study aims to address these gaps. The next chapter will consider the methodology and outline how the research methods for the study were implemented.

Chapter 3: Methodology and approach

Introduction

In this chapter I outline my epistemological position, research design and how this was implemented to meet the aims of this collaborative study. Qualitative mixed methods were applied to explore family practices and restorative approaches in the context of DVA and child welfare concerns, with two participant groups: family participants (mothers and fathers) and CSC practitioner participants, social workers [SW] and family group conference co-ordinators [FGCC]. A combination of in-depth, semi-structured, interviews (in-person and telephone), focus groups and observation of practice were conducted to address each research question. I give consideration to my role as the researcher in this study before moving on to the qualitative methods utilised. Information regarding participant recruitment, data production, data analysis and my ethical approach are outlined with consideration of some of the methodological challenges encountered.

Theoretical framework

This study is interested in understanding social phenomena as produced through social interaction: the meanings, descriptions and stories that people ascribe to their experiences. This corresponds with a social constructionist epistemological position and sits under the umbrella of an interpretivist ontology, emphasising the sense people make of their own lives and experiences rather than there being an objective truth that the researcher can discover (Mason, 2017). Language as a socially constructed phenomenon is central to social constructionism and linked to power and representation. This emphasises the researcher's role as both interpreter of participant's constructions of their social world, and co-constructor as constructions are represented as a version of social reality and composed through the research encounter (Mason, 2017). In this way knowledge is (re)constructed by the researcher and is in a constant state of revision, produced through social interaction and diverse social experiences that are historically, socially and culturally situated.

Feminist post-structuralism

This study is located in feminist theorising. Feminist theory is diverse and multidimensional with its own blind spots and limitations (Mann, 2012). However, there is overarching commonality in feminist research identified by the rejection of objective reality, acknowledgment of explicit power dynamics in the research relationship as signifying ethically and morally poor research, and identify social inequality through a critical, emancipatory stance (Ramazanoğlu and Holland, 2002). This broad approach is adopted in line with a specific feminist poststructuralist epistemology and intersectional positionality. The justification for this theoretical approach will be discussed in this section too.

Feminist standpoint theory privileges women's voice and experiences, recognising that these have been marginalised through patriarchal oppression and gendered inequality. However, in relation to DVA, it can be argued that feminist standpoint theorists have primarily been concerned with revealing women's oppression at the hands of men, with little sympathy towards understanding the experiences and voices of men (Smart, 1992; Featherstone and Trinder,1997). As this study seeks to address the multiplicity of family voices, a feminist standpoint lens would narrow, rather than broaden understandings of family lived experiences and practices from the perspectives of all family members.

Feminist perspectives on DVA, privileged women's insights and understanding of their situations by highlighting issues that had previously been neglected to reveal women's lived experience and the 'private' aspects of their lives. Research on women's experiences of family life (Oakley, 1972, Dobash and Dobash, 1979;1981;1988 Barrett and McIntosh 1982) highlighted the way in which gender and power were interwoven in the understanding of family and personal relationships, and effectively revealed women's experiences of violence, abuse and subsequent state inaction. Much of the focus of DVA research and resultant practice has been informed by feminist standpoint epistemology. Women's voices have been privileged but can only give a partial account because women do not have an objective or privileged insight into reality (Featherstone and Trinder, 1997), because no one can! Thus, feminist standpoint perspectives limit a broader understanding of DVA and gendered relations because

women's narratives became the dominant narrative, reinforcing a gender lens that ultimately reduces knowledge that can support families in situations of DVA.

A feminist poststructuralist approach seeks to examine the relationship between knowledge and power and how truths are established as truths (Featherstone and Trinder, 1997). This approach views knowledge as socially situated and influenced by the knower's social and historical vantage point. This viewpoint is important to this study as the dominance of feminist standpoint epistemology in DVA research has privileged women's voices as more `real` accounts of reality, and fixed gender categories, constructing DVA as a universal, essentialising experience rooted in gender inequality (Featherstone and Trinder, 1997).

Instead, a feminist poststructuralist perspective challenges rather than reproduces fixed gender categories by deconstructing categories of 'woman' and 'man' to understand how differences between differently located groups and communities are socially situated. The developments in feminism through postmodernism, poststructuralism and postcolonial perspectives have focused on multiple voices that are generated from different vantage points (Mann, 2012). There has been a paucity of research that transcends fixed gender categories man/woman, victim/perpetrator. The focus on gendered relations in families in the context of DVA reduces the knowledge social workers require when working with the complexity of family life in these situations. Yet there is a need for family-led approaches built up from families own understanding of their experiences and meanings. A poststructuralist feminist research practice can make a significant contribution to understanding DVA, by disrupting dominant narratives and making variable meanings possible. This is important as the aim of this study is to privilege family voices; not as fixed subject positions but evolving, complex and socially and historically located, in order to support ethical social work practice in the context of DVA and child welfare concerns.

However, merit exists in considering perspectives that 'bridge the gap' and can further DVA practice. Ristock and Pennell (1996) provide a framework of feminist `links and interruptions` for DVA practice that bridge the gap between feminist standpoint and post structural perspectives by taking a reflexive approach to knowledge that is situated in the participant's social location and provides 'links' to feminist standpoint epistemology. This 'interrupts' women's standpoints, to include multiple voices that

trouble assumptions about relationships and DVA. Thus, different stories are generated to challenge absolute truths and reinforce the situated and partial nature of knowledge claims that have the potential to lead to transformative ways of seeking resolution in families.

Intersectionality

Intersectionality provides an underpinning for this study and is a critical feminist theory that rejects the idea of static conceptions of inequality. Early feminist scholarship highlighted commonality and sought to unite women through assumptions that all women shared similar experiences of oppression. However, this led to essentialised perceptions of women that were challenged by the critical insights of Black feminist scholars. The emphasis on the commonality of women's experiences of gender inequality were seen as an appropriation of the radical women's movement by White, liberal middle-class women, to shape the movement to address their own interests (Lorde 1984; Hooks, 1984). The theorising of this activism, identity and oppression led much later to the coining of the term 'intersectionality' by Crenshaw (1989) as detailed below.

> Intersectionality is a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking. (Crenshaw, 1989, p.149).

Intersectionality has its roots in Black women's activism and scholarship in the anti-slavery and civil rights movements in the USA. These voices amplified how gender , `race` and class intersect with social structures to reproduce social inequality, thus, providing an analytical lens to interrogate how interlocking forms of oppression and power position people differentially (Collins and Bilge, 2016). Intersectionality theory has moved on from essentialised and additive identity categories of `race`, gender, class, and so on, to a broader analytical tool to understand power relations on a micro and macro level. As such, it describes the complex interplay of a multiplicity of factors that shape people's sense of self as influenced through and by social, cultural, economic and political factors that are mutually influential and affected by historical and social power relations.

Black feminist activism and scholarship (Hooks, 1981; Lorde, 1984; Crenshaw, 1989; Jordan, 1995) deconstruct the categories of 'woman' and 'Black' to emphasise Black women's experience of oppression, and challenge classic feminist standpoint focus on the universality of gender oppression (Sokoloff and Dupont, 2005; Collins and Bilge, 2016). Thus, intersectionality has developed beyond a focus on how `race` and gender interlock, emphasising the interplay between different forms of discrimination and oppression. As some people will be more vulnerable to DVA (Fahmy et al., 2016; Sokoloff and Dupont, 2005) and consequently also likely to be vulnerable to social work intervention in their lives (Bywaters et al., 2018; Ferguson et al., 2020), an intersectional lens is applied in this study to provide a wider understanding of people's lived experiences of DVA.

It can be argued that feminist post structuralism conflicts with an intersectional feminist ontology (Brah and Phoenix, 2004), however they are brought together in this study because they offer creative potential for considering the plurality of voices, the intersectional and gendered experiences of DVA by families. This epistemological approach is congruent with my personal and professional values for social justice as it places the experiences of marginalised individuals and families at the centre of the study to challenge individualised, deficit focussed responses to DVA.

Reflexivity and positionality

Reflexivity is a recognised process for generating knowledge in qualitative research (Riesman, 2002; Mason, 2017), and is characteristic of qualitative research quality (Blaikie, 2010) and in keeping with feminist research (England, 1994). Reflexivity is understood as a fluid and active process where the researchers lens is directed internally. It involves a process of self-conscious, critical self-reflection of the researcher's ongoing position in the research process, and acknowledgement that the researcher's role and relationship with the research context will influence the research process and findings (England, 1994; Berger, 2015). Reflexivity and the necessity of a nuanced understanding of my positionality was familiar to me through my social work profession. Here, it also carried individual responsibility to scrutinise my values and assumptions in practice with others and actively consider the effect that my position had on the setting and participants.

My positionality is shaped by my experiences as a first generation Indian-British woman. My parents arrived in England as immigrants from India in the 1960s. Growing up in Coventry in the 1970s and 1980s, I experienced racism, casteism, classism and sexism. Making sense of these experiences was facilitated through anti-racist activism, reading and connecting with other experiences of marginalisation. This led me to the writings of Wilson (1978), Carby (1982), hooks (1982), Lorde (1985) and Anthias and Yuval Davis (1992). I learned later that these influences were linked to intersectional theory (Crenshaw 1989, 1991). Thus, my positionality within this research is shaped by lived experience of the intersection of gender, `race` and class which has facilitated an understanding and curiosity about the way that some voices and experiences are marginalised (Davies and Gannon, 2012). This aligns with a broader research voice that challenges dominant power relations in research practice (Ramazanoğlu and Holland, 2002) by developing knowledge insights from those whose voices are often marginalised.

`Race' and research positionality

Researchers have reflected on the challenges and possibilities of being racialised researchers, researching predominantly White majority participants (Twine, 2000; Törngren and Ngeh, 2018) and the importance of attending to the practical and ethical dilemmas of acknowledging `race` within the research process (Twine, 2000). I was aware that undertaking this research as an Indian- British woman, that I was likely to be in a minority within professional and family participant research settings. This is the pattern of my lived experience, of education and workplaces, other than the conscious choices I made to work in Black and Asian women's organisations. Intersectionality and critical race theory have facilitated my analysis of racism as ordinary rather than an aberration (Hooks 1982; Crenshaw 1989). I have learned to function in the `mainstream` of White, Eurocentric cultures and organisations and the insidiousness of racism. Therefore, it could be said that I was primed for there to be 'something happening'. However, when racist comments were made during fieldwork, in an unfamiliar city and spaces, I did not anticipate it. As a new researcher, I was experiencing racism within a researcher role, where there were different considerations of power relations that whilst similar to some of my professional

experiences of social work and home visits, were different and unnerving in this new role.

Below are just some of the situations requiring reflexivity on my racialised positionality as an ethical consideration in the research process, whilst simultaneously seeking to establish research relationships with some participants.

- In the first week visiting a locality team I walked through a busy shopping area where two older White women looked at me and one woman shouted, 'I just wish they'd all go back to their own country' and then spat at me.
- In a different area a practitioner cautioned me to avoid coming to the office on St George's Day because 'it can get pretty nasty if you're not White'.
- I was greeted at the door by one participant with, 'Come in, we're not racist'.
- I knocked on a participant's door and a young girl looked out the window and shouted, 'Mum, there's a Paki lady at the door'.
- A participant narrated that 'All Paki men are groomers'.

These encounters raised many questions about how to proceed in the moment: What was the right thing to do in these situations? Should I comment and risk retaliation and alienating families that I had come to speak to? By not acknowledging comments, was I complicit with racism? What difference would it make to the research process? I made a judgement to ignore them in the moment, with mixed satisfaction and disappointment. This experience attuned me to the need for ongoing reflexivity and consideration of the different power dynamics in the research process.

The aim of the research was to gather information, ultimately to make a positive contribution for families' lives. I did not want to alienate participants. Being explicitly racialised through research encounters by people in the research city and participants, reinforced my sense of 'other', whilst I was simultaneously being welcomed into family homes. This was a fluid situation and I needed to refocus on the practical act of interviewing participants. It did not feel appropriate in the moment to challenge comments. I moved beyond these remarks to consider how to put participants at ease

so that they would talk to me about difficult situations where people had been in harmful relationships.

After the fieldwork had ended, I reflected that the accumulation of racist comments (there were other encounters in neighbourhoods while making visits) contributed to me feeling vulnerable on visits to and in family homes and offices, where I was also listening to painful stories of trauma and talking about DVA. I did not feel that I was in any immediate danger; however, I became more safety conscious and was reassured by the practical strategies to maintain my safety. For example, I was careful about where I parked, sharing my whereabouts and contacting my supervisor and Northford research link team manager, before and after visits. I was offered debrief time with my supervisors and felt well supported. But there was also a creeping sense of anxiety as the fieldwork progressed due to the wider political context (the post-Brexit referendum and the rise of national populism) and my own experiences of increased everyday racism out on the streets in Northford and my home city.

A collaborative research project

Social work requires robust evidence-based research to support practice (Teater, 2017) and partnerships across practice and academic settings can create learning opportunities that further knowledge creation and exchange across applied and academic settings. It is within this context that this research was conceptualised as a collaborative study between the University of Sheffield and Northford local authority. The study provided a unique opportunity for praxis-oriented research in a statutory social work setting. Collaboration offered evidence-based research to be undertaken through access to family members, practitioners, managers and CSC processes and practice.

A collaborative research advisory group was formed at the start of the research process that included key stakeholders: a senior manager, FGC team manager from Northford CSC; an academic lead from the university and me. The group met four times in all, at the start of the research to clarify the focus of the research on practice and seeking to understand how RP and FGC were applied with families affected by DVA and CP concerns. This was a broad focus, and, in this respect, the group did not overreach their involvement, other than setting the parameters of the practice focus

and identifying key channels of communication for me to pursue, research contacts and progress the research. The inclusion of family voice and people with lived experience of contact with Northford CSC were identified through the pre-existing Family and Friends Advisory Group (FAFAs) (see below). The research period was interrupted a few months into my writing up stage of the study by the Covid-19, thus delaying formal reporting back.

Methodological framework

I adopted a facet methodological orientation (Mason, 2011; 2018). Facet methodology assumes a broad view for seeing the world as 'multi-dimensional, complex, contingent, entwined and connected' (Mason, 2017, p.43) and is compatible with the feminist post-structural and intersectional underpinnings of the study too. Facet methodology is based on the visual metaphor of a cut gemstone and its numerous facets. This facilitated both an openness and acceptance of uncertainty within the research process as varying levels of insight and enquiry were brought together to understand multiple connections and influences between phenomena as 'facets of insight' rather than objective truths or total knowledge (Mason, 2017). The metaphor of the gemstone helped to consider the multidimensional, fluid context of this research in different settings; families homes, communities, social work and FGC teams and locations, together with research relationships, family practices and the intersection with CSC encounters.

Abductive research strategy

I adopted an abductive research strategy because it emphasises understanding that reflect the meanings that participants give to their experiences, whilst also acknowledging the role of the researcher as reconstructing knowledge (Blaikie and Priest, 2019). This strategy emphasises theory building derived from the researcher describing meanings, language and experiences that participants have shared, and using these to derive concepts that deepen understanding about the inquiry at hand. This was a reflexive and iterative process of moving back and forth between the data and reading relevant literature. reflection and linking the findings to family practices framed by an intersectional analysis.

While my literature review chapter identifies relevant literature, my review of the literature was not a linear process of identifying and reviewing all the literature before fieldwork, then data production, analysis and write up of my findings. Data production and analysis highlighted themes that necessitated further reading and literature searching. As such, relevant literature is identified in my literature review chapter and also within my findings and discussion chapters. This demonstrates the iterative process of literature searching and reading alongside data production and analysis to support me to explore meanings in my data more fully as indicated by an abductive strategy.

This strategy was most appropriate for this study with both sequential and simultaneous purposive data collection. For example, the first FAFAs meeting informed individual family and practitioner interviews, which in turn informed focus group meetings and observations of practice. There was member checking with the FAFAs and practitioners by having follow up meetings towards the end of the fieldwork period, to check my sense making of data with theirs (Birt at al., 2016). In addition, all family participants were asked if they wanted a transcript of the interview. No one took up this option. This was not offered to the practitioner participants due to the limited time available.

Study design

The primary aim of this study is to gain insights from the narratives of family participants and CSC practitioners about family practices and RP, where there are DVA and child welfare concerns, to further academic and applied understandings of families living with adversity. As such, the study was designed to respond to the research questions below, in the most appropriate and effective way.

Research Questions

1. What family practices are described by family members and practitioners in the context of DVA? (How do families ‘do’ family in the context of DVA?)

2. What are the family narratives of DVA and contact with Children’s Social Care (CSC) Services?

3. What are the opportunities and limitations of restorative practices (RP) to support family resolution in the context of DVA?

Qualitative mixed methods

Mixed-methods research examines social phenomena usually by combining quantitative and qualitative approaches (Bryman, 2016). There have been calls to reframe mixed-methods research in ways that transcend the quantitative/qualitative divide and refocus methods to effectively support data generation aligned to the focus of inquiry (Mason, 2005, 2018; Gabb, 2009). In this study, I mixed qualitative methods to explore different perspectives and my primary methods of data production were semi-structured interviews and focus groups and included observations of practice too. These methods were used sequentially. For example, involving families from the onset was an ethical imperative given the marginalisation of families in contact with CSC (Featherstone et al., 2014; Hood, 2012) and, in particular, the marginalised experiences of mothers (Keeling and van Wormer, 2012) and fathers (Philip et al., 2019; 2020) in situations of DVA and child welfare concerns. As such, I prioritised meeting with the Family and Friends Advisory Group.

Table 1. A qualitative mixed-methods study

Ontology and Epistemology	• Interpretivist • Social Constructionist
Theoretical perspective	• Post structural feminist • Family practices • Intersectionality
Research Strategy	• Abductive
Qualitative Methods	• Semi-Structured Interviews • Focus Groups • Observation
Data Analysis	• Thematic Analysis (Braun and Clarke, 2006)

Data production

This is a qualitatively driven mixed-methods project with a dual focus, firstly to study family practices of families impacted by DVA from the perspectives of family participants and practitioners and secondly, to study contact with CSC and RP with families and practitioners, from the perspectives of family participants and practitioners.

Mixed qualitative methods: in-depth semi-structured interviews, focus groups and observations of practice were used to facilitate understanding at a micro (family/private) and macro (state/public) level. The field work and data production for the study took place over a nine-month period from February 2019 to October 2019.

I kept a research fieldwork diary to record my reflections that I began at the start of the study and ended after the data analysis period. This was a reflexive activity that helped me to reflect on decisions about my research design, fieldwork and the emotional impact of researching this sensitive area (Silverman, 2013; Malacrida, 2017). I used the research diary throughout the data analysis process to contextualise the data and cross reference themes that were generated through reading through interview transcripts. I also made drawings of homes, where people sat during interviews and the layout of the family rooms where interviews were undertaken. I also made audio recordings sometimes before interviews, but mostly after interviews to record reflections and key thoughts contemporaneously.

Family and Friends Advisory Group (FAFAs)

A key aspect of the study design was meeting with the established Family and Friends Advisory Group (FAFAs). This group included people that had, had experience of CP processes as parents, grandparents and family friends, and notwithstanding the contested nature of the term, were ‘experts by experience’ (McLaughlin, 2008) who met quarterly, supported by the Family Group Conferencing Service as a peer support and advisory group for Northford CSC. The first meeting with FAFAs was purposive: to share my draft research design and methods, gather knowledge about the fieldwork context, and consult their views on approaching families to talk about sensitive issues to help me review my research design. There were important practical and discursive suggestions made about my approach and proposed communication with families.

This included being advised not to wear a lanyard when visiting families to minimise ‘being like a social worker’, emphasising I reflect on power dynamics inherent. Thus my contact with the FAFA group was through an advisory capacity and not data focussed on them as a group.

I made a number of changes to my research design following the FAFAs first meeting.

- I had originally wanted to interview family groups, starting with individual family members, then having a second interview with the family group where that was safe and possible. I realised that this was not probable where individual family members did not feel comfortable, and situations were changeable. I decided that I would still work with teams to access family groups but would be flexible and meet individual family participants and pursue contact with other family members where appropriate.
- I decided not to ask families to create a storyboard to describe their week. This was in recognition of the different levels of literacy there might be and acknowledgement that situations could be fragile and not appropriate to ask for storyboarding when there were ongoing family difficulties.
- I decided to continue with the proposed semi-structured interviews as an accessible method.
- The discussion on confidentiality needed further clarity and I decided to include an example when seeking consent, of when I would break confidentiality and share information. I needed to make it clear how I would act when I thought there was a safeguarding situation.
- I agreed on an incentive of a £10 gift voucher for each interview and as advised purchased these from local supermarkets in the area I was visiting, rather than a city centre shop that would necessitate a bus journey to spend them.
- I decided to base myself with the locality FGC teams first, rather than the social work teams first, in each of the three areas, to optimise access to families, where trust in services was reported as potentially higher.

Semi-structured interviews

There is a long history of DVA research that has utilised qualitative interviewing to gain greater insight into women's experiences (Dobash and Dobash, 1979;1992). While quantitative research using survey methods has yielded significant data on the prevalence and differentiation of DVA (Griffiths and Hanmer, 2005; Johnson, 2005; 2008), it was not appropriate for this study where more nuanced insights into people's experiences and understandings of DVA and state intervention were being sought.

I was interested in hearing about family practices and chose to conduct a semi-structured interview method rather than a specific narrative method such as the biographic narrative interpretive method (BNIM) (Wengraf, 2001). The BNIM aims to elicit an uninterrupted narrative from participants that potentially could have led to a high volume of data without structure, a longer interview, or a lack of data where participants may have been reluctant to share their stories on a first meeting. However, I did not completely reject BNIM and utilised non-directive 'open questions' through the interviews. This was to facilitate the participant to direct their own narrative. I incorporated narrative inquiry and probing to bring a focus to my research questions (Reissman, 1993), starting with more open questions and moving towards more specific ones. This supported participants in recalling memories and experiences in a 'free association' way that provided a 'relational account' (Gabb, 2009, p.42). As such, participants shared a wide range of experiences, emotions and relationships, and moved between events across their life course. In this way, narratives were not chronologically ordered but were structured through their feelings and accounts of relationships. I found that even conducting semi-structured interviews led to a large volume of rich data.

I had an interview topic guide (see Appendix 4) with pre-defined topics linked to the research questions that I wanted to explore with participants. I utilised this guide flexibly, being sensitive to the process and context and was open to participants sharing their stories in the way that they chose.

Focus group interviews

I organised two focus group interviews with practitioners. The first focus group (March 2019) focused on locating practice with families and the challenges and opportunities

that practitioners identified. A pilot study that I conducted earlier (September 2018) in the same local authority evidenced the use of written agreements with families suggesting separation in the context of DVA. I wanted to learn about service responses to DVA and if the separation model was still in use and the nature and extent of RP more generally.

The focus group brought practitioners together that elicited views and feelings about everyday practice with families, DVA and CP practice situations . While they took time to organise and coordinate, the groups were insightful having different practitioners (Social workers, FGC Co-ordinators, Caring Dads and DVA social work trainers) together from different areas of the city, that worked with different communities in Northford. The same practitioners (10) were involved in both focus groups. The second focus group was six months later (September 2019) towards the end of the fieldwork process where I was able to introduce themes and observations generated from the data. This also facilitated member checking with the group.

Information about practitioners involved in the study is available in Appendix 2 and 3, this is deliberately limited information to support anonymity, as some teams were small and there was a lack of diversity within the practitioner sample.

Observations

Observations were made of some practice during fieldwork both as a participant observer in team meetings and also a non-participant observer in CP meetings and at multi-agency meetings too. Observations of practice were not the primary method of data production but did produced data in the form of reflections that were recorded in my research diary.

Access to family participants

I was reliant on practitioner engagement across different teams and locations for access to families. By sitting in teams and familiarising myself with team members, this facilitated conversations about the research study. I was able to ask that families be approached and followed up on those that were interested. I reflected about the possibility of bias and only having families that had a good experience of intervention. This initial concern of bias did not hold true whilst I was speaking to families, who shared varied experiences of provision from different practitioners.

Access to family groups was not possible due in part to the sensitivity of the topic being researched. Some participants did not want their partner or family to be contacted due to their vulnerability, the fragility of family relationships and a lack of family members identified to approach. For example, there were a number of families where partners had agreed to also take part, and there were children of eligible age (over 9 years old) and grandparents interested. On following up, one grandmother declined when I arrived to interview her, despite having consented, because she said it would be too painful to revisit her experience of DVA; especially as her grandchild was possibly going to be placed in out of home care. A couple initially consented and subsequently withdrew consent, stating that their lives were more settled and they did not want to revisit the difficulties in their relationship or talk about DVA.

Access required perseverance. Ongoing communication via texting to remind families I was going to be there was critical for data collection. Once families had consented to be involved, I arranged interviews. I texted a few days before and on the morning of the interview. There were several occasions where I had driven to the city and did not realise the participant had texted to cancel the interview, arriving to find no response, having to rearrange and on one occasion told to go to a coffee shop and come back a few hours later.

Access to male participants was slow through FGC and SW teams. I approached the Caring Dads service, and they shared contact details of five men and four consented to a face-to-face interview. In addition, despite requests, access to ethnically diverse families was limited via SW and FGCC.

Family participants

I interviewed 15 individual family participants (see Appendix 1). This included nine women and six men. All the families involved in the research were known to CSC and had current or previous children that were subject to CP plans and included mothers and fathers that were separated from children through state removal. All family participants had been assessed by social workers/FGC Co-coordinators regarding the level of DVA risk posed and were identified as there being a low risk of DVA between couples at the time of the research.

All women had contact with CSC. Eight of the nine women had an active social care case for their child(ren) at the time of the interview with one case having closed six months earlier. This contrasted with the fathers. There were four fathers that had active social care cases for their children. There were two fathers that had previous contact with CSC and their children's cases had been closed for over two years prior to the interview. Participants identified DVA, emotional abuse, physical abuse, parental mental health and substance use as reasons why they thought CSC had intervened in their lives.

Practitioner participants

Individual practitioner interviews were conducted with six practitioners (four women and two men). This included three social workers and three FGC coordinators. Practitioners were represented from all of Northford CSC geographical area teams.

For the focus groups I sought a sample of eight practitioners from different geographical teams to include a mix of social workers and family group co-ordinators. I wanted practitioners to commit to two focus groups for continuity. The first would be near the start of fieldwork and the second focus group to take place towards the end of fieldwork. This number was exceeded with ten practitioners attending the first practitioner focus group (some did not confirm and arrived at the focus group on the day). This felt like too big a group but continued with ten participants for the focus group.

Ethical considerations

As a collaborative project ethical approval was sought and agreed through two processes. Firstly, through the University of Sheffield ethics process. Once this was agreed this was submitted to Northford City Council via CSC Head of Service and agreed through their ethical process too. In addition ethical criteria from the Economic Social Research Council (ESRC) as funders of the research were also adhered to. The code of human research ethics for social work research were also applied (BASW, 2012). I noted a commonality in the ethical guidance across these different ethical processes that I adhered to in this study. These include avoiding harm to participants, research to be carried out with the aim to produce identifiable benefit, participants to

give voluntary consent and be treated with dignity and justice through the research process, such as during the write up and research dissemination.

The protection of research participants from risk of harm through the research process and related activities, is crucial, particularly when researching areas deemed sensitive (Holland and Shaw, 2014). DVA is a sensitive research topic that has been extensively researched with accompanying academic inquiry on the ethics and methodological challenges of researching DVA with women victims (Skinner et al., 2005; Dickson-Swift et al., 2006; Downes et al., 2014), children (Katz, 2015; Callaghan et al., 2019) and fathers that have been abusive (Harne, 2005; Augusta-Scott and Maerz, 2017).
A sensitive research topic is defined as 'research which potentially poses a substantial threat to those who are or have been involved in it' (Renzetti and Lee, 1993, p.4). This definition encourages reflection on the potential for harm to participants and researchers, facilitating a broader consideration of the consequences of the research.

Informed consent

Informed consent is intrinsically linked to ethical practice in the context of this research and was sought verbally, confirmed in writing and face-to-face at the start of each interview. Participants were made aware that they were free to withdraw from the study at any point without giving a reason.

While the recounting of experiences of DVA can be distressing, there is a long history of women victims sharing their stories (Dobash and Dobash 1981; Dickson-Swift et al., 2006). Research has supported women by providing space to reflect on their experiences and feel validated by empathetic research. Research with men who have been violent to an intimate partner has also yielded benefits for men to reflect on their behaviour and consider appropriate support (Perel and Peled, 2008; Augusta-Scott and Maerz, 2017; Gadd and Corr, 2017).

A positive empowerment approach (Downes et al., 2014) was adopted, where participants were considered as active agents in the research process and a situated approach to informed consent. There were times when participants made significant disclosures about previous abuse, and some became tearful in their interview. I checked if participants wanted to continue, recognising that informed consent,

particularly with sensitive research topics, needed to be an active process through the research process rather than a one-off contractual obligation.

As such, the key principles of Ackerley and True's (2008) feminist research ethic were used to guide my research practice. These principles emphasise attentiveness to the power of knowledge, the power of relationships within the research process and the requirement for critical researcher reflexivity through the research process. This ethic was brought into action with the positive empowerment approach (Downes et al., 2014) in the research and facilitated a robust ethical orientation, for the sensitive nature of the research.

The research process is outlined in table 2 below. While presented in table format with connections between research activities, this was not a linear process but an iterative process of organising meetings and interviews, moving between co-location with different teams, interviewing family and practitioner participants throughout the fieldwork period.

Table 2: Research Process Map

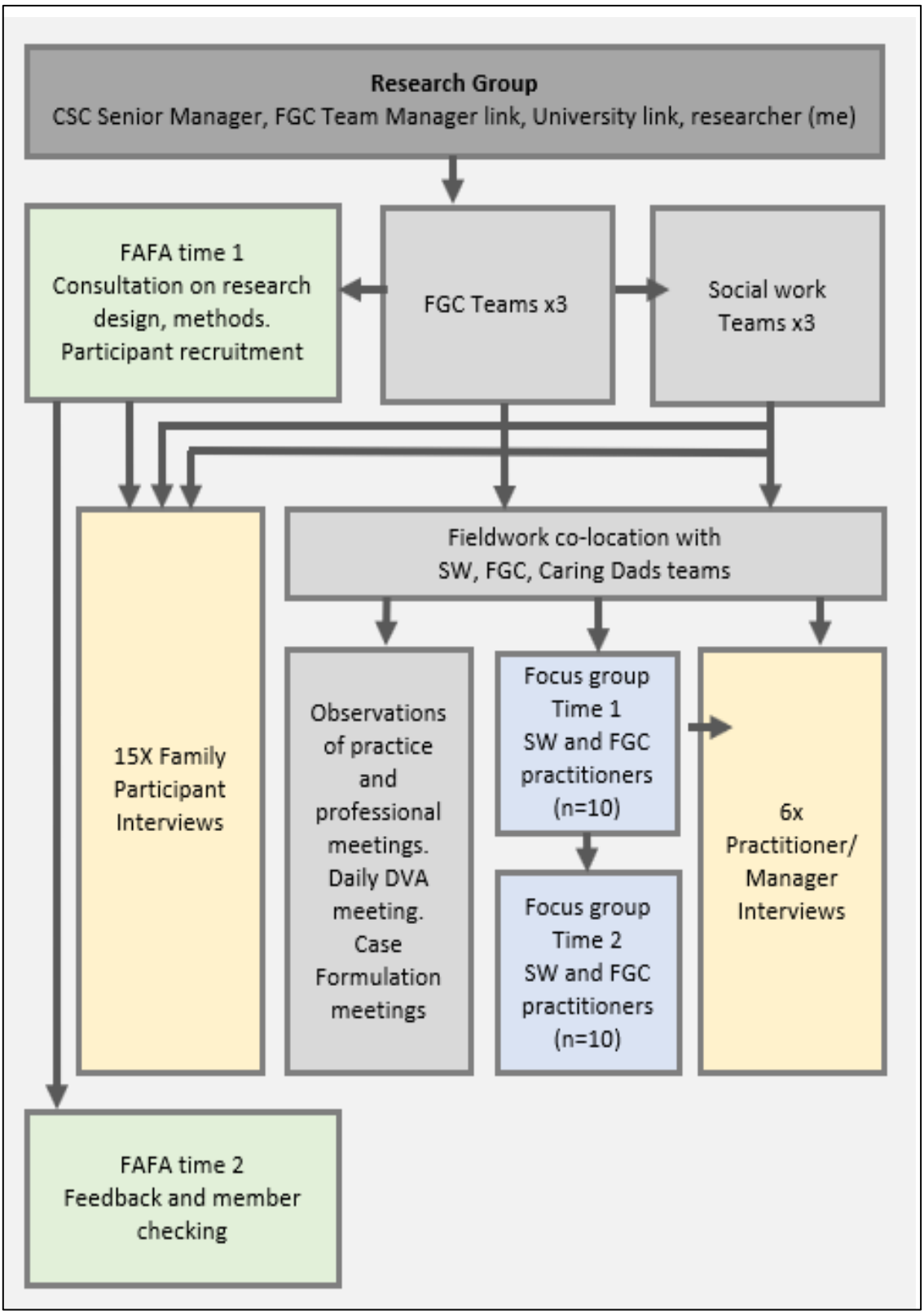


Table 3 below identifies the data sources for the study.

Data Sources Activity and Duration		
Individual Interviews with Family Participants (15)		
13 in person interviews	1hr - 1hr 50 mins	See Appendix 1 for further details
2 telephone interviews	35 - 45 mins	
Practitioner interviews (6)		
6 in person interviews	1hr - 1hr 15 mins	See Appendix 2 for further details
Focus Groups		
Time 1 (March 2019) 10 Practitioners	1hr 35 mins	See Appendix 2 for further details
Time 2 (September 2020) 10 Practitioners	1hr 30 mins	
Observations of practice		
Co-location with 3 FGC area teams	30 days	Reflections recorded in fieldwork diary
Co-location with 3 SW area teams		
Co-location with Caring Dads Service		
1x Daily Domestic Violence Risk Assessment Mtg	5 hrs	
2 x attendance at Child Protection Core Group Meeting	2x 1hrs	
1 x Edge of Care panel meeting	3hrs	
2 x Case Formulation meetings	2 x 3 hrs	

Data analysis

Data analysis started at the point of transcription. The interview data included the transcribed interviews and my reflections immediately after the interview, as captured in my research fieldwork diary. This led to rich data from a range of perspectives that required an integrative approach to data analysis. I initially combined a voice-centred relational method, The Listening Guide (Doucet and Mauthner, 2008), with a thematic approach (Braun and Clarke, 2006), incorporating intersectional analysis to

understand the nature of the relationship between participants experiences and overlapping inequalities.

Part way through the writing up process, during the Covid-19 pandemic, I lost vision in one eye for four months and took a leave of absence. Working on screen and reading was difficult and so I listened to interviews again and again and recorded my reflections on audiotape. When my vision returned, I transcribed these analytical reflections and was struck by the detail of the sensory experiences I remembered recalling smells, the weather, light (and lack of) during interviews. Being forced to engage with the data auditorily for a period of time emphasised different `facets` of the interview encounters that may not have surfaced had I been simultaneously listening and transcribing the interviews whilst staring at the computer screen.

The Listening Guide (Doucet and Mauthner, 2008) is a voice-centred relational method of data analysis that aligned with my theoretical framework and pursuit of 'working reflexively with both the critical and constructed subject and with translating epistemological conceptions of relational narrated subjects into research practice' (Doucet and Mauthner, 2008 p.404). This method facilitated listening and reading for multiple voices and relational power dynamics, to offer different vantage points across the same data through five stages. I included an additional fifth stage at the beginning as I transcribed all interview data, which Doucet and Mauthner (2008) did not.

1. Listening and transcribing - reading through the transcript and transcribing while also reflexively making sense of data, noting my thoughts, interpretations and assumptions (these were not limited to this stage).
2. Reading - reflexively making sense of what is happening (e.g. by asking 'What is the story?').
3. Reading - considering the participants' 'I' statements.
4. Reading - regarding relationships and relational subjectivities.
5. Reading - focus on structured power relationships and intersectionality.

I completed four family participant interview transcripts at each stage of the approach outlined above. This proved to be too time consuming and due to the large quantity of data, I needed to adopt an analysis method that would facilitate me stepping back from

the narrative focus and facilitate the identification of broader themes across the different aspects of the research and practice settings too. Therefore, I abandoned *The Listening Guide* and adopted thematic analysis (Braun and Clarke, 2006) which also involved becoming immersed in the data through repeatedly reading and re-reading transcripts to become familiar with the content. However, I found coding the data with reference to my research questions flowed more easily with this method.

I annotated and coded the data at different stages, then generated initial themes, followed by re-reading transcripts and my research diary to check that I had generated meanings from the narratives and key concepts. I found this challenging because of the large quantity of data and wanting to balance the identification of themes with my commitment to representing the participants' narratives. Although the cumulation of reading and re-reading the family interview transcripts was upsetting due to the stories shared, I clustered my analysis so that the family participant data were focused on first and together, followed by analysis of the practitioner data and then the observational data. Once themes were identified in these clusters, further cross-sectional coding was completed across the dataset. The process of data analysis was interwoven with reading and writing up.

My data analysis was also informed by my positionality and was reflexively considered through using my research diary and recording my own process of sense-making in interaction with the stories I was hearing and immersed in. I was challenged by the emotional labour (Hochschild, 1983), of the research process, hearing, transcribing, 'sitting with' experiences of abuse and adversity, and recognised the emotional labour of the participants in the retelling of their stories too.

Dissemination of data

As part of the collaborative nature of the study, it was agreed that a summary of the findings would be disseminated to Northford CSC as the partner agency. This will take the format of the formal write up of this thesis and publications will be drawn from the completed thesis to disseminate for academic learning. A summary report in an accessible format will also be shared with the FAFAs and family participants.

Conclusion

This chapter has provided an overview of the theoretical framework, the study design and the methods utilised to produce and analyse data. There has been consideration of the sensitivity of the research topic and detail of the ethical approach adopted. The focus of the study has required a qualitative mixed methods approach, using semi-structured interviews, focus group and observation in order to foreground the stories of families, practitioners and practice. Analysis of data and consideration of the dual focus of the research, on family practices and family experiences of state intervention, entailed that the data were divided into three chapters, representing the data findings and each respectively addressing the three research questions. The first of these chapters will follow and explores family participant narratives of family practices in the context of DVA.

Chapter 4: 'Doing' family in the context of DVA and child welfare concerns

Introduction

This is the first of three findings and discussion chapters. This chapter explores family practices, the 'doing' of family in the context of DVA and CP concerns, and responds to the first research question: ***What family practices are described by families in the context of DVA and child welfare concerns?*** The chapter starts by providing a context of family participants' early lives based on their own narratives and then moves on to substantiate the importance of maintaining family ties and connectedness for participants in the context of DVA and other adversities. The key sub-themes explored in the second part of the chapter relate to maintaining family ties and connectedness in the context of:

- Adult relationships after traumatic experiences of DVA,
- Fathering and mother during and after DVA,
- Caring and protecting children during and after DVA,
- Desire for `normal` family life,
- The difficulties of discussing DVA.

Participant characteristics and social and economic circumstances

Fifteen participants were interviewed (see Appendix 1). Most of the participants were born and grew up locally, were White British, came from working-class backgrounds and lived in social housing in inner and outer city council estates in Northford. These commonalities do not suggest a unitary experience of ethnicity or class, as an intersectional analysis asserts that both are mediated by other identities such as ethnicity, gender, age, and sexuality (Crenshaw, 1989; 1991). Neither were these homogeneous council estates but characterised by a lack of investment and came high on local and national indices of deprivation (Ministry of Housing, Community and Local Government (2019). All participants had contact with CSC due to DVA and CP concerns and twelve participants had an active case at the time of the interview. The reason for current CSC intervention was self-reported by participants and included

DVA, emotional abuse, neglect, parental substance use and parental mental health difficulties.

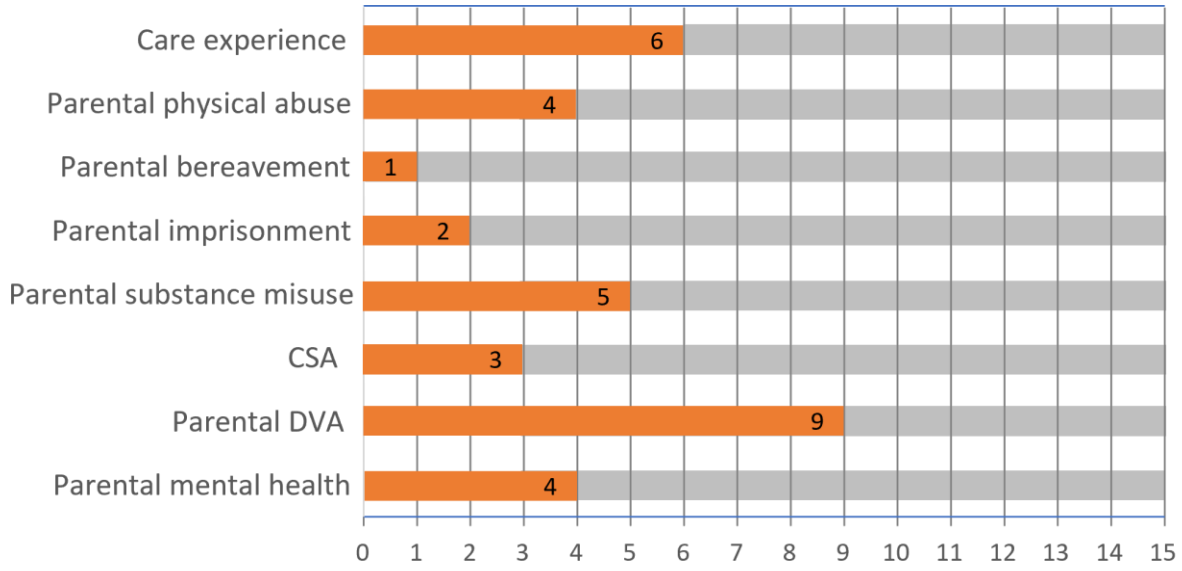
Family participant narratives illustrated a range of concerns about their everyday lives beyond DVA and CSC intervention. Twelve participants were unemployed and in receipt of welfare support at the time of the interviews (although there had been previous employment for some). Two fathers were self-employed, and one mother worked part-time. Almost all participants (n=14) reported economic hardship. Visits to homes revealed a lack of material possessions, with limited carpeting and furniture. Notably, participants did not describe their experience as living in poverty directly, choosing other terms such as '*money stress*', '*money worries'* and '*never having enough money'*. This may indicate that parents did not see themselves as living in poverty, or at the least they did not want to discursively frame themselves as such because they saw this as stigmatising (Tyler, 2013) and/or an alien label.

A striking finding was the extent of children's long-term health conditions reported by parents as this had not been a direct question in the interviews. This included asthma, ADHD, autism, cerebral palsy, congenital heart defect, chronic eczema, epilepsy, severe reflux, and ongoing conditions without diagnosis. This necessitated greater contact with health services, hospital stays, caring responsibilities and financial costs. Parents expressed concern for children's health and the challenge to secure resources. In addition, the involvement of a range of agencies introduced greater professional intervention in addition to CSC professionals which was experienced, particularly by mothers, as burdensome.

The early lives of participants

Detailed accounts emerged of multiple adversities suffered by participants that started in childhood. Stories of childhood abuse, neglect, parental DVA, parental mental ill-health and alcohol use by parents. Nine participants reported having contact with CSC in childhood due to childhood abuse and maltreatment, and six participants had care experience. The table below identifies the varied factors reported as present in participants early lives.

Table 4: Participants early life experiences



There was a link between lived experience of structural inequality, experiences of childhood abuse and CP intervention for most participants, confirming earlier research correlations between poverty, childhood abuse, and greater state intervention into family life (Broadhurst and Mason, 2013; Bywaters et al., 2016; Fahmy et al., 2016). Adverse childhood experiences caused suffering, impacting family relationships and family functioning, as reported below.

> Well, I had all the domestic violence around me when I was younger, like. My dad he used to do all to my mum and my brothers, the beatings. I saw it. My brothers got taken into care when I was quite young … But he never hit me. I was his little girl … but my brothers did, they were violent, they'd beat me … still have a go now (Rhianna).

> I had to bring up my brother's cos my mum was so out of it. She lost two babies after birth then had a miscarriage; she drank a lot […] I think to forget. So, I've been more of a mum to my brothers (Becky).

> There was all the violence with my dad, that messed us up and my mum she had all the mental health. He left but then we were left with her and that was messed up too, one of her with her fellas sexually [pause] abused my younger sister and I was in the room too (Jon).

Thirteen participants recounted a high level of exposure to parental DVA. This included stories of parental rage, volatility, and incidents of physical and emotional abuse. There were reports of attempts by participant mothers to leave fathers/partners who were abusive. This led to periods of instability from repeated moves, fear and distress from parental patterns of separating, post-separation violence and parental reunification following DVA.

Rodger connected his use of DVA with his father's use, reflecting how violence against women was normalised in his parents' relationship and other adult relationships around him.

> My dad used to hit my mum, usually in drink which is what I did. I'd seen domestic violence. And I think, maybe I just felt it was acceptable to do that because I'd seen it and done it and been there. And it just felt like normal, but it's not normal, you know (Rodger).

Rodger reflects on his violent behaviour as learnt from his own experience of being fathered. This reflects social learning theory (Bandura, 1977) which has been a prominent explanation for the intergenerational cycle of DVA where direct or indirect exposure to parental violence in childhood can reinforce values and norms that are repeated in subsequent adult relationships.

In a similar way, Rhianna recounted how exposure to severe parental DVA as a child normalised DVA victimisation and links her experience of 'taking' DVA in her adult relationships.

> Is it a surprise I ended up like my mum? No! I saw her take it and take it. It was normal, just what happened. All that shit goes around and comes around (Rhianna).

This suggests Rhianna's own belief in an inevitability of her experiencing DVA after having witnessed her mother doing so. Wider research shows that while an association between childhood exposure to DVA has been found to increase the risk of subsequent use of DVA and victimisation as an adult (Renner et al., 2005; Radford

et al., 2019), it is too simplistic to suggest a direct causal link. Many children that are exposed to parental DVA do not go on to use DVA in their adult relationships. A complex interplay of factors including socioeconomic circumstances, frequency of exposure, severity and duration (Smith et al., 2018). Thus, while participants reported exposure to parental DVA and understood this as learnt behaviour there were also other contributory factors that influenced their childhood family practices and exposure to DVA and their likelihood of replicating this behaviour into adulthood.

Adult relationships and DVA

Some women's experiences of family violence continued from parental exposure to DVA in their adolescent and adult relationships. Six women experienced DVA in more than one adult relationship. Women's accounts of DVA differed about the nature, frequency, and intensity of DVA suffered; however, all women narrated experiences of physical and psychological abuse in their intimate relationships, that increased over the course of their relationships, and more so during or immediately after pregnancy. Women had to find ways to function within the constraints of their DVA relationship and some used alcohol, drugs, and cutting as coping strategies. This was not the entire experience for all women interviewed and not every woman used these coping strategies. Earlier experiences of abuse disrupted participants' sense of self, and self in relation to the world, creating difficulties in interpersonal relationships for some.

The effects of DVA were reflected in women's narratives on self-identity and the incomprehensibility of the abuse suffered. *'I was lost'* and *'I lost myself'* was narrated by several women in the study, to describe a detachment from self that Herman (1992) argues is indicative of the effects of trauma. *'Shutting down'* or disconnection *'from knowing'* was described by several women as a state that they *'slipped into'* to guard against the reality of everyday experiences of abuse. This was an emotional numbness to the abuse they were experiencing, an alternative to having to consciously endure it, as described by Ashley below.

Ashley	I'd had enough, I became a plank
Permala	What do you mean a plank?

Ashley Dead wood! The plank years! [Laughs]. I didn't want to. I decided. I'm not going to feel anything, to be honest I lost some years to that, to drink and other things.

Here, the use of the word '*plank'* has a dual meaning. It is an inanimate object, 'a thick piece of wood' to be walked on, and a colloquial term meaning 'a stupid person' (Macmillan Dictionary). These meanings are emphasised by Ashley describing herself as *'dead wood'* too, something that is 'no longer considered useful or necessary' (Macmillan Dictionary). Although identified as a state of not feeling, this is juxtaposed with Ashley's account of how she endured the most severe abuse in her relationship during 'the plank years'. Ashley used alcohol and drugs to numb herself from childhood abuse, DVA, loss, and shame from being separated from her children. This was also reported by other women separated from their children and echoes Broadhurst et al., (2020) study on how child removal by CSC predisposes mothers to further adversities, anxiety and shame. For Ashley, this was a period of eight years and three different relationships, where there was DVA, substance use and mental health difficulties for her and her ex-partners.

Violence and suffering were embodied through interview settings as women revealed abusive experiences through displays of injuries sustained through DVA, and tattoos of the names and faces of separated children as noted by Broadhurst et al., (2010) and Morriss (2018). Women relayed abusive incidents of biting, spitting, being strangled, dragged by the hair, having objects thrown at them and threats of being killed. Two women described being under constant surveillance and tracked by mobile phone (Stark, 2007). Three women described broken bones (arm, cheek, collar, ribs and a fractured skull). Two women had been stabbed: one in her thigh, another in her chest. In another incident, one woman had had hot cooking oil poured on her back while she was watching television.

Additional transgressions were shared, such as partners having affairs with other women and sending sexually explicit images and texts to the women's friends. This showed a lack of respect for the women's feelings and emotional security. Four women stated that their partner had had sexual relationships with other women while they were together, with two women having children at a similar time to other women their partner was in a relationship with.

Living with DVA and prolonged states of stress and fear negatively impacts women's physical and emotional health. The link between childhood abuse, DVA and the detrimental impact on women's physical and mental health has been illustrated in previous research (Levendosky and Graham-Berman, 2001; Humphreys and Thiara, 2003). In the current study, women's accounts indicated the negative impact of cumulative abuse, embodied through depression, anxiety and chronic conditions. Injuries sustained from childhood abuse and adult DVA were not always taken seriously by medical professionals, as illustrated by Kay's experience.

Kay	I've got arthritis in my spine, four bulging discs [laughs], I'm still recovering from a dislocated knee and then I suffer with depression and a personality disorder. I have to have nerve blockers and anti-depressants every day. Sometimes I lose sensation in me legs then I have to go to hospital.
Permala	How long have you had these health difficulties?
Kay	I've had pain in me back and legs as long as I can remember and bipolar since I was eighteen. I got worse when I met him. The GP said the pain was all in me head and I said, well it's not in me head it's in me back. Eventually he sent me for an MRI, and he was shocked because the bulging discs, it's usually something older people get.

All women spoke about the impact of DVA on their mental health. This included anxiety and depression as well as living with a prolonged sense of hopelessness. Four women shared their diagnosis of bipolar and personality disorder. Two of these women were given their diagnosis at 18–19 years of age, the two others were diagnosed in their late twenties when they were living with abusive partners. Three women stated that they had delayed seeking medical treatment for physical and mental health concerns because they feared state intervention and their children being removed. Even where women had separated from their partners, the physical and emotional effects of abuse were reported as ongoing for all women.

Interconnected difficulties – Jon

The following case description illustrates interconnected difficulties starting in Jon's childhood that was dominated by experiences of physical and emotional abuse, exposure to parental DVA and maternal mental ill health. The depth of focus presented in this section, for his individual case description and data, illustrates issues related to the complexities of 'doing family' as a father while struggling with a range of issues, including DVA.

Jon (30 years old, White British) lives with his son Joey (11 years old, White British) in a two-bedroomed flat. Before this they lived with Jon's partner (Gina, 30 years old, White British) and their two son's (3 and 4 years old) and her son Adam (13 years old, White British) from a previous relationship. Jon and Gina are in a relationship, live across two households and have daily contact. Jon divides his time between his flat and his partner's home. After Joey has gone to school, Jon visits Gina's house and returns for Joey after school and the whole family spend weekends together.

Before coming to live with Jon two years ago, Joey lived with his mother (Lisa, 35 years old, White British) and her partner, and Lisa's children from a previous relationship. Jon and Lisa's relationship broke down soon after Joey was born. Jon continued to see Joey regularly until he was six years old; this gradually changed to a few times a year when Jon and Lisa met their current partners and subsequently had additional children. CSC contacted Jon to request that he become Joey's primary carer because Lisa was unable to keep him safe. Joey was sexually abused by a stepsibling and physically abused by his stepfather. Jon was ambivalent about taking on Joey's care and decided to do it on a trial period.

At the time, Jon and his partner were living with their three children in a two-bedroom house and Jon was working night shifts. The family were struggling on a low income and Jon felt that Joey joining their household added further financial and emotional burdens. Adam was unhappy about sharing his bedroom and his stepdad with Joey. Adam started bullying Joey. Jon reports that he continued to feel conflicted about caring for Joey and shared this with CSC who offered to rehouse the family to a larger property to help ease tensions.

Jon explains that six months after Joey moved in, he lost his job. Tensions between family members increased, particularly between Jon and Gina, and there was a DVA episode. Jon says he could not cope with the family stress and started '*disciplining'* Joey by being physically and emotionally abusive to him. There were also reports of DVA by Jon against Gina. Jon states that the social worker suggested to Gina that she separate from Jon due to DVA, his '*anger issues'* and current abuse of Joey. Jon and Gina did not want to separate. After `*a serious argument*`, Jon left abruptly with Joey and moved to his father's house.

Jon's early life experiences of physical and sexual abuse, exposure to DVA and inconsistent care due to maternal mental health resulted in him being placed in the care of his aunt and then his father. With his father he was subjected to further physical and emotional abuse from the age of 9 years until he left at 18 years old. He recognises his own rage and how this can 'get out of control' and he attributes this to the reason he is 'being physical' and abusing Joey. Jon connects his current difficulties, experiencing 'uncontrollable rage, outbursts, and a build-up of unreleased tension' to his own experiences of childhood abuse, cumulative adversity, current family stress and CSC involvement.

Jon links some aspects of his experiences of abuse to his son's experiences as described below.

> My mum and dad split when I was young, and I went to live with him [dad] … It was like a boot camp living with him. If I did anything wrong, I'd get hit a lot, with anything he could grab hold of, anything. I was nine when I first went to live with him. Same age as when my son came to me. There's lots of parallels I see, between me and Joey. But I can't help him. I don't know how to help him properly [...] I keep saying to Joey, 'I'm still here aren't I?' I don't understand what you've been through. But I was in the same room when something similar happened.' I've not given much detail because he's only eleven. But I said to Joey, 'I've managed to get through it all' (Jon).

Jon's experiences of being fathered are disconnected from his own violent fathering practices. While he identifies with Joey, there is a matter-of-fact manner in the way

that he narrates their ‘parallel lives’ that lacks empathy for Joey, and how Joey might be impacted by the abuse that he has suffered living with his mother and now living with his father. ‘Parallel lives’ also suggests that Jon cannot see Joey beyond a reference to his own victimisation and his victim-only narrative, which has been identified in men’s narratives on DVA and familial abuse (Augusta-Scott and Maerz, (2017).

Jon does not mention DVA when I ask him how CSC became involved with the family. He focuses instead on the family violence involving Joey.

> Social Services got involved because I had anger issues, and I was getting rather violent with Joey. It wasn’t just that, it was what happened to him at his mum’s, and I was confused about how to deal with some stuff that he’d been through. I couldn’t cope very easily, and we were six people living in a two-bedroomed house. I didn’t have a job, I had very little money. It was just so much stress and that led to me being aggressive and violent with him (Jon).

Jon shares that he struggles to care for Joey and himself at times. He has been reluctant to take on caring responsibilities, describing economic insecurity, family social circumstances and his own emotional health as reasons. Earlier in the interview Jon described having difficulties regulating emotions, feeling ‘constantly agitated and stressed’, experiencing unpredictability and rage, ‘going from nought to a hundred in a second’. Although he does not state it directly, his descriptions of his early life experiences and current emotional state are suggestive of characteristics of complex trauma (Herman, 1992) that is known to originate from exposure to persistent childhood abuse and adversity

Jon narrates his physical abuse of Joey and attempts to try different ways to parent him with strategies that can help Joey to ‘calm down’. In this way, Jon attributes his own struggle to regulate his emotions to his abuse of Joey. This is evidenced through his account of a typical day as narrated by Jon below.

> Permala How would you describe a typical day for you and Joey?

Jon Joey gets up before me so plays in his bedroom or reads books whatever he does … depending on what time I get up; I get our breakfast. There were times when he was stealing the food when we got here. So, I say don't get breakfast until I get up and then when I get up you can have your breakfast.

Permala Stealing the food?

Jon Just taking it without asking. He wasn't fed at his mum's. I understand that but since he's been with me and when we lived with my partner, he always got food. I see that he shouldn't have that problem anymore because he's been with me for a while now. He'll get up, gets his wash, has a brew, brushes his teeth, get dressed, I'll do the same … When he first moved here with me, he was eating everything, everything you get hold of. Using three bowls of cereal time loads of sugar loads of milk and I just couldn't afford it.

Permala That's hard [pause] He's a growing kid.

Jon At one time he was having breakfast here and having breakfast at breakfast club, then he wasn't eating his tea. So, I said, 'You can't do that you can't have breakfast here and at breakfast club you need to have one.' I tell him, 'If you want breakfast club then to get a brew', apple juice I got some apples in the other day too. Then he has his dinner at school and comes home. Recently it's been microwaveable meals because that's all I can afford right now for him. I'm not proper eating myself and have had to go without meals sometimes.

Jon is providing for a family across two households and 'has to be strict' with money and food as both are limited, emphasised by his report of going 'without meals'. In this way he is narrating values and norms of a 'good' father by providing food and boundaries (to mitigate against Joey's stealing) within the resources he has available. In this context, the significance of food for Joey, who has recently left his mother and stepsiblings, where he was physically and sexually abused and neglected, is not

connected to Joey's relationship with food by Jon. In addition, there is food insecurity which may explain Joey's 'stealing' and, as Jon described earlier in the interview, Joey's 'binge' eating and also, Jon's behaviour as food insecurity has been associated with an increase in parent to child physical abuse and aggression (Helton et al., 2019). Jon adopts authoritarian fathering practices that he describes as 'controlling', asserting that Joey does not leave his bedroom in the morning until Jon is also awake and can provide breakfast or not to avoid duplicating meals that he can have at school.

Above, I touched on the fact that Jon's fathering is authoritarian, controlling and rigid, with the use of violence to discipline and punish his son. This is an instance of the boundaries around authoritarian, disciplinarian and abusive fathering practices merging (Heward-Belle, 2015). Through his own narration, Jon presents himself as a risk to Joey physically and emotionally. Jon also wants support for himself and his own victimisation to be acknowledged. He needs his conflicted feelings about parenting Joey to be heard. He also wants practical, economic and emotional support to parent Joey and his other children. He realises that 'it went too far' between Adam and Joey but does not reflect directly on his own abuse of Joey beyond reporting it to me.

Jon is in a double bind. He is angry with CSC for the family's current circumstances and while he expresses his need for support he does not trust CSC to provide the support he wants and articulates this below.

Permala	How would you like things to be?
Jon	Just a nice slow-paced take it day-by-day life. Just forget about everything that happened in the past and let it go. But I can't, it's a part of me. I've kept in that long that it's become a part of me. That's why I said he [Joey] needs some therapy. You need to let it go because it's otherwise going to become a part of you. I can't open up to people. I can't talk about my feelings. I'm more than happy to sit there and tell people what I've been through. But I can't tell them properly how *I feel* about it all. It's just become a part of me.

Trauma informed practice (Bent-Goodley, 2019) could help Jon and Joey to get support and understand how their respective experiences of childhood abuse and trauma are impacting their relationship. There is also a need for practical support, basic furniture and material resources and economic resources to ease food insecurity and make their home more comfortable. Fathering practices of care and abuse are interconnected in complex ways for the family, and for Jon and Joey in particular. Jon is displaying both harmful and caring practices. There is little support for them to have their needs met or understand how their experiences of trauma have become entangled, impacting their relationship and family functioning. Jon has engaged with local services to address some of their practical needs, yet there is a lack of support from CSC to support him to deal with his own and Joey's individual and collective experiences of abuse and trauma.

Jon was not able to contain or reflect on Joey's emotional state other than to reference it to his own feeling state ('*I feel*'). Jon also describes not having emotional support throughout his life or his needs attended to as a child. A lack of support can then be experienced as a family practice where abusive experiences are not contained or resolved and become embedded in the way that family is done. That is not simply to state that abuse is a family practice but, as Jon's story illustrates, the impact of unresolved trauma is entangled across generations and there is a desperate need for resolution. Jon wants Joey to have the support he did not as a younger man. A family practices lens helps us to think about how families 'do' family but also how wider structures impact family. Thus, a lack of support for the family also contributes to practices that families want to change but do not have the means to.

Family practices and DVA

Fathering

Discourses on good fathering have identified the social and cultural importance of 'involved' fathering. Involvement is set against a background of political interest and moral expectations for fathers to be economically and emotionally involved in family life (Featherstone, 2009; Miller, 2011). Contemporary fathering is not only about involvement in practical childcare practices that have previously been seen to be traditional mothering practices. There is also an emphasis on 'being there' for children,

emotional closeness *and* engagement with children beyond practical childcare (Dermott and Miller, 2015). Normative 'good' fathering therefore involves a range of practical and emotional practices that signify 'being there' for their children. Fathering occurs in different contexts and is dependent on situated social, cultural, economic circumstances. It can be argued that involved fathering is a classed concept, with middle-class fathers being associated with normative fathering more than working-class fathers because of their capacity to display economic and emotional engagement (Gillies, 2009; Dermott and Pomati, 2016).

All men were partnered and living with children and/or in regular contact with children. Two men shared that they had biological children that they had no current contact with, following the breakdown of relationships with previous partners. The way that parents in the study spent time with their children varied across families and appeared to be principally shaped by socio-economic circumstances. Living in poorer areas where there was access to fewer resources, meant less opportunities for spending time with children beyond the home and locality. The three participants in employment had access to a car, otherwise other families' mobilities were reduced to a small geographical area. Thus, for the majority of participants, everyday life was practiced in the home and locality.

All participants were asked about their typical day and elicited varied responses. While all fathers who participated in the study had been in employment at some time, most were unemployed at the time of the interview and the two fathers that worked were self-employed with fluctuating employment. Therefore, most fathers had regular contact with children and fathering practices were fluid through the day.

Three fathers facilitated their children's physical activity through engagement in sports, as well as taking children to the park. Physical activity with children was gendered, with fathers narrating greater activity with their sons than daughters and engaging in traditional masculine sports such as football and martial arts. This confirms fathers' willingness to engage and perform dominant masculinity through displays of strength and force through 'doing' fathering and sport (Earley et al., 2019), as evident in Jon's story.

Permala How was it when you were all living together?

Jon It got to a point where my stepson Adam was hitting Joey a lot. Adam comes up to the flat sometimes and I have had to say to him, 'No violence in this house, no violence, unless it's controlled like.' Me and Adam are into martial arts and Joey's done a bit of martial arts too. Sometimes we spar with each other, and I get those two to have a little wrestle on the floor. And it's always controlled to a point. If I see one of them getting too far that's it, it's done. But I think me doing that helps them out, because they get to settle their differences in a controlled manner. And I can't honestly afford to take them all to martial arts again otherwise I would, so I just have to use my experiences to help them as well as much as I can. Because even I have little sparring sessions with them and have a little fight.

Jon's repetition of the word 'controlled', violence where there is predictability, is juxtaposed with his account of his 'loss of control' and the unpredictability of this. Jon describes the sparring sessions as 'controlled' yet provides no insight into the impact of his or Adam's violence on Joey or their relationship dynamic. For Jon, martial arts at home are a display of 'good' fathering. He is teaching skills and displaying masculinity by participating in sparing sessions with the boys. This reinforces his role as father to both, and dominant masculinity provides boundaries to their physicality alongside attempting to set boundaries for acceptable physical contact. Thus, he simultaneous tries to reduce conflict between the boys, where previously he admits that he had not prevented this.

Jon positions himself as the referee, 'controlling' how far the boys can go in their sparring. He emphasises control as a fathering practice that can help the boys to settle their differences. This is problematic because he also gets involved in sparring with the boys, and this activity contrasts with his own narrative of uncontrolled violence and struggle to regulate his emotions, and the outbursts that he attributes to physical abuse of Joey. This suggests that he is simultaneously trying to deal with his own affect and teach the boys greater emotional regulation through a traditional masculine sport

linked to discipline and practice. This is not a socially detached concept, as the idea of boys acting out their aggression through perceived legitimate physical activities is arguably seen as ‘good’ parenting for middle-class children through involvement in competitive male sports.

Sporting activities, and martial arts, in particular, can contribute to managing emotions because this involves confronting both one’s own fear while also trying to evoke fear in others (Vaccaro et al., 2011). The practice involves performing masculinity by suppressing fear, empathy, pain, and shame through strategies that display control including emotional regulation, mastery, and a show of strength and force. It can be argued that Jon is attempting socially acceptable fathering with his sons by his efforts to bring them closer through a shared activity that Jon feels competent at. This attends to Jon’s earlier narrative of wanting to connect with Joey because he ‘does not know Joey or know how to connect with him’. However, sparring is a problematic activity given the family abuse of Joey, making Joey vulnerable to continued abuse that could be justified as ‘controlled’ violence by Jon.
These practices offer insight into how fathers perform fathering in the context of challenging emotional, social and economic circumstances.

Mothering

Mothering was performed in changing and challenging circumstances, and their children were the source of their most significant relationships. On being asked to describe themselves participants talked unprompted about their mothering identity and the importance of children. Relationships with children were credited with supporting mothers’ recovery from DVA as noted in earlier research (Katz, 2015). Here children provided purpose, hope and structure to women’s lives, particularly post separation.

Mothering practices centred on the rhythm of everyday life and practical aspects of parenting. Anita (34 years old) lived alone with her three children (aged nine, thirteen and fifteen). After several attempts to leave, Anita separated from her partner of twelve years, who was also the father of her youngest child. Anita reported a history of DVA often linked to alcohol dependency for her and her partner. A neighbour called the police after her partner physically assaulted her and she left to stay with a friend. This precipitated a mental health crisis and hospital stay. Anita had been discharged from

hospital six months prior to the interview and her mental health difficulties and alcohol dependency were ongoing.

Permala How would you describe a typical day for you?

Anita Busy! They're still at the schools, different schools mind, where we used to live before, and I didn't want to swap. I'm hoping to get a house back in that area. So, we're up at six out by seven and get there for eight. Two buses both ways. Then on the way back we're not home till five, five thirty at night cos of buses.

Permala That's a lot of time on buses.

Anita Yeah ... suits me. Just keeping going. The kids keep me going, keep my mind on them. Otherwise ... well … I'm lucky to have them, to be here really.

'Keeping going' was a recurring phrase used by women in varying circumstances including being newly separated, lone parenting and living with partners and DVA. It conveyed the practical and existential experience of surviving a life day by day. For example, Anita's children provided her with a distraction from past and present difficulties and gave her day a welcome structure. Keeping her 'mind on them' helped her to manage her mental health difficulties through *doing* mothering. This reinforced the importance of children as a positive focus to anchor mothers' lives.

Mothering post separation provided an opportunity for women to explore new practices. Kay (34 years old) is a mother of two children and lives alone with her daughter Maisie (3 years old). Kay suffered sexual abuse as a child and was placed in out-of-home care from the age of three. There was DVA in her previous relationship and Kay's older child was removed from her care when she was 14 months old and subsequently adopted. Kay learned she was pregnant again (with Maisie, her second child) during care proceedings for her older child and ended her relationship with her partner. Kay has lived alone with Maisie since she was born, as a lone parent household.

Permala What's everyday life like for you both?

Kay It's great, I love it. If it weren't for her, I wouldn't be here … I'm glad they've give me a chance to be a mum cos I've never really been shown what mothers do. I think like am I doing it right. Yeah, I've had care workers, but they weren't mothers like ... so I think am I doing this right? Am I actually doing it right? Like some parents that haven't even been in my situation ... like, my friend's kid is such a fussy eater. His mum gives him sweets and juice and she said, 'How have you got yours to eat proper food and veg?' ... Its cos I've done it from day one ... and I'm a consistent person and she's not a sweetie person. She loves her fruit. Even though I'm not a keen one. I try and give her different tastes and encourage her.

Kay's focus on the 'doing' of mothering was interwoven with tensions between feelings of doubt and competence about the 'right' way of doing it. She locates her parenting in the context of her life. By questioning, 'am I actually doing this right?' she simultaneously seeks evaluation against normative 'good' mothering and references her out-of-family care experience. Kay's account of mothering is an exploratory and mostly fulfilling process. While this is Kay's narration, she is doing better than the peers she describes, and the doubts she displays can also be understood to be part of 'good', reflective, attuned parenting style (Cooper and Redfern, 2015) and evidence an inner confidence about her mothering post separation.

While mothers indicated that parenting alone often brought loneliness, insecurity and financial hardship, all mothers that had left abusive relationships and were subsequently parenting and living alone stated that they felt more positive about their parenting. There were also conflicting emotions and expressions of guilt at the loss of a 'proper family', an idealised heteronormative family set up. However, women were trying to build independent lives and engaged in the 'keeping going' mantra. These examples offer insight into how mothers learn to adjust their practices post separation and how change in parenting is possible in the aftermath of DVA.

Practices of care and protection of children

This section focuses on parenting practices of care and protection of children, including through DVA. Limited narratives arose from this study on the impact of DVA with a focus on protection from physical abuse. However, mothers' accounts showed parenting practices were gendered with all women identifying as primary carers for children and reporting that they undertake most household work, even when they lived with or had regular contact with their partners. There was little in the women's accounts of fathers undertaking care of children other than 'doing nappies and bottles' and 'taking them out'. This contrasts with fathers' accounts in the study in which they reported their involvement in everyday practices of care including feeding, caring for sick children, dropping off and picking up from school, putting to bed and taking children out to the park.

> If I didn't look out for them no one would. He wasn't bothered bout them. (Ashley)

> He didn't care about where kids are, he had nothing to do with their lives, 'cept shout at them, wind them up and make them scared. (Becky)

Responses to questions about parenting through DVA focused on where children were physically during DVA and the strategies parents used to prevent children's proximity to physical violence. Parenting narratives emphasised the physical protection of their children from DVA, with few sharing how the care of children may have been impacted and compromised by DVA. During all the research interviews with parents and mothers I sensed parents' reluctance to focus on parenting practices during DVA. Most possibly because parents felt they may be judged about their parenting and children's exposure to DVA. This suggested a need to preserve their identity as 'good' parents that kept children safe. Hence parenting narratives emphasised physical protection from DVA, with few sharing how the care of children may have been impacted and compromised by DVA.

Caring practices during DVA: by mothers

Mothers across the sample narrated a number of similar practices to protect children from exposure to DVA by attempting to prevent DVA from escalating. They did this by trying to appease their partner, ignoring abuse by 'trying to keep my mouth shut' and 'trying not to react' to abuse or aggression. Other strategies involved keeping children out of the way of fathers, especially when they were home late and had been using alcohol or substances, as described by Kim below.

> I tried to get the baby to sleep before he came back but then he'd wake him and try and play with him and he'd [baby] get really upset and then he'd [partner] get mad cos he was crying, and he'd say, 'What's wrong with him?' and have a go at me (Kim).

There were also accounts of deliberately keeping children awake late at night to distract fathers when they returned; noting that children's presence could temper paternal aggression at times and prevent escalation. Mothers also sent children to friends' homes or invited friends over when they sensed tension as a way of trying to de-escalate the situation.

> My friend cross the road would take them when I thought he was going to lay into me proper. I'd take them over before he got back if I could. He didn't know where they were, thought they were in bed, he was raging that much that he didn't care. He wasn't bothered whether they heard what he was doing (Ashley).

The most common practice adopted by mothers to minimise exposure was to create physical distance and 'put' children in a different room or shield them by creating a physical barrier between children and their partner. The emphasis on physical protection of children was an important practice because mothers did not want their children to 'see' the abuse. When there was no time for this, some women tried to move to another room themselves and placate partners until they had created distance. Having visited participants' homes, it was apparent that those small spaces would not allow for much physical distance, therefore there was a likelihood that all individuals living in such proximity would be exposed to any DVA that took place there.

Mothers also identified physical protection as their ‘first instinct’, ‘to get kids away from him’, in part because some did not know if fathers would hurt children. When I followed this up, some mothers shared their worry of children being hurt, but did not expand on how children had been impacted or physically hurt in the past.

> He was so het up; I could never be sure he wouldn’t lash out on them. So, I just got them out the way (Becky).

I found women emphasised the importance of providing safety for their children, either through physically removing or shielding them. Some women clearly felt uncomfortable in the interview by my exploration of their mothering, as seeking clarification about how they thought that their mothering was affected was interpreted as criticism and met with defence. There was a focus on maternal protectiveness and women wanted to tell me how they protected their children as best they could at the time.

> Becky Well, when I thought he was going to start. I got them out the way.
>
> Permala So you’re thinking about yourself and the children at that time.
>
> Becky Yes ... but I just tried my best to get them out the way.
>
> Permala That must be difficult when he’s threatening you.
>
> Becky Yeah.
>
> Permala That’s so hard.
>
> Becky Yeah [pause] Look! I did my best at the time. You think I wouldn’t go back and change it, yeah, I would … then, when it’s happening, you don’t know what’s going on, like it was so sudden. This one time he just came at me from

> other side of room, did this kinda flying kick into my side what knocked me down. I was on the floor, and I'm not thinking where kids are, I'm in fucking pain on the floor.

Becky's narrative illustrates how being a victim of DVA prevents her caring practices as a parent. The physical abuse described is all encompassing and yet mothers are expected to protect children in situations of DVA. The significant focus on protecting children across mothering accounts suggests women's agency (Buchanan and Moulding, 2021) and contrasts with wider judgemental and blaming reactions to mothers who struggle to care for children whilst experiencing DVA (Lapierre, 2008; Perel and Peled, 2010). By emphasising protective practices mothers are able to preserve their identity as 'good' mothers and meet their own and societal expectations of normative mothering.

While my interview questions were not intended to cast doubt on the women's ability to protect their children, several mothers interpreted my exploration of family practices during abuse as being critical of their ability to prevent children's exposure to DVA. This is important because it highlights the judgement that mothers have described when being interviewed by police and CSC professionals (Keeling and van Wormer, 2012), by emphasising themselves as protectors first, rather than victims first and conforming with idealised gendered expectations of mothering. This evidences how mothering is complicated before, during and after leaving DVA relationships . abuse is left unexplored from women's perspective.

Contradictions arose in accounts within the same interview, where parents stated that children were not present but also exposed to DVA. This suggests it was difficult for mothers and fathers to talk about children being exposed to DVA, there being a difference between intent to prevent children's exposure and the challenges of doing this in the moment.

Caring practices during DVA: by fathers

How do fathers' practices compare? There were limited details shared in men's accounts of DVA and little on their care and protective practices towards their children during DVA. Four of the six men acknowledged that their children's exposure to DVA

was negative. There were varied and limited accounts on where children were during DVA. These included children being in bed, in another room or present when there was violence. Where there was acknowledgement of children's exposure to DVA, fathers did not acknowledge the harmful impact on children at the time, the same finding seen above in mothers accounts.

Some fathers identified how abuse to children rather than their partner motivated them to try to change their harmful behaviour. Rodger described how he 'pushed' his partner and 'punched' his 16-year-old daughter while intoxicated from alcohol. He explains that this episode involved his daughter while earlier episodes of physical abuse had involved only his partner. Rodger was motivated to seek help after this incident because of the harm he inflicted on his child rather than his partner.

> Well, it's the effect on my children, you know what?, it was a really poignant thing realising that, and you know, I don't want to be violent in front of my kids, I don't want to hurt my kid, it's as simple as that. That's my daughter and she saw me do that to her mum too (Rodger).

Rodger's arrest and subsequent help-seeking after this abuse was motivated by wanting to change his fathering.

Two fathers did not talk about the impact of DVA on their children at all. These were the youngest fathers and still in relationships where DVA was reported and CSC involvement suggesting a reluctance due to professional scrutiny but also a lack of distance from DVA relationships. Three fathers perceived the impact of their children's exposure to violence as harmful to their children. These fathers expressed regret and shame, describing how specific DVA episodes created turning points that motivated them to take steps to change and seek help. For example, Sam reported violence from his partner against him when she was under the influence of alcohol and substances. He described how he would put the children upstairs or to bed when he sensed his partner was 'about to kick off', and that his children were in bed when situations would become 'really intense' and trigger violence usually when his partner was 'craving, using or in the shadows [withdrawing]'.

The imagined 'normal' family

This section focuses on participants' experiences of living with ongoing difficult relationships and how family relationships change over time. Participants' connections to their family of origin were strained. This stemmed for some, from abuse in their family of origin, ruptured family relationships and ongoing abusive family relationships that were part of participants' experiences of family. These family relationships were maintained through family practices of tolerance, resistance, fear, pain and acceptance, and also provided a blueprint for how current difficulties could be borne and overcome with time.

Contact with fathers was linked to women's desire for 'a normal family'. For mothers in this study, a 'normal family' was described as 'living together as a couple without DVA, with the kids and having a nice home' and having enough money 'to do things, go on holiday'. Some mothers pursued this through trying to make their relationship 'work' and prioritising the need for children to maintain relationships with their fathers, because they wanted to provide ongoing connection despite difficulties for themselves and their children. This created invidious situations, as described below.

> I'd play it down. Yes, he hurt me, but I'd tell them that 'Daddy loves them, that I love Daddy'. I kept that going for him … for us (Faye).

> It's easy to say, 'get out of the relationship', but until you've been in it you don't really know. Like how you want it to be better for yourself, for the kids, for him, 'cept he doesn't think you're doing it for him. So, you're always in the wrong trying to make it better for everyone (Becky).

Becky and Faye describe how they continued to protect the image of their partner as loving to the children, rather than focus on their partner's abusive practices, as a way of maintaining family, whilst hoping for change. This was even when this led to them always being in the wrong no matter what they did.

Participants' connections to their family of origin were not always positive. In the context of histories of childhood abuse and adversity, difficult relationships occurred

with family members for the majority of participants. Strained and volatile relationships were part of all participants' experiences of family. There was estrangement, repeated ruptures and unresolved difficulties. Despite this, many participants recounted stories of reconciliation with parents and siblings that had been abusive. Sometimes after years of little or sporadic contact. This gave some participants hope and strengthened their desire to seek contact with abusive ex-partners, hoping that there would be change and the opportunity to establish a better ongoing relationship, as described by Jess.

> I want them to see their dads. I saw all the violence with my mum and dad. My mum and dad talk now. My mum said if she can get over it and forgive … you know. So I have let it go. I didn't see my dad for years when I was growing up. But, you know, he's changed from when he were young. Obviously grown up and he's a totally different man now. I'm glad I see him (Jess).

Jess describes how she feared her father due to her exposure to parental DVA and could not have imagined as a child that she would want a relationship with him as an adult. Her mother had forgiven him, and this led to Jess and her brothers making contact. In the quote above Jess's resolution with her father provides hope and an imagined future where her children have contact with their fathers despite DVA in her relationships. Similarly, Jon had 'come to an understanding' with his father after suffering years of physical and emotional abuse from him, because he wanted his children to have `normal` family connections, as quoted below,

> I see my dad now. It's not easy but there's not much family and he helps out with the boys and that. I had to get past it, but it's still there. But he's family. The boys need a normal family with grandparents and that (Jon).

Jon maintains an ongoing relationship with his father despite his abusive experiences and ongoing trauma, to prioritise his children having grandparent presence in their lives. This is borne out of a desire for `normal family ` but also a recognition that there are few people that can help support him with care of the children too. In this way, family practices of acceptance of continued relationships with family members that

have caused harm and suffering also provide support and care and also part of participants experiences of family.

Most women found support from paternal family and paternal mothers raised further challenges post separation about how to navigate relationships and connections in the context of DVA from partners. Most participants narrated continued contact with paternal networks post separation. Given descriptions of early lives, participants had experiences of difficult and abusive relationships, having families that they had learned to live with (Gillis,1997). These experiences of harmful and abusive relational practices act as a counterweight to the contemporary idealisation of normative family life (Smart, 2007).

Similar to mothers, fathers narrated their desire for their imagined normative family. Here Mark links being a `good father` to an idealised heteronormative traditional family structure and relationships.

> In a way, I was pissed off with his mum [child's] because, like, I wanted to bring my son up in a loving environment, as in Mum and Dad, you know what I mean, I'm old school. Well, maybe because I only had that until I was seven or eight and then my dad died. I wanted my son to have what I didn't have, as in that loving relationship. But he's getting it between his mum and my partner now, but I'd have liked it to be a partner where me and her would grow old together. And it's our house, I wake up with the kids, put the kids to bed, that would have been my dream (Mark).

What Mark wants for his own son, a traditional family, a 'dream', is reflected in his own loss of this dream; an idealised, normative conception of family based on what he does not have. This was also connected to the loss his father at a young age. Interestingly, he acknowledges blame towards his ex-partner but does not expand on his role in the end of the relationship and how he might have contributed to the loss of his 'dream' too.

Keeping family together

Some of the women's mothering practices indicated the importance of keeping the family together in the context of DVA. Having regular contact with fathers reflected mothers' own expectations and those of wider society, of 'good mothering'. This includes responsibility for the quality of the father-child relationship and ensuring fathering is 'good' (May, 2008). Ongoing relationships with fathers provided family connection and a sense of belonging. Parents spoke about the importance of their children having continued relationships with fathers and paternal family even where they were separated and in difficult situations as reported below.

> It's not about me it's about Cassie. She absolutely adores her dad. She doesn't know what he's done, she doesn't know that he's sexually assaulted Tina [her stepsister]. She's too little. But I want to make sure she is safe, and it has to be a contact centre. I don't know how it's going to work (Ashley).

> He's her dad at the end of the day and if I don't fight for her to have him in her life now, well he's not going bother later is he (Rhianna).

Both these quotes are from mothers who are trying to gain support from CSC for ongoing contact with ex-partners. They report that this has not been supported because of the risks posed by the fathers, and their continued desire for maintaining contact has also been identified as their failure to understand the risks that they are potentially putting their children under. This also links to failure to protect discourse and will be discussed in chapter six. Yet there is a need to understand the women's rationale for continued contact from a relational perspective. Smart's (2007) concept of embeddedness helps to further thinking about how, family ties work to embed us in relationships that are both thought of as good and difficult. Where children were involved mothers sought to maintain relationships with partners, to give their children a sense of identity and family history.

Women placed high expectations on themselves as mothers to care for children through challenging circumstances, and to keep their family intact by preserving a positive perception of fathers for children. Some mothers sought contact with ex-

partners, wanting children to have a continued relationship with them. This was in part, an imagined future comprised of shared care of children and violence-free contact between the parents (Morriss, 2018). This practice was at odds with the women's experiences of CSC intervention, where separation without resolution was often enforced and parents were threatened with child removal if they continued contact with abusive partners. This confirms that current CSC practices are not working to meet families' needs, a theme that will be returned to in the next chapter.

Contact with fathers was sometimes sought at the risk of ongoing DVA post separation. One mother spoke about her upset because her ex-partner would not acknowledge their son or have any contact with him.

> I don't know why he denies him. He's his kid but he doesn't want to know him! We see him all the time, only lives round corner. I see him looking in pram at him. One time he was with his new girlfriend, and he was looking at him [child] and I said, 'Have a good look, he's yours!' She said, 'Well, can't be sure.' So, I went for her. He stood in the way and kinda pushed me. He did say he knows, but then he denies him and lets her shoot her mouth off at me (Becky).

Becky seeks connection with her ex-partner for her child and herself. Having her child's paternity unacknowledged is a source of hurt and shame that she finds difficult to move beyond. Becky shares that CSC have told her not to see her ex-partner due to past DVA. Despite this, she reveals that she sometimes seeks him out around the locality and texts him to try and force a confrontation in the hope that he will acknowledge their child. He has threatened to hurt her if she persists. Without his acknowledgement, Becky is forced to accept a lack of financial support, with no respite from caring for their child and the identity of a stigmatised lone mother (Skeggs,1997).

Being a 'normal' family

The yearning for a 'normal' family was linked to the display of an idealised heteronormative family. This was described as a couple living together with their children in one household that was economically viable. Some women tried to make their relationships 'work' in pursuit of this by minimising DVA and other transgressions. The pressure to perform this in the face of DVA, is reported by Faye below.

Faye And probably say for four years, it was just the whole, pushing, hitting, throwing things, but it was more emotional abuse that got to me, as in the weight put on because I'd now had a second child, and nobody's going to want you. I'd have lasses messaging me, saying, 'your partner's sending us inappropriate pictures, he's flirting with me, he's chatting me up.' And then I'd confront him, and then he'd be like, 'I'm really, really, sorry, I don't mean it, I'll stop it.' Then there'd be times when it would be, 'Oh, someone's hacked my Facebook, it wasn't me.' And you'd believe it because in your head you want to for your children and their Dad, like, it was stupid my response, because my friends would say, 'Why are you putting up with it?' And I was like, 'but my children both have the same Dad, we're together, you know?' Not the fact that he's calling me every name under the sun making me feel bad, hurting me. It was keeping my family together.

Permala Why was it important to you that they had the same dad?

Faye Well some of my friends had children that had, like they might have two children, but they both have different Dads. Some wouldn't even be with either of them and they'd struggle to get money off them too. Whereas in my head it was, I've got this perfect family unit, we have nice clothes, a nice house, and you know, on picture everything looks perfect. That's what I wanted, but behind closed doors I am crumbling, a nervous wreck, crying myself to sleep.

Faye's account highlights her overwhelming need to keep her family together and display an idealised normative family, driven by her children having the same father. Women's perceptions of self are formed through self-evaluations against normative 'good' mothering and, also, recognition of the ways in which their mothering can be

‘othered’ (Phoenix 1991). Faye seeks to distance herself from the shame that comes from her place in a wider social context, one that she recognises can easily confer feelings of shame about mothers that have children from relationships with different men (Skeggs, 2013). She seeks to avoid what she sees in her friends’ lives and the shame they experience at micro and macro levels from having no financial support from partners, raising children as lone parents, and being seen as an inferior mother. Faye’s relationship provided financial security for her, a home and status as a mother living with her children and their biological father. Faye was able to access credit because her partner worked. This provided an opportunity to accrue debt and display the ‘normative’ family she yearned for. Debt worsened tensions with her partner but also embedded her further within the relationship.

> But then I’m also into this lavish lifestyle because I wanted my child at the time to have everything I ever did, I got into the whole credit cards like my mum did. *A lot of debt!* By the time I was 20 I was twenty grand in debt, and just everything my child wanted I gave to them, the eating out, clothes everything! He [ex-partner] still wanted the house parties, the raves, and the good time. It was all on debt (Faye).

Faye was embedded in an abusive relationship that also provided opportunities to perform her imagined ‘perfect little family’. What was unobtainable was superficially made possible through the contemporary practice of consumption-driven mothering (Krzyzanowska, 2020). This enabled her to escape the reality of her circumstances, providing a gateway to the social and material trappings of her imagined ‘normal family’.

The internalisation of social norms and values can give rise to feelings of shame where there is a tension between the way that people want to ‘do’ family and the way in which they do it in reality: ‘Shame refers to personal self-esteem, which is inseparable from the esteem that others have for that person’ (Neckel, 2020, p.162). For Becky and Faye, having children with different partners and not being able to perform family in the way they would like, the shame they describe is embedded in social constructions of gender and class at a private and public level (Tyler, 2013). Their shame is not only linked to how others construct them but also based on perceptions they hold of themselves.

Talking about DVA and not talking about DVA

Callaghan et al., (2016) assert that violence is always emotional, and emotion is always embodied. Emotion was reified through the interview context, through participants' narratives, and my reaction to these accounts. The majority of participants recounted stories that seemed to be detached from the intensity and distress that they were recounting. Some had retold their stories many times and the cumulative impact of abuse and suffering was powerful to hear, yet they appeared disconnected from the emotion of their stories. My interpretation of the lack of emotionality at times during interviews linked to the way that participants narrated coping in situations of overwhelming terror, when emotion was denied and not always expressed directly but embodied through injuries, health, living conditions, and inscribed on bodies.

One mother said that she was only able to reflect on her children being impacted by DVA years after her DVA relationship ended and her children had been removed from her care and subsequently adopted.

> Faye — My children were three and about nine months-ish. So, I was always at that point, my children never see it, they're not in the room when it happens, but now looking back, just cos they're not in the room, doesn't mean, a), they don't hear it, b), they don't sense it when they come back in the room, or they don't sense the tension between Mummy and Daddy, they don't see the holes in the door, they don't see the broken glass, they don't see Mummy shuddering every time he comes home from work, and scared, and body language changes. [pause] These are all the things, as I've grown and learned, and slowly processed through the years, after everything that's happened, you know. At the time when I was going, well my children aren't here, you know, they're not in the room, but they don't need to be in the room, it still affects your children, no matter what.

Permala So thinking back, at that time, how do you think they were impacted?

Faye So, I couldn't go there. It was hard enough trying to get through all that was happening. I was ... I think, I thought … If I don't think about it, then they're not affected even though I kind of knew. I just focused on trying to make things nice for them.

It has taken Faye many years to make sense of what happened. Her understanding of her children's experience of DVA shifted over the years and she has come to recognise that they were active, not passive, subjects. Reflections made by her after the end of her abusive relationship. At the time, it was too difficult for her to acknowledge fully the impact of DVA on herself or her children because of feeling overwhelmed by her experiences of abuse, and her fear and shame of losing her children. The interplay between memory, reflection and understanding are important here. Many participants remembered their own experiences of childhood and adult abuse, yet parents could not recall, or at least did not share, their understanding of their children's experiences of exposure to DVA.

Several women said they were unable to 'go there', to think about how their mothering was impacted by DVA. They also described several factors that prevented them from changing their situation. This included both love and fear of their partner, fear of isolation, poverty, homelessness, lone parenthood, shame from not having made the relationship work and children losing contact with fathers. Faye recounts that she could not acknowledge how DVA affected her mothering at the time but went on to describe her efforts to mother during the DVA she experienced.

Faye There was one night where, I was trying to put my youngest son to bed, and again these messages were coming through on my phone, and I was like, I've had enough. Like, someone had sent a picture of obviously his private parts, and I was like, 'you promised, you know, I'm sick of it.' So, I had my hair in a big messy bun, and he gripped my hair, and I had my son like, his head was

facing me, and I was cradling him, and I was trying to put him to sleep. So, he's come in the bedroom, grabbed me by my bun and just pounding my head.

Permala Oh no

Faye And the child's screaming, I'm saying like, 'the baby, the baby, let me just get the baby off me.' So, he released, and I put the child in the cot and I was walking towards him and then, we had a forty-two-inch TV in the bedroom, he'd gone over to the dresser, picked the TV up and just launched it at me.

Permala Oh

Faye The kids saw it, one was like quiet, the baby was just screaming. I had blood coming from my head.

Faye's account illustrates the terror and extreme challenges of trying to keep herself and her children safe in the face of DVA. Faye appealed to her partner to stop. While her partner momentarily refrained from violence, her reminding him that the children were present did not prevent him from attacking her in front of them. His violence became more severe, and the children's presence did not prevent his ongoing abuse.

> So, the thing I didn't want to happen, the thing that I tried to keep back all that time, happened. I lost my kids, my relationship ended. That perfect family I wanted just broke. I'd been trying to keep it going, in the end there was nothing. I lost my house, I was a wreck, in hospital. Even through everything that happened … I couldn't put it right and that was the thing I was trying to stop but I couldn't. That's how I lost my head (Faye).

While participants shared limited accounts of children's exposure to violence overall, accounts of abuse illustrate the challenging context in which women struggle to

mother. The distanced telling of these accounts suggests that women's reluctance to talk about their mothering at the time DVA is occurring is because there is a need to detach from emotion and memory (Enosh and Buchbinder, 2005). Faye's narrative was interwoven with experiences of earlier abuse and attempts to make sense of her feelings of limited agency at times. She expressed feelings of shame that living with DVA stopped her from being the mother she could be, and shame of being separated from her children. Also she described how this had mirrored parts of her own childhood exposure to parental DVA and so more shame from 'history repeating' itself. Data suggests that part of mothers' reluctance to discuss mothering relates to early experiences of abuse and entrenched feelings of shame. Two other women in this research described a sense of shame in not having broken the cycles of abuse and comparing themselves to their own mothers who also suffered DVA in their relationships.

Discussion

This chapter has reported on family practices as described by family participants in the context of DVA and CP. There are two key findings that I wish to talk about, firstly, the impact of early life adversities on participants and secondly the significance of maintaining adult relationships in adversity.

The stories recounted by the majority of the participants are of multiple adversities from early life through to adulthood. These are stories of childhood abuse and maltreatment, social inequality and cumulative disadvantage. The detailed accounts from parents of abuse in their early lives evidence that these adversities had far reaching consequences and confirm research with parents (Broadhurst et al., 2020; Philips et al., 2019; Mason et al., 2020) linking histories of disadvantage, child maltreatment and abuse, CSC contact, emotional and relational struggles to continuing difficulties in adult relationships.

These accounts illustrate that parents living in situations of DVA and CP concerns have considerable histories of abuse and trauma. Each participant had a complex story about their lived experiences and their parenting. Although people's lives varied, a common feature was early experiences of childhood abuse that set in motion further challenges and the accumulation of more adversity. The themes generated through

these narratives will be discussed below and address the impact of early abuse and trauma on family practices, mothering and fathering practices.

Trauma and abuse

An understanding of the impact of multiple trauma for participants is important for gaining insight into their relationships. Many of the ways of coping that were recounted, to deal with the impact of multiple adversities, can be attributed to the consequences of childhood abuse and persisting trauma in line with theories of complex trauma (Herman, 1992; Van der Kolk, 2014). Complex trauma (also referred to as complex post-traumatic stress disorder and/or complex PTSD/CPTSD) can develop in response to multiple traumatic life events involving interpersonal relationships such as child sexual abuse, DVA and community violence (Herman, 1992). Complex trauma also involves the ongoing and long-term impact of living with persisting trauma (Brierre and Spinazzola, 2009; Van Der Kolk, 2014) and includes symptoms of PTSD, such as re-experiencing trauma in the here and now, avoiding external reminders of trauma and hypervigilance due to a heightened sense of threat (Herman, 1992) alongside more chronic 'disturbances in self-organisation' that are characterised by difficulties in regulating emotions due to a state of hyper-arousal (fight or flight), a negative sense of self and difficulties in making and sustaining relationships. This can lead to ways of coping through dependency on alcohol and substances, avoidance of relational intimacy and dissociation from feelings. Stigma and shame are also present in trying to manage both the experiences of trauma and responses to trauma (Neckel, 2020). Participants accounts gave rich descriptions that met this picture of complex trauma experience. Understanding how trauma impacts participants' sense of themselves and how this played out relationally can help professionals to engage differently with parents where DVA is present alongside childhood abuse and adversity.

Many of the feelings and behaviours that participants narrated could be seen to fit with the consequences of childhood abuse and ongoing complex trauma (Briere and Scott, 2014; Van der Kolk, 2014). Experiences of childhood abuse, adversity and social inequality could lead to social suffering and trauma. This was evident in participant accounts of difficulties in their intimate relationships. This is not to suggest that all participants that experienced childhood abuse and adversity will develop complex trauma, but that there were shared factors in accounts where childhood abuse, multiple adversity, living with reduced social, economic and material resources and

poverty, led to unresolved trauma and pain that was reflected in interpersonal relationships and family functioning.

An understanding of the impact of multiple trauma for participants is important for gaining insight into participant lives. These findings resonate with other research with mothers (Broadhurst and Mason, 2017) and fathers (Philip et al., 2020) where there were histories of childhood abuse and maltreatment, connecting to disadvantage and a predisposition to further adversity and contact with CSC and recurrence of child removal. While Broadhurst and Mason (2017) and Philip et al., (2020) did not focus specifically on DVA and contact with CSC, DVA featured significantly, alongside parental mental health, substance use and CP concerns. This also emphasises that DVA is not experienced as a singular issue for parents that have contact with CSC, and this is confirmed by this study.

The findings also suggest a link between childhood abuse, social inequality, vulnerability to adult abusive relationships and contact with CSC and CP proceedings. This is not to suggest that all parents that have suffered childhood abuse will go on to have adult relationships where DVA is a factor and have parenting problems and intervention from CSC.

Family practices

A family practices lens helps to think about the themes of connectedness and relationality that came through participant accounts. Smart (2007) maintains that 'familial roots that can locate a person emotionally, genetically and culturally are essential for ontological security and a sense of self' (Smart, 2007, p.81). All participants located themselves in relational 'webs'. Firstly as parents and then through rich histories of early life including their own parents, professionals and wider networks, as well as their current household arrangements living with partners, parents, separations and/or divorce. These descriptions of self are relational. All participants were embedded within family relationships that extended beyond their partner, children and those they lived with. A lack of acknowledgment of relatedness brought feelings of shame and yearning, for example, where parents were not acknowledged by ex-partners as parents, or where they were separated through state intervention and there was estrangement from previous partners and children. This was not an end in the relationships as parents embodied relationships through

practices like letter writing, celebrating birthdays and tattoos, yet there remains a yearning to be acknowledged. While family practices across time, then, can offer 'ontological security and a sense of self' (Smart, 2007, p.81) as just described, they can also be experienced as psychologically and emotionally suffocating when associated with histories of abuse and adversity. Therein lies the difficulty of ending relationships.

Embeddedness as a family practices concept reflects the tenacity of those bonds and links and the importance of always putting the individual in the context of their past, 'their web of relationships, their possessions, their sense of location' (Smart, 2007, p.45). Family relationships are particularly important for understanding and contextualising practices. Smart (2007) discusses the difficulties families have in sustaining relationships with kin and family members where there are difficult emotions. Her concepts of embeddedness and connectedness within family relationships is used to consider how the bonds that tie family cannot be taken as an 'a priori good thing' (Smart, 2007, p.137); that is, that people can be embedded in families or relationships that are not easy to leave or escape from. She uses this as a counter to contemporary idealisation of family life and importance of family relationships and intimacy (Smart, 2007, p.137). This is not to assume that families are binary, either good or bad, but the importance of contextualising harmful practices within the context of peoples lived experiences.

These narratives call on professionals to recognise the everyday contexts of family lives, where DVA is part of multiple adversities that need to be acknowledged. This includes the need to address early life experiences and the structural and relational contexts within families, rather than a focus on individualised interventions and failings.

Normal Family

Frequent uses of the word 'normal' were used when parents expressed a desire to maintain family connections in the hope that they could be a 'normal family', and also when they signified their desire for 'normal' family forms. This was also inferred when stating that they were not a 'normal family', both when describing their current family and their childhood experiences of family. Being a normal family was subjectively and culturally defined, with participant accounts revealing a focus on relatedness. There was an emphasis on idealised heteronormative nuclear family forms, where parents

live together with their children and perform care of the children together including the routines of putting children to bed, reading to them, spending time together. This was set against current circumstances and relationships, where there were ruptured relationships, DVA, other adversities and, for some, a denial of paternity, all contributing to a lack of shared care and co-parenting.

Not all participants identified 'normal' family as heteronormative and residing in one household. However, they still understood 'normal' as connected to relatedness and desired relationships that provided ontological security for children. Their 'normal' was not about family forms but about the doing and displaying of family. This included the desire for practices where they could 'sort out' difficulties, 'stop the violence', be at a CP meeting without shouting at each other in front of other people, have their parenting identity acknowledged by the other parent, or make arrangements so that their children could have safe contact with each parent. There were strong desires towards the resolution of difficulties; therefore, being a 'normal' family was also about finding a way of *becoming* 'normal' rather than an end in itself. In this way a more fluid sense of family is imagined.

While more evident in mothering accounts, fathers also desired `normal` family , especially non-resident fathers that wanted increased contact with their children and perform fathering in the way that resident fathers might do, for example, Mark's account of sleeping in the same house as this children and performing everyday routines and Jon's account of wanting to live with his partner and child, illustrate yearning for connection (Perel and Peled, 2008) and similarly to mothering practices, the need for relationality with partners, where there is DVA and rupture.

Talking about difficulties in families

Research with families (Smart and Neale, 1999; Smart, 2007; Gabb, 2008) has noted that family members are reluctant to talk about family difficulties and that it can be difficult to get to negative feelings within research on ongoing family life. However, my experience in this research was that participants were willing to talk about difficult and harmful aspects of their lives but not necessarily the detail of harm. There is scope here for further research where there is ongoing harm and trauma and state intervention.

In an attempt to integrate traumatic memories, as part of supporting parents with earlier experiences of abuse, Enosh and Buchbinder (2005) identify two conflicting goals: the need to recollect and process traumatic memories and the simultaneous need to create distance and detach from traumatic memories and the threat involved in recalling and connecting to these memories is emphasised.

> For most participants in domestic violence research, there is an inherent need to reconstruct the experience of violence in ways that are coherent with their perceived identity and with a 'normalised' life story, and in a manner that has both meaning and its own internal logic (Enosh and Buchbinder, 2005, p.11–12).

Understanding the process of recollecting traumatic experiences can challenge a person's sense of self and their attempts to make sense of the past (Plummer, 2001). Remembering, therefore, relates to self-identity, their sense of self in relation to others in the world and the interview encounter as a display of self (Finch, 2011).
My attempts to explore how parenting practices were affected by DVA were met with defensiveness suggesting that participants felt shame and trauma recounting how their parenting was challenged by DVA. Part of parenting in the context of DVA is the difficulty of accepting the extent to which parenting is affected. I reflected on the few opportunities there were for participants to talk openly about how their parenting may have been affected, without reprisal from services. Despite their best efforts, mothers described how it was difficult to protect their children whilst under attack. It was only after relationships had ended, where there was distance from the abuse and support to make sense of their experiences that some mothers reported being able to reflect on the difficulties of living with DVA.

Mothering practices

Much of the literature on mothering and fathering in the context of DVA has focused on parenting deficits and linked the impact of abuse on women to the detrimental impact on children's development (Levendosky, 2001, 2003; Lieberman, et al., 2005). This has presumed a causal relationship of trauma from mother to child, rather than a broader consideration of mothering experiences of abuse and agency in the context of DVA (Lapierre, 2008, 2010; Moulding, et al., 2015). There has been a narrowing of

mothering in the context of DVA to an ‘adequate or not’ debate (Lapierre, 2010). This reductivism fails to recognise how DVA intersects with structural factors at a macro level and complicates everyday mothering (Sokoloff and Dupont, 2005). Furthermore, the focus in research and practice on maternal protectiveness in situations of DVA reinforces gendered expectations of women as protectors without consideration of the situated contexts of abuse in which mothering occurs (Moulding et al., 2015; Buchanan and Moulding, 2021).

Mothering narratives were focused on practices of good mothering in the face of DVA; notably minimising exposure and trying to prevent and pre-empt DVA. Women recounted how practices to protect children were not acknowledged by family members or professionals (Keeling and van Wormer, 2012). Partners, professionals and family assumed the care of children to be the responsibility of women. This was particularly so during DVA, despite mothers and fathers being present. Many of the women despaired at the lack of recognition of their attempts to care and protect through DVA.

Women’s self-evaluations of being a ‘good mother’ were linked to their own biography and imagined futures. The mothering role was significant to them because of the lack of other roles available to the majority of women participants, and it often provided the only opportunity for a sense of fulfilment and control (Featherstone and Trinder, 1997). Women were protective of this role and reluctant to acknowledge that their mothering did not meet their own or societal expectations of ‘good’ mothering. This may also have been an attempt to guard against shame of being ‘othered’. Thus, mothering was performed in the words of one mother as ‘good as it could be, given my situation and could have been better without the violence’ (Becky).

Mothers did not talk about the impact of DVA on their mothering easily or spontaneously. This is similar to findings from earlier research with mothers (Peled and Gil, 2011; Moulding et al., 2015; Wendt et al., 2015). Most women shared how they protected children during DVA episodes and gave limited accounts regarding unpredictable episodes. Mothers were asked further questions that sometimes elicited defensive responses and most did not share their perceptions of children’s experiences during DVA episodes or in their aftermath, until they had left abusive relationships and were recovering. In this way, this finding reflects Perel and Gil

(2011), where there was reluctance by mothers and fathers to talk about DVA that children may have experienced.

Participants who were in relationships where DVA was current were less likely to share how their mothering was complicated by DVA. Mothers were more likely to share their experiences of mothering during DVA after they had left abusive relationships. This is consistent with previous research that illustrates how mothers are reluctant to talk about their mothering through DVA due to mothering being compromised, and to guard against feelings of guilt, shame and helplessness (Lapierre, 2008; 2010; Peled and Gil 2011; Wendt et al., 2015) and recalling traumatic experiences (Enosh and Buchbinder, 2005).

Participants were aware of professional surveillance and mother blaming that made them responsible for the care of children even in extremely challenging situations of DVA. There was a focus on maternal protectiveness (Ferguson et al., 2020), rather than consideration of current or earlier life experiences beyond the DVA relationship. Yet women's and men's stories begin before they are parents. Judgemental CSC practices and exclusion of fathers make it difficult for women and men to be seen in their own right and as individuals rather than just in their social role (Hanmer and Statham, 1999). By not attending to the personhood of mothers and fathers in situations of DVA and CP concerns, professionals miss understanding the context of family practices and also miss opportunities to help meet the safety and protection needs of all family members.

Fathering practices

Previous research with fathers who use DVA has evidenced that some men have been victims of childhood abuse and maltreatment themselves (Augusta-Scott and Maerz, 2017; Brandon et al., 2019; Philip et al., 2019, 2020). This is not to suggest that all men who are abusive have been abused themselves. However, fathers in this study were more willing to describe their own experiences of abuse, rather than their own harmful behaviour as partners and fathers. This supports calls for more holistic service responses to fathering experiences.

Jon's account contained insights into everyday caring and abusive fathering practices but little acknowledgement of DVA in his relationship. He was the only father living

alone with his child, although this was a split household. While he narrated his own experiences of childhood abuse and adversity, there was also some recognition of his son's abusive experiences, yet this was framed from his own victim narrative and requires trauma-informed practice that can support him to recognise responsibility for his abusive behaviours too. Augusta-Scott and Maerz, (2017) describe a trauma-informed narrative approach to explore men's experiences of being victimised. They advocate narrative engagement that addresses both experiences of abuse and responsibility as distinct aspects of the helping process.

Research with men who use DVA is limited and there is even less on fathers that use DVA and have contact with CP services (Heward-Belle, 2016). However, studies that have been undertaken identify that how men talk about their abusive behaviour illustrates minimisation, denial and forgetting (Hearn, 1998; Courvo et al., 2008; Perel and Peled, 2008; Heward-Belle, 2016, 2019). This has been explained as an attempt to minimise their responsibility and, therefore, reconstruct their identity (Hearn, 1998). This is confirmed in this study too as fathers gave greater detail of earlier abuse they had experienced than their DVA behaviours towards partners.

Research on fathers that use DVA has focused on men's abusive parenting practices with limited consideration of the diversity of harmful fathering practices (Heward-Belle 2016, 2019). There has been some attention to fathering vulnerabilities and relationality where fathers yearn for close relationships with children and attempt to be 'good` fathers (Perel and Peled, 2008). This study contributes to existing literature and illustrates how fathering is shaped by some men's histories of childhood abuse, cumulative adversity and ongoing trauma in the context of intimate relationships. This is contrasted with cautioning by some feminist researchers against a focus on men who use DVA as this can marginalise women's abusive experiences (Pinni and Pease 2013). This highlights the tension between men's lived experiences and not allowing men to 'get away with it', (Featherstone and Peckover, 2007) where the centring of men's lived realities can be used as a way of detracting from their responsibility for using DVA. However, my findings support an argument for men's use of DVA to be contextualised in their lives and take account of structural and interpersonal harms from histories of abuse, trauma and adversity. This confirms a need in practice for men to be seen beyond binary risk or resource categories (Scourfield, 2006; Haworth and Sobo-Allen, 2020) but rather as 'both/and' (Philip et al., 2020). That is to say, *both* the

risks *and* resources that men present in families (and to themselves) need to be considered to better understand the challenges and possibilities for positive changes.

Service responses

Childhood abuse and ongoing multiple adversities need to be responded to with humane practices. This requires an understanding of the lived experiences of families, the context of their lives and relational practice. This means setting up systems of trauma-informed practice and relationship-based practice to support recovery and repair within relationships.

The adversity and disadvantage that participants have experienced is embedded within wider social inequality and social problems, yet service interventions try to manage social problems as distinct and singular. The evidence from participants' accounts details that DVA is interconnected with earlier life experiences, previous CSC contact and their relationships. Therefore, CSC are selecting the problem they want to see and focus on DVA without consideration of the wider lived experiences and histories of people and families. This reinforces difficulties rather than providing support for the family to alleviate challenges.

Positive changes in this study for some families involved finding ways to continue to maintain connections with family members, such as with parents that had been abusive to participants, who were involved in their lives and caring for children and grandchildren. Families found ways of continuing practices of relationality which social work practice can learn from. Yet there is currently a reluctance to bring families together and a continued reliance on separation-focused responses rather than thinking about supporting safer lifelong connections.

Conclusion

The concept of family practices and displaying family have been useful for exploring the complexity of 'doing' family in the context of DVA. This chapter has evidenced that parenting practices are fluid with parents adapting their practices in the context of DVA and again post separation. Where ongoing DVA and familial abuse existed there was evidence of mothers and fathers wanting their lives and relationships to be different and yearning for change and connection and uncertainty about how this could happen.

Parents' narratives of early life experiences, relationship histories, socioeconomic circumstances, and state intervention provided a glimpse into the varied and complex challenges of parenting through DVA. These narratives have evidenced the need for parents to have opportunities to express their story as individuals in their own right beyond fixed mothering and fathering roles. In the next chapter, I turn to family participants experiences of contact with CSC due to DVA and child welfare concerns.

Chapter 5: Family narratives of DVA and contact with Children's Social Care (CSC)

Introduction

The previous chapter reported on family practices in the context of DVA. This chapter moves on to explore families' experiences of contact with Children's Social Care (CSC) and child protection processes, where DVA had been identified as concern for the welfare of children. This chapter will address the second research question:
What are the family narratives of DVA and contact with Children's Social Care (CSC) services?

This study is situated within an English local authority (Northford) that received funding from the DfE Social Care Innovation Programme (2015–2016) to spread RP across CSC services, with a specific focus on expanding restorative services for families' experiencing DVA.

This chapter focuses on three key interconnected themes generated from my research data. The first theme involves family experiences of earlier contact with CSC, how experiences of childhood abuse and maltreatment and contact with CSC in childhood shape subsequent encounters with CSC. The second theme concerns relationships with social workers and explores how participants navigated relationships, identifying positive and negative experiences of social work contact in the context of DVA. The third theme explores participant experiences of CP meetings and processes. All themes are illustrated through participant narratives.

Experiences of earlier contact with CSC

Participant narratives of contact with CSC as adults were located in earlier experiences, starting in childhood for twelve of the fifteen participants, and continuing through their life course. Of the twelve, ten had enduring histories of contact with CSC and seven of the ten reported that their grandparents had CSC involvement, making some children of participants the third or fourth generation to have CSC involvement, of which they were aware. These early experiences were frequently connected to abuse and difficult family circumstances, with fluctuating contact.

Participants' histories of CSC contact were revealed when asked how CSC became involved with their family. Some examples are in the three accounts below.

Jake (23 years old)

Jake Well they've never really not been involved! Since I was in the womb! [laughs]. This time they've been involved for six months but before that … I've had them in my life all time I've got cases since I was born like. Since I was born really, up to being 18, yeah.

Permala So since you were in your mother's womb?

Jake Yeah pretty much since, yeah, I've always known them … and seen paperwork. My mum had all the domestic violence in her life.

Faye (27 years old)

Faye My mum didn't have it easy growing up. She herself was put in a care system from a very early age. [pause] And then my mum … as I've grown up, she's been open, my mum suffered abuse as a child and things like that. Then I found out my mum got raped as teenager too and that's hence why my older sibling was put up for adoption.

Ashley (37 years old)

Ashley Well. Social workers … they've been involved forever! My mum was in care, she said she wasn't fed or looked after properly. I think it was more abusive because it made her schizophrenic. And I was two, then six when I was in care because she was abusive to me and got with men that were really violent to all of us.

Nearly all participants recounted childhood histories of abuse, neglect and family adversity. Thirteen out of fifteen participants recounted exposure to parental DVA and childhood experiences of physical abuse, neglect and emotional harm.

Nine participants reported care experiences as children, with two participants placed with maternal grandparents and others in local authority placements. With some having more than one period of reunification followed by further care experience. Therefore, inconsistencies in care were a feature of many participants' lives. For example, Charlie was separated from his older two siblings who were placed with their maternal grandmother when his mother was imprisoned.

> Yeah, it was when my mum went to prison and we was put in care, it was just me and my little sister. It were when I were five to eight. It weren't that good you know. They [other children in same LA placement] used to make us do all the stuff and that. We used to complain but they didn't do anything. Unfortunately, my sister got raped by another person in care so it wasn't the best of times (Charlie).

Charlie and his sister were placed with his maternal grandmother following the sexual assault of his sister. They moved again to live with his mother a few years later when his mother was released from prison. Charlie spoke of feeling angry and let down by CSC because he and his sister were not protected from abuse and feeling powerless about decisions that were made.

In another story, Jon details CSC involvement with his family as a child due to his mother's mental health and hospitalisation. His parents were separated and this led to him moving in with his father, rather than being placed in the care of other family members or the local authority, which he would have preferred.

> I do think our lives could've been different [pause], if I'd got help from social services as a kid … yep, who knows. My mum was in and out of hospital on tablets, she was depressed. Tried to commit suicide a few times in front of us and blamed the cat for it. Just really screwed up. I went to live with my dad, and he was really rather tough with me. It was like a boot camp living with him I couldn't do anything wrong otherwise I'd get hit a lot, with anything he could grab hold of pans, spoons, anything. I was nine when I first went to live with him. So I

been in the same situation as Joey [son]. Because I was also in the same room when my sister was sexually abused. We both had a similar upbringing at the same time in our life. Social services didn't do anything for me. I was left with my dad and he just battered hell out of me for years until I left (Jon).

Charlie and Jon did not understand how and why decisions were made by CSC at the time they were children, decisions which prolonged participants' suffering in abusive situations and contributed to feelings of low self-worth, especially where their siblings had been accommodated and they were the only child(ren) to remain with parents. These decisions were still incomprehensible to them as adults. Although there was contact with a range of professionals, participants tended to identify social workers as the ones responsible for their earlier experiences and the embodiment of 'the system' and state authority. Earlier encounters with CSC were a reminder of practice that had caused suffering to participants. Participants' mistrust of professionals as adults was often located in these earlier encounters.

Some examples of positive encounters of childhood contact with CSC were reported. Here Kay recounts her enduring relationships with residential workers from the children's home she lived in from the age of three years old:

Kay Well I got brought up in care system from being three. I was my daughter's age now. I left at sixteen but was still under social services till eighteen. Then, they tried to foster me out into a family and I couldn't cope with it so I asked to go back to the kids home. I was seven when they tried to get me into a foster care and I couldn't cope with it and I said I wanted to go back home. So they managed to get a bed for me. I'm still in touch with my old care workers, Sheila and Mike. I've known them since I were twelve.

Permala You've kept in touch all these years.

Kay Yeah cos they've been my family, well I know they're not my real family, but they've been alongside me and they've always had

> my back. They've been here for me and Cassie. All social workers came and went, never any time, but Sheila and Mike, they've been my constant.

Similarly, Faye's family had a long history of contact with social care. Faye's children are the third generation to have been placed in out-of-home care, making the same local authority corporate great grandparents.

> My grandma, so that's my mum's mum, had six of her children in the system. In a way looking back, me and my cousins all say, thank God, because they got some sort of upbringing. The ones that stayed with her … well. Not good. Back then, it was house mothers or something who looked after them and one of those house mothers, she's still in our lives. She was like an adoptive mum to my mum (Faye).

While these positive recollections were not of social workers, they are significant to Kay and Faye because they have provided lifelong connections across generations and signify the importance of enduring relationships.

There was an overwhelming wish for earlier encounters to have had a different outcome. Some participants reported that current social work contact did not acknowledge childhood CSC intervention or recognise the need to repair relationships between parents and CSC as an organisation. For example, Charlie felt that if he and his sister had been placed with their maternal grandmother and not in out of family placements, this would have avoided family separation, abuse in care and trauma into adulthood. His narrative on current contact was interwoven with past experiences and brought feelings of threat and anxiety.

There was no evidence from participants that earlier relational histories with social care were recognised in more recent contact. Yet these experiences overshadowed current practice and added to the complexity of encounters and parent-social worker relationships, without being acknowledged. Not attending to historical state harms in meaningful ways was both a missed opportunity and limitation for RP.

Relationships with social workers

Participants recounted mixed experiences of relationships with social workers as adults. The sporadic histories with CSC involvement meant that many participants had experienced relationships with many social workers, including a turnover of workers too. Mixed experiences were consistent with studies on parental experiences of CP processes (Dale, 2004; Smithson and Gibson, 2017; Morris et al., 2018).

Good relationships were characterised by workers that could relate well to parents, were reliable, spent time with the family, showed compassion, were friendly, had a sense of humour and provided practical and emotional support. Effective communication skills and a non-judgemental approach were noted positively too.

> She's helped me because she hasn't judged me. She's listened and she's helped, she doesn't just want to take Cassie [daughter] away. She wants to help me. She got me to the [women's DVA] groups and she does what I needed so she's pretty supportive. And I can talk to her (Ashley).

In the following account, Kay (34 years old) compared her mixed experiences of social work relationships.

> They didn't understand right, how hard it were, how I were terrified of him [ex-partner]. How they didn't help me by keeping him [ex-partner] away from me (Kay).

Kay discovered she was pregnant with her second child whilst care proceedings were pending with her first child, and originally concealed the pregnancy from her social worker until a decision had been made for adoption. She thought that if the social workers involved knew at the time, they would remove her second child too.

Kay So obviously the social got in touch and they said, 'Right, well you've got a choice, you can either keep us or get a new social worker.' I said, 'Well I want a new social worker cos if I have you, it's a constant reminder of my baby being taken.' So I got a new

social worker and this one's been brilliant … Obviously, I had to have another pre-birth assessment again. She said, 'Right you need to prove you can keep away from him this time or you won't be able to have the baby.' Well that were it! [pause]. I weren't … he won last time. He certainly wasn't taking another baby off me. These two social workers were really supportive with me.

Permala Can you tell me what was supportive?

Kay They told me strategies, like what to do if he approached me and they put an order in place. I said, 'I'm a stronger person now. I haven't been with him for a while now and he can't get in my head.' I just said, 'I want to protect my daughter' … They put me in touch with a counsellor to discuss the abuse and they said I was an easy target cos I was abused and they're going to help me explain it to my daughter. They're going to do some life story work with me too.

Kay's narrative of not getting the help to keep her abusive partner away from her is contrasted with the first social worker's emphasis that Kay needed to 'prove you can keep away from him this time'. Yet what was helpful about her second worker was the legal, practical and emotional support that also helped Kay to make sense of her abusive experiences.

Interestingly, it is the accounts of women that previously had children removed from their care due to DVA relationships, and subsequent children that remained in their care, that were most positive about relationships with their current social worker. These positive relationships were contrasted with previous difficult relationships where women felt that their social worker did not understand their fear and blamed them for being in abusive relationships.

There was a legacy of social care involvement in some families' and contact with a range of professionals. These relationships carried their imprints into current relationships with CSC and were intertwined with family experiences of rupture and

trauma. There were decisions made that changed participants' lives bringing suffering, shame and disappointment but also safety and hope.

However, the experience recounted by most participants across (often several) social worker relationships was poor. Participants reported feeling judged, treated as inferior and were required to make changes without adequate support and resources. These encounters added more stress for families, as reported by Jake (23 years old).

> I don't like them. I can't stand them. They come in with … well they got really good jobs and they act like they don't have family problems. Like they're professionals and you know we can all have family problems. They just ask you to do this and that and … asking me to make all these changes and these changes … but nobody really asks you how you wanna be helped to make these changes … It's just more stress and no help (Jake).

Examples of workers' poor interpersonal skills compounded the power imbalance, creating fear about children being removed, and blocking parents from sharing their interpretation of their difficulties. Participants reported that expressing anger or frustration could lead to punitive responses from social workers. Here Rhianna shares her experience of being assaulted by her ex-partner in the street, following a chance meeting post separation.

> Well I didn't particularly like the social worker because she was rude and she could have gone round it different. Like what she was saying … they were making out it was like my fault … and I don't know, like it was my problem. It was him that took her [their child], it was him that beat me up and they made out it was me. So I got quite pissed off about that … (Rhianna).

This was a highly charged situation and although her child was returned safely to her care an hour after being abducted, Rhianna was upset that her behaviour was the focus of intervention rather than her ex-partner's. Rhianna reported being blamed by the social worker for not protecting their daughter and being out with her 'at the wrong time'.

Poor communication and a lack of respect from professionals led to feeling devalued and stigmatised. In another example, Charlie reports being judged by their social worker. Charlie has care experience and his more recent contact with CSC was after ‘a domestic argument’ with his partner Jess after she called the police to report DVA and a social worker visiting the family following a referral by the police.

Charlie She [social worker] tried to make out that I was a certain kind of person. She was talking down to me basically and telling me that I need to go to anger management and stuff. That I’d threatened to hit the children. She was just making things up, and so I told her to leave the house.

Permala What do you mean making things up?

Charlie When I’d said Leon [oldest child] wasn’t going to bed and so I said, ‘he needs a smacked arse to send him up’, and she said I was threatening to hit him. I said ‘No it’s not! It’s a figure of speech’ … But she said, ‘No you threatened to hit your child and you need to go to anger management’ and she kept saying it. So I told her I’d never hit my child.

Permala Then what happened?

Charlie Then we got another social worker [pause]. So instead of asking me questions and putting all pressure on me he’s [new social worker] been like playing with the kids asking them questions and then coming to us after. Just spending more time with us, instead of jumping to conclusions.

Though there is a need to explore what Charlie means by ‘a smacked arse’ and the potential risk of harm to Leon, here Charlie is objecting to the manner in which he is communicated to, that he experiences as judgemental and authoritarian, rather than humane and curious. The first social worker’s approach is contrasted with the second, where the focus is on ‘spending more time with us’. While the safety and welfare of

family members needs to be assessed, the way in which workers do this influences parents' engagement and feelings of alienation and potentially puts families at further risk.

Earlier in the interview, Charlie recounted his experience of being placed in out of home care as a child and his fears of this being repeated with his child. He is understandably wary of any social work involvement. His account evidences the differences he recollects in the social workers' approach and his preference for non-judgemental practice that engages all family members, rather than a specific focus on him.

Families felt threatened by CSC power and intervention. Not being asked about how they wanted to be helped frustrated participants and was representative of 'doing to' them rather than the 'doing with' RP ethos that the authority was trying to embed (Mason et al., 2017). Many participants recounted feeling judged and not being 'treated like a person'. There was a lack of interest and curiosity about them as people in their own right, separate from their parental role. These adult experiences were interwoven with childhood experiences of CSC, and intergenerational experiences for some too, that exacerbated feelings of fear and threat.

Additionally, the lack of recognition of the impact of participants' experiences of abuse and previous CSC contact demonstrated a failure to recognise trauma and respond appropriately to this in practice (Ruch et al., 2010). Missed opportunities to help by state services where fathers specifically highlighted schools and CSC. Some participants shared experiences of difficult family practices from parental DVA, gendered expectations to display hegemonic masculinity in their family and community, experiences of abuse and adversity from challenging social and material family circumstances. Fathers recounted that they needed help through their life course but did not know how to get the help they needed at different points in their lives. Reflecting back Jon's account below, illustrates that greater curiosity and a relational approach would have helped him in his fathering role.

> I think what would have helped me then, is that the social worker and professionals involved were more empathetic, of my past, what I've gone through, and had more understanding of why I got like that. The

> fact that that's me in general and I can't really change that but obviously with the help that I got, has helped change me a bit. When they found out I was hitting Joey [child], they didn't understand me or get to know me. In my opinion all they saw was the child, they didn't see me. They just saw that Joey's been through this, had that done to him and now me doing what I was doing to him. But the help I got actually took note of what I'd been through – Stronger Families and Caring Dads. They got to know me a little bit and why, this is the reason he's doing that. I could see the moderators and even you getting upset about what I've been through in the past, but the social worker I had didn't. If I was to have any more help, I'd like someone who was more understanding and took the time to sit and listen to my story. I felt judged by the SW [social worker], but Stronger Families, no judgement whatsoever. They helped me out with carpets and I did a star chart and I had to compare it with after the help and before. I felt more understood by them than I ever had by any social worker. Just more understanding would help me (Jon).

Jon's account highlights what he found lacking in his social worker relationship, in comparison with professionals from voluntary services that he was referred. In common with Kay's account above, these participants found support and recognition from services that they were referred to by their social workers. Here, the social workers' brokered services that provided community-based, empathetic, person-centred support, that they could not necessarily provide due to the constraints of their role. This finding correlates with Murphy et al.'s (2013) assertion that social workers are significantly compromised from building person-centred relationships due to tensions in their role, where technocratic processes are emphasised over ethical, relational practice.

Participant experiences of childhood trauma and adversity, and previous contact with CSC led to low levels of trust in relationships, with professionals and others. The concept of cumulative trauma (Khan, 1974) is relevant here because the life histories shared, evidenced participants linking childhood experiences to adult adversity and relationship difficulties. This included accounts of an intergenerational cycle of DVA for some, both as perpetrators and victims of DVA, and attempts to make sense of

some of the difficulties they currently faced and their contact with CSC. These accounts featured a corresponding lack of appropriate support at key times in their lives (and the lives of parents and grandparents in some cases) especially from CSC. There was heightened awareness of the imbalance of power imbued through CSC intervention and the precariousness of some situations, as summed up by Charlie below.

> To be honest I'm a bit worried … Yeah worried. Cos they can take kids off you, can't they. It's like one slip up and it can all go downhill really quick, can't it. We're just trying our best really (Charlie).

There was a fear of recurrent intergenerational child separation into state care. These findings substantiate participants adopting strategies to navigate state authority in everyday encounters with CSC to avoid this. This will be explored further in the following section through a focus on the two couples involved in the research, all of whom were interviewed individually.

Couples, DVA and navigating relationships with social workers

This section will focus on two couples, where DVA was ongoing and there were also CP concerns.

Jess and Charlie

Jess is a 30-year-old White-British woman and lives with her partner Charlie, a 22-year-old White-British man. Charlie and Jess live together with their eight-month child Toby and Jess's two children from her previous relationships. They have different experiences of social care, with Jess having had limited contact as a child due to parental DVA and Charlie having had very difficult experiences involving family rupture, care and family reunification.

CSC became involved after Jess had contacted the police and reported Charlie's violent behaviour towards her after an argument.

Permala Can you tell me how social services became involved?

Jess Yeah. One of my fears was well, that they were going to say you have to separate. That's cos I know people that have had to

separate and they haven't separated and then lost their kids, which is … what I … would never like. I think that's because they've gone past what social workers said. But we've done everything the social worker said … and worked with them. If you work with them … you can get the help.

Permala And how have you been helped?

Jess Ermm. It's taken a while cos [pause] well … Charlie didn't really get on with the first social worker cos he felt she was like 'This is what you've done' which wasn't the case. It ended up getting changed cos she wasn't our proper social worker and we got assigned another one. But he gets on with this one. I don't know cos it's a male or whether the last one were a woman. I think it's how they speak to you as well. Cos Charlie doesn't like to be spoken down to. He felt like he was being talked down to. Charlie goes a lot on respect, he'll give respect if he feels like he's had it and I think he just felt attacked. Especially when he knows he's got an anger problem and he's willing to get help. He weren't working with them at first and that's why I think we got assigned another one and then obviously they've put the children on emotional abuse child protection. But they've said that because we've been working well with them, we're on our way to a CIN [child in need] plan which is voluntary so. We'll see.

Permala What do you think will happen?

Jess They're saying it's a risk with us arguing and Charlie kicking off. It's a risk and it does sound really bad and I cried my eyes out. They said cos it's down as this, we can get all the help we need, so it's not just what we need to do, it's what housing need to do, health professionals. They'll get us all sorted out. Just so that everyone's on the same page [pause]. Err, emotional abuse sounds really bad. I hate talking about it and I cried my eyes out when they said that, but do you know something, it's been one

> of the … It's been a good thing. If they hadn't of got involved, I don't know where we'd be right now. We could have been in a worse situation. It could have escalated. Anything could have happened.

On being asked about how CSC became involved with their family, Jess recounts her fear of having her children removed like other families she knows. She reports that Charlie and she are being cooperative with CSC, rather than 'going past social worker'. Jess emphasises Charlie's need for respect, repeating this and his 'anger problem'. There is a need for professional curiosity about what this means for Jess and Charlie within the context of their relationship and DVA. Jess struggled to articulate how she or the family have been helped by CSC to date. Although she is hopeful they can help with longstanding family needs. There is shame from being identified as an emotionally abusive parent and she repeats, 'it sounds really bad and I cried my eyes out' and 'I hate talking about it'. There is also fear about how Charlie's relationship with their social worker might impact on the family and potentially 'go against them', recognising that families that challenge professionals are identified as resistant and problematic (Shemmings et al., 2012; Morris et al., 2018; Quick and Scott, 2019), rather than difficult emotions being acknowledged as a normative part of interactions that need to be worked with.

Charlie and Jess are fearful of the potential of being separated from their children due to CSC involvement. Earlier Jess recounted that she had told Charlie that if there was a choice between having to separate and end their relationship, or keep her children, she would keep the children. This exacerbated tension between them, making Charlie anxious and angry at the prospect of 'losing my family over again'. Jess does not want to risk being separated from her children, recognising that the more they 'work with' CSC, the more likely they are to have the case closed. Thus, while there was mistrust and fear of social workers, there was also hope and recognition that CSC could help the family too. Jess struggles to articulate how the family have been helped but affirms that CSC involvement has been 'a good thing' and that the situation could have been worse for the family.

Jess has been trying to get help to address the overcrowding and lack of adaptions in the home and secure additional disability support and resources for her eldest child

Noah (10 years old) at school. These needs have not been addressed and the family have continued to struggle. These have been consistent family needs for years. Jess is reluctant to accept the category ‘emotional abuse’ as an accurate description of their circumstances because she believes that having their needs addressed earlier would have taken pressure off their relationship. She is reconciled to CSC involvement as necessary in pursuit of access to services that are increasingly hard to come by. The current crisis has been exacerbated by years of unmet needs, a new baby, overcrowding and economic hardship. The transactional nature of practice requires her to accept the label of emotional abuse in this instance, in the hope that long standing needs will finally be met.

Charlie and Jess are unlikely to be the only family awaiting support for longstanding preventative services, a situation where family difficulties can escalate resulting in a demand for CP provision (Hood et al., 2021). Their account illustrates how families can reach acute crisis points before services will become involved. The fear of child removal can prevent participants from being open about the nature of DVA in their relationship (Hughes et al., 2011). While Jess is optimistic that practical needs will be addressed, there is little in her account about specific support to date. Jess minimised DVA, stating earlier ‘it was just a push’ when asked about what prompted her to seek help from the police. This was contrasted with her account that ‘It could have escalated. Anything could have happened’, suggesting she was aware there was potential for escalation of DVA. She points out that social care intervention is ‘good’ and will help them ‘get sorted out’ practically. There is reluctance, borne of fear, to name her experience of DVA to CSC, and she is caught between her family’s needs and her fear of service intervention.

A week after my interview with Jess I learned that Charlie seriously physically assaulted her and that she was hospitalised. Six months on from the interview, I learned that Jess and Charlie had separated. Jess was still awaiting rehousing, had not been contacted about adaptions to her current home and no additional support was in place for Noah’s transition to secondary school. Jess was hopeful for support, yet at the time of CSC intervention, she was unable to share her experience of DVA or secure the support she needed to help her children.

Kim and Jake

Kim is a 26-year-old White-British woman and in a relationship with Jake, a 23-year-old White-British man, for three years. They have one child together, Max, aged 13 months and Kim also has a six-year-old daughter from a previous relationship. Kim suffered child sexual abuse and neglect as a child and was placed in out-of-home care from eight years of age and lived with three different foster families up to moving to a young people's hostel at the age of sixteen years old.

Jake is a father of two children, Max and another child (2 years old) from a previous relationship who he has no contact with. Jake has recently moved out of the home he shared with Kim and the children. As a child Jake suffered parental DVA and abuse from his father. He is the oldest of four children. He recounts that as a child, no one could control him at home or school, that he was 'always in fights' and 'was trouble' for his mother who 'had to call the social on him' because he was `out of control`. He became known for being 'trouble' and 'a good fighter', and as a young man enjoyed the status of 'someone not to be messed with'.

Jake reported that due to parental DVA, his three younger siblings were placed in out-of-home care. The decision to remove his siblings and not him continues to be incomprehensible to Jake, because of the continued abuse he suffered and resulting trauma. His father had left the family home but continued to visit and perpetuate DVA. Jake missed his siblings and blamed his mother for this 'for years'. He was excluded from school several times and drifted into criminal activity and contact with the criminal justice system. Jake describes how he continues to feel 'angry all the time' and `explodes`, suggesting struggles to regulate his emotions from an early age, indicating trauma (Herman 1992). Not getting the help he needed or wanted at key times in his life, including from school or CSC, is a repeating theme in Jake's narrative. As he says, 'There was no help for me, I didn't stand a chance'.

At six months old, their son Max became ill with breathing difficulties and was hospitalised for six months without a clear diagnosis. Max's discharge coincided with Jake learning that his court case and charge for aggravated assault, against a stranger in a pub, was imminent and there was a strong likelihood of him receiving a sentence. Both Kim and Jake shared that Jake goes on 'benders`, staying out late drinking and

using drugs. It was after one of these nights that he returned in the morning and became abusive. In the account below Kim shared the situation.

> He gets so angry and starts throwing things when he's like that. I locked him out and he kicked the door in, that's when I called police. He needs to get himself sorted. I don't want my kids taken off me, how I'm supposed to cope with two alone and one that's a really poorly baby too? (Kim).

Kim reported that these` benders` had increased and she feared Jake's abusive behaviour, separation from her children and Jake too. Recognising the challenges of mothering through DVA and alone. From a separate interview, Jake's recounts the same evening below.

Permala Could you tell me how social services got involved this time?

Jake They got involved when … erm … I'd been out on night out with my friends. Me Mrs was carrying on, I'd come home in a really foul mood, she wouldn't let me in house, I booted the back door off its hinges. And I let me self into house … It's like 7 o'clock in morning, kids was up in the living room. [I can hear his mum's coughing from the kitchen]. I didn't realise. I was off my head.

Permala What were you on?

Jake I was on cocaine and I was on the beer, been on it for two days straight and then come home and she wouldn't let me in. [pause] So I kicked the door off, run in the house, I carried on screaming, didn't even realise the kids were in the living room, so she's phoned the police, the police come out and I'd run off by then so I wouldn't get locked up … erm and obviously with it being a domestic violence case, they rung the social worker, they've come out and they've been here since.

Permala Was that the first time they came?

Jake Eerm yeah that was the first time they came and opened the case. They've been before. But they've been called in past for things but they've never been able to do owt because it's not true. People mixing things and causing trouble … family members. Not going into detail with names but other parts of her family. Some of them know my past record and they just thought it was a bit of a bad situation. But they've closed all the cases but this one time it's been open because it's quite a domestic violence case as they call it. Even though there was no violence**,** they called verbal shouting domestic violence cases

Permala Why do you think they've stayed involved?

Jake Because the kids were there. I understand why they're there and I understand why they're still there now. But [pause]. To be honest we spent six and a half months … a long time in hospital, they use to come, they were never no help. You can imagine money wise we spent in there, they were never no help, even Kim's PA would help her, they would pick and choose … but down to the social workers there was nowt … they just wanted to tick their boxes and say we've done our job.

There are tensions in Jake's account, where there is admission of using drugs and alcohol, and later stating that he doesn't have a 'drink problem' yet 'has benders and loses control'. He also understands that CSC involvement, because 'it's quite a domestic violence case, as they call it'. Jake links the current situation with the stress of his son's ill health and a lack of practical and emotional support. Given his previous experience of CSC contact, he is not hopeful that they can help currently.

Permala There's been a struggle with money … what else would have helped?

Jake Yeah … especially when we were in the hospital. When I did come home I came over here, [his mother's home], to get some sleep, chill out, cos I really didn't want to go to work. Ermm [pause] apart from that, that was it really, that's all we did for six and a half months and not one really helped, yeah my mum helped, my dad helped, our family helped, but there were no help from professionals, that's what they're supposed to do.
It wasn't even just a lot of help, you know, maybe sometimes, because we spent so long in there, the money we spent, it could have been food parcels, just anything, just to help us get by even, someone to talk to while we was in there, because all we had was each other, we were on each other's toes constantly, it was obviously a lot of arguments with being in there … every time someone [hospital staff] would ring and tell them we'd been arguing she [social worker] was straight on the phone … 'merh, merh, merh' I said, well you try and stand in our shoes, there's a lot of stress, we've got a lot of stress to deal with and still to come. And she doesn't understand it like that, they just want to get their boxes ticked and say we've done our job.

Permala You've had a very difficult time, lots of stress, and did you tell your social worker?

Jake I'm seeing her tomorrow, I don't really like her to be honest and I'll be truthful, I can't stand her, I don't like her.

Permala Why is that?

Jake She's never once been here, never once been here to see me and she expects me to go to Northford constantly.

Permala Never been here? Even though you all stay here.

Jake Not once been here. Does she think I'm made of money; you know what I mean, I have to go to city to pick him up and she

> expects me to see her all the time, does she think I'm made of money … So you know it's like I was saying with Paul (FGC), first time he ever rung he said I will come to you. I sent him me address and he said, 'yeah it's not a problem, I know where you live', he's come.

The lack of practical and emotional support at a time of crisis, and not being visited at his mother's home, compounds previous experiences of CSC as not being a helping agency. Jake is angry about this and does not want to see the social worker in case his anger 'boils over' and makes the situation worse for the family. In addition to this, Jake has been told to attend a sixteen-week Caring Dads course to address his DVA behaviour and fathering. He does not think he has difficulty with his fathering but does acknowledge that his substance use exacerbates his anger, but also provides an outlet for his stress.

CSC suggested separation to Kim and Jess, 'they told us to have time apart'. This resulted in Jake's move to his mother's home in a neighbouring town. Jake was reluctant to separate but acknowledges that it has eased tension with 'less arguments and more headspace'. Jake is angry that having moved as suggested by CSC, the social worker has not visited him. Jake recognises that there is an expectation for him to evidence his compliance and visit her, at her request, in the neighbouring city. This will incur additional costs and time, a three-hour round trip on public transport. Additionally, Kim has struggled with childcare since Jake moved back to his mother's house. They are continuing to see each other 'when they can'. Kim and Jake want to stay in a relationship yet are finding this increasingly difficult and fear that the children might be removed if they do not comply with the separation.

Using the social discipline window (Wachtel and McCold, 2001) as a frame to understand Kim and Jake's experience of contact with CSC, both authoritarian and neglectful CSC practice are identified by them. This includes their reports of being told to separate, Jake being required to attend a Caring Dads course to address his DVA and fathering, and the expectation for Jake to meet his social worker in the city. Practice that Jake and Kim experience as neglectful includes the social worker not visiting Jake at his mother's house and not being supported practically or emotionally when Max was in hospital.

Jake feels that he is being tested by CSC, to see how committed he is to his child and partner and to show this by travelling to meet the social worker. He reflected that had he been the mother, their social worker would have visited him by now. He experiences gendered practice as exclusion, which compounds his feelings of not being 'worthy' of CSC help, not as a man or as a child. This current experience with CSC triggers reminders of earlier contact and the enduring nature of his relationships with CSC, and of the difficulties in his life.

Permala When you say you've always been involved in some kind of violence is that family violence?

Jake Well all violence … and family violence … my mum, when I was living with me mum, she was going through domestic violence, she went through it with my dad … The social worker was always involved … and then it's just carried on through life really. It's all I've ever really seen … and I don't want to be that person.

Permala What person is that?

Jake The person that I am today [pause]. I can be a horrible person and I'm very violent when I'm that way out … but … I need to control my sen really … things are … they are starting to work … but … and that's where I'm stuck at the minute … under a bridge.

Jake recognises his violent behaviour, although he does not talk specifically about violence against Kim. He does not want to meet the social worker but does want to find a solution, to manage his emotions and feel more in control. There are very few options available in their current situation for Jake to get the support he needs and wants.

The way that the couples have experienced professional authority has had a direct influence on their engagement with CSC. Where parents identified professionals' practice as 'doing to' them (authoritarian) rather than 'doing with' them (restorative),

parents reacted in two ways: avoiding and posting contact, or 'playing the game', by going along with the social worker in the hope that some needs could be met. These findings echo earlier research (Dumbril, 2006; Reich 2005) about deferring to or resisting professional authority to avoid shaming encounters. For both couples however, the nature of DVA and the impact of this on their family relationships was not something that they reported they could share with CSC, for fear of their children being removed from their care. Thus limiting opportunities for increased safety for children and mothers and resolution for the family.

Parental experiences of CSC meeting encounters

Parental recollections of CP meetings were overwhelmingly negative. While there were some positive experiences of support that arose from meetings, the process of meetings was reported as tense, stressful, 'humiliating' and professionally focused. Participants' accounts described power imbalance and feeling 'outnumbered' by professionals. There were accounts of being judged and reprimanded for something that they had or had not done, making some feel defensive and fearful that there would be an escalation and their children would be removed. Some parents sought to 'get through them' by deferring to professional authority. These experiences align with other research into parental experiences of CP processes (Reich, 2005; Dumbrill, 2006; Ghaffar et al., 2012).

The next section will focus on the experience of professional meeting encounters from the perspective of two participants. These interview extracts indicate parental experiences of CP meetings and the relational context of practice

Rhianna

The following extract was taken from contemporaneous fieldnotes during a core group meeting I had been invited to observe. Rhianna had consented to my presence through her social worker, Mica, prior to the start of the meeting. My aim was to introduce myself to her at the start of the meeting. However, when I arrived I was asked to make refreshments for the other professionals and missed Rhianna's arrival. Rhianna is 22 years old, White-British ethnicity. She lives in a lone parent household with her daughter Rosie (18 months old). Rhianna is separated from her ex-partner Ewan (22 years old, White-British ethnicity).

Start of fieldnotes - There were five people in the meeting room: Rhianna and her 18-month-old daughter Rosie, Mica, health visitor (HV) and housing officer (HO). I was instructed to make drinks and return to find that the meeting has started The HO is talking when I enter the room. No one introduces me. I don't know the HO or HV names.

The HO is asking Rhianna if she has had the rubbish removed from her front garden yet.

Rhianna No, I can't afford to have it picked up.

HO Well it needs to go, it's a hazard [abruptly].

She is telling Rhianna off and doesn't respond to Rhianna stating she has no money to do it. No one else interjects. The professionals discuss the rubbish and Rhianna looks at the floor and picks up a toy and passes it to Rosie. The HO asks Rhianna when she thinks she could find the money to do it, she wants a clear date '2 weeks/ 3?' She looks at Rhianna and then Mica for a response.
Rhianna shrugs her shoulders, 'I don't have the money, I can't afford it and anyway I'm not even staying there'. Mica asks her where she is staying.
Rhianna At a friend's, it's not safe to stay there [her home] is it.
There is a discussion about whether Rhianna can maintain her tenancy or if she should move again. The discussion moves to Rhianna inviting Ewan (ex-partner) to the property.

HO Well it's not going to be safe for you if you've told him where you live and he's been round. Why was Ewan at the property?

Rhianna He knows I live there. It was her first birthday and I wanted him there. He wasn't going to batter me in front of my family.

HO [looks at Mica] What's your take on this. What if she invites him again?

Mica [looks at Rhianna] I'm worried that this is your normal, living with this level of risk for yourself and your child.

Rhianna looks at Rosie who is on the floor. Winds up a toy and puts it near her on the floor.

HO We can't keep rehousing her because there's a risk of domestic violence and she's putting herself at risk by telling him where she is.

Rhianna looks at me and then at Rosie who is crawling away from her towards the door.

HO [looking at HV and then SW] She doesn't see it does she.

Rhianna doesn't say anything. She looks at me. Her eye contact indicates our joint outsider position – visible yet invisible – mirroring my researcher role, amplifying my unease at her public shaming, me observing for research purposes and saying nothing.

The meeting is a perfect example of the punitive 'doing to' rather than restorative 'doing with' mantra that is commonplace in Northford to describe how they wish to work with families. No one in the meeting follows up on Rhianna saying she cannot afford the rent arrears or have the rubbish removed.

Professional frustration dominated the meeting. Rhianna was incidental. No one asked her what her concerns or needs were. Rhianna was denigrated and shamed, with few opportunities to speak. There was a chasm between professional interpretation and Rhianna's definition of her difficulties. (End of field note - Core Group Meeting note 24/4/19)

Later that week I interviewed Rhianna at her home and mentioned the meeting.

Permala We met at the meeting last week …

Rhianna Oh yeah, you were there [laughs]. Well, they was having a go weren't they … so I let em. Didn't matter what I was going to say … so I just let em. And I took it [laughs].

Permala Took it?

Rhianna Well when they all get together like that talking about my life! I zone out. They no idea, fact they don't want to know. I knew from just looking at faces it was one of those … you know … meetings where you look, smile and keep this [points at her mouth] shut.

Permala What would you have liked to say?

Rhianna (sighs) I just want him to have her. So it's not all on me. I want her to have a dad in her life. But you can't talk to them 'bout that. Oh … no … no … no. That's a no-go!

Rhianna indicates that the meeting dynamic is a familiar experience, 'one of those meetings', where she is silenced. Her strategy is to say little, recognising that the professionals are not there to listen to her, rather, to talk to each other. The focus was on the professional interpretation of risk, risk to tenancy and risk posed by Ewan visiting. This leaves no opportunity for Rhianna to express her concerns or needs.

Rhianna It was like I wasn't in the room, they were talking at me, it weren't too easy, I just end up drifting off in my head.

Permala What would you like to have said?

Rhianna They kept going on about keeping her [Rosie] safe and I do that. I do that, but who keeps me safe? And cos we'd had that huge argument at the first meeting, we don't have meetings together. So how do they think I am gonna sort it out if they won't even meet us together in the same room? Well, it's just not going to help me, in any way. Fact, it made it worse cos he still blamed me for the arguments and got paranoid 'bout what I'm saying

> ’bout him in the meetings he wasn’t at … again! … All on me. See!

Rhianna’s framing is that she is scared of her partner but does not want him to know this. She avoids staying in her own house because of her fear of him and chooses to stay with a friend, where she is less isolated and has support. Despite her fear of Ewan, Rhianna (and Ewan) want Rosie to have a relationship with him. For Rhianna, the DVA she experiences and wanting Rosie to know her father are connected yet separate issues. CSC deciding that Rhianna and Ewan have to have split conferences is exacerbating tension between the couple and compound feelings of frustration and dejection about CSC involvement and her situation. Additionally, Rhianna is constructed as having no awareness of the dangers posed by her ex-partner, yet her strategy to keep herself and Rosie safe by staying at her friend’s house is criticised as her not taking responsibility for her tenancy.

Rhianna’s story needs to be contextualised in her lived experience of exposure to severe parental DVA and having contact with her father throughout cycles of separation and reunification in her parents’ relationship. Mica’s comment, ‘I’m worried this is your normal’, confirms Rhianna’s narrative of having lived with family violence all her life. Rhianna shared that ‘violence is normal in my family’, recounting family violence throughout her life. There had been a recent incident of being ‘punched in the face’ by her brother because he thought Rhianna had ‘shamed’ their mother at an earlier case conference. Whilst Rhianna recognises that violence is harmful, it is also accepted and expected, and can be routinely normalised when past familial violence and DVA permeate adult relationships (Mannay, 2013).

Understanding Rhianna’s family practices has the potential to open up a different way of working with her and locating practice in her lived experience of relationality. Rhianna is concerned about her safety, yet the meeting constructs Rhianna as not ‘getting it’. This results in Rhianna being silenced and her safety concerns being unexplored in a meaningful way, creating unsafe situations for her and her daughter, yet the focus in practice remained on the risks posed by Ewan that Rhianna was having to manage, while there was no contact with Ewan.

Parents recalled feeling stressed and anxious prior to meetings, attacked and judged during meetings, and confused and stressed after meetings (Ghaffar et al., 2012; Smithson and Gibson, 2017). Confusion was described where parents stated, 'we're doing all asked of us' yet more was being asked at each meeting, 'like a never-ending shopping list' and left many feeling deficit and confused about what was being asked and how they could meet CSC expectations.

Sam

Sam is a 33-year-old White-British man and primary carer of his two children. When his relationship with Millie (30-year-old, White-British woman) ended he moved to his mother's house, initially alone, while the children continued to live with Millie in the family home. CSC were involved due to DVA, reported by Sam from Millie. Several incidents occurred where arguments escalated into violence and damage to property. Sam reports that this was always when Millie was 'under the influence or desperate for them' (alcohol and cocaine). Sam called the police and CSC became involved, closing the case soon after it was opened. However, after Sam moved out concerns were raised about the children by school and CSC involvement revealed an escalation in Millie's drug use, concern about recent relationships with men that were abusive to her and the children. The children were placed with Sam and had supervised contact with Millie. This changed to an overnight stay after eight months.

Sam reported that he was 'forced' to attend the sixteen-week Caring Dads course. I was curious why, given his narrative about CSC being involved due to Millie's escalating drug use and DVA against him. Sam relayed his understanding of the reason as 'punishment for being a man and getting angry' at a case conference meeting. The extract below contains a number of themes and is included at length to illustrate Sam's experience of CP processes and the impact this had on him and his relationship with Millie. I have included a long and unedited interview extract with Sam as it gives insight to his family practices, how they intersect with his experiences with CSC and the lack of power to contest CSC practices.

Permala So how did you come to do the Caring Dads course?

Sam Because we were at, we were at one of the meetings that went up to child protection and we had [name] as the chair. You know her?

Permala No.

Sam Well she was the chair of the child protection meeting. And she'd heard about something, I got a report off one of the neighbours saying my kids were crying and screaming that they want their daddy and stuff and she [Millie] was heard just shouting at them and stuff. So I went down. So when I went down to the house, kids both came screaming, crying out the house. Both clung right to my legs, begging me to take them to their Nanan's.

Permala Hmm.

Sam So I put them in the car and walked up to the house, pretty casually. What the fuck have you been doing to my kids? And, you know what Millie does in defence. She says she's going to ring the police because I'm kidnapping my kids.

Permala Right.

Sam So like, right, I'll tell you what, I'll get them safe, get them home safe, I'll ring the police and say, and tell them exactly where the kids are, why the kids are here. Anyway she reported like a disturbance with the police so it was noted down. And before I could say anything, the chair says, so are you the perpetrator of domestic violence Sam? Right, yeah. Even though the only evidence what they've got from the police is me ringing the police on this

psychopathic woman right, but I was perpetrator, because I raised my voice basically for my kids.

Permala So it was the chair of the conference that said this?

Sam Yeah, yeah. So she says, so you're a perpetrator of domestic violence. And I was like pretty stunned, like a rabbit in the headlights. You know, I was a bit like shell shocked from myself. Well you're a perpetrator of domestic violence she said again. You were arguing with Millie in front of the kids. I was like, well I wouldn't put it as that, but she wouldn't take no for an answer.

Permala Hmm

Sam Right, so I was pissed off. I had to keep my mouth shut because this woman … And it was almost seemed like she hated men or something like that. Every time, yeah. Every time I spoke I got shot down.

Permala So you …

Sam I got to the point in these meetings where I just, for my own sanity, I had to just keep my fucking mouth shut and just absorb anything she wanted to say to me.

Permala And …

Sam And eventually we had a meeting. It was actually on the meeting where there was a good turn around with kids. Because the kids in my care have progressed for, so well in a matter of months, they were happy, they had extra school, extra activities. I

take them ballet and dancing on a Saturday and stuff around my work, they look loved, anything they need I cater for, right. And on this meeting where I already got forewarned that it was going to get dropped and they were going to stay with me, she, this chair of the meeting was going on about something. I can't remember what it was. I was more concerned in the fact that I couldn't fucking speak. So I fucking walked out. I think I had a little go at Millie because…Well one thing that my social knows is, me and Millie can just talk as normal, you know, like when we're exchanging the kids and stuff, we can talk as normal, you'd think we'd been mates forever, right.

Permala Yeah.

Sam And like I say, with this chair of the conference meeting, the last one, the last time I ever saw her, she kept shooting me down again and it really pissed me off. Because my understanding of this woman, she told me basically I was a perpetrator of domestic violence. From there, I had to go on a Caring Dads course, which I wasn't happy from the start because I knew potentially what kind of men I'd be meeting.

Permala Ok

Sam And they weren't me, right.

Permala Yeah.

Sam So I wasn't happy and I got reassured by the social, my social worker saying it'll be a good thing in the end. Because when you go to court you can say

you've done this work, so it's all like backs up any other allegations that I'd been domestically abusive.

Permala Did you attend the course?

Sam Yeah. In the end. I seemed to be a bit more unique compared to some other blokes. Because you know like when you see snippets of like things they pull off of YouTube or Google or something and there's a man and a woman, and he's been violent. It was like I was the woman.

So anyway, this chair, on the last time I saw her, I got fucking pissed off and I went out for a smoke and … What did I do? I swore, I swore. Because when it comes to my kids and I'm arguing a point and it feels like it's not getting across, or I'm being accused of something, I'm like, you know, I get very passionate.

Permala Yeah.

Sam Right, so I swore and she says, oh I think you need to go outside. I says, right, yeah. I'm off out for a cig. So when I came back in I went as soon as she come in I says, do you hate men? I told her outright. Do you hate men? Because it just certainly seems like you fucking hate men.

Permala Yeah.

Sam And she was like, you can't bring sex into this. Well I'm telling you. And she started going bright red. Because she probably knew she'd fucking been too harsh.

Permala Yeah.

Sam Because you've got to think, I'm a man, right. And I know in most cases it'll be a man being a prick.

Permala Yeah.

Sam Right. This wasn't the case. I knew that, right. But every single meeting I'm in a room full of women, right. And you've got a very manipulative, twisted woman [Millie] here, right which may I add every single meeting lies were being, she'll outright lie to every single professional and then you go, all right, okay. Then boom. That lie's gone.

Permala Yeah.

Sam And then she'd start crying and give some fucking stupid reason why she lied. But all the time, every time she lies, because it's directly covering, covering up some danger to my kids. It fucking gets, it gets my back up, right. So that's why I feel like I've got to un-foil all the lies.

Permala And did anyone else say anything in the meeting?

Sam Oh yeah, in the end, but I suffered so much sort of, I don't know what to call it. Because usually it is a man being a prick. Every time you get a woman like that crying with crocodile tears, and they're all like, aww. All over her.

Permala So you got…

Sam And then all of a sudden I'm being accused of being nasty to her.

Permala Right, okay.

Sam I'm not. I'm voicing my concerns, they're my children. So you see, it's like my social worker, she'll say, it's like a stereotype kind of thing. I'm a tall guy, you know, whatever. I usually, I'm a very, keep myself to myself kind of pretty quiet person. When I'm talking about a situation I can talk a lot, right, and when I talk all these facial expressions come because, you know, I might screw up my face. I might look like I'm really angry.

Permala Yeah.

Sam But I'm not. And my social worker will say, look you come across as though you're intimidating but, you know, you don't intimidate me.

Sam's account illustrates how gendered expectations about acceptable and unacceptable emotional expression are reinforced through CP processes. His account shows DVA is fixed through a binary lens of women as victims and men as perpetrators. Though Sam's narrative challenged this binary, the process failed to consider the nuance of the interdependencies, strengths and difficulties in Sam and Millie's relationship and how this plays out in CP process and impacts family functioning. According to Sam, he is coerced to attend a sixteen-week course to address his fathering despite the meeting having agreed the children are thriving since being primarily in his care. Sam is humiliated and 'raging' by this experience because he cannot protect his children when they are staying with Millie. He feels threatened as 'the only man in a room of women' and instructed to temper his emotions and facial expressions to meet acceptable requirements of 'good masculinity,' mastering his emotions and showing limited emotional expression (Fox and Pease, 2012). He is required to conform to the gendered and emotional regimes at play even though this

is incomprehensible to him. Sam struggles to find words to express how he felt in the meeting, recounting that his experience was beyond words, raw and visceral.

Magyar-Haas (2021) maintains that 'humiliation can be seen as the (intentional) instrumentation of shame' and is 'inherent in social work practice' (ibid, p.72). Sam feels shamed by being labelled a perpetrator. He finds this abhorrent, given his own experiences of parental DVA and it triggers Sam's rage, leading him to ask the chair 'Do you hate men?' On leaving the room, Sam's social worker follows and reiterates his need 'to control his emotions because he is coming across as an angry man,' asserting that he modifies his emotions so that he is not perceived negatively as a 'stereotype of an angry man' by those in the meeting. The social worker is complicit in maintaining the restrictive gendered and emotional regime.

Sam's account evidences an emphasis on his 'traditional' construction of masculinity and what it means to be a 'good' man and father, as recounted earlier in the interview. For him, this means providing for his family, protecting women from violence, being able to 'handle himself' physically and protecting his daughters. Foremost amongst this in his account is protecting his daughters from Millie and the partners currently in Millie's life. He is frustrated that he cannot provide care and protection of his daughters in the way he wants and experiences this as a failing both as a man and as a father.

This is a complex situation and defaulting to gendered practice belies the complexity of it. There are multiple needs and vulnerabilities including complicity, harm, parental histories of abuse, unresolved trauma and addiction. Sam and Millie need CSC to help yet recognise that their involvement is also negatively impacting their family practices and is detrimental to the strengths in their relationship. Sam reports that he has loved Millie and that they can be civil to each other and talk 'as though they have been friends forever' when exchanging children, despite their separation. However, the build up to meetings creates tension between them causing suspicion and arguments.

Discussion

The majority of participants did not experience CSC as a restorative or caring service because the focus on risks they presented to their children due to DVA, negated participants' needs and lived reality. While DVA was the primary factor identified for CSC involvement, participants' accounts revealed a wide range of challenging social

and economic circumstances. The presence of these challenges in the lives of families that have contact with CSC are recognised as increasing vulnerability to CP interventions (Featherstone et al., 2014; Parton, 2014; Hood et al., 2021). Although there is not a direct causal link between inequality, child abuse or neglect, and adult DVA, factors associated with inequality increased the likelihood of DVA (Sokoloff and Dupont, 2005; Fahmy et al., 2016) and intervention from CSC (Bywaters et al., 2018). Yet CSC encounters were singularly focused on the risks presented by DVA.

Participants' experiences of DVA in the context of difficult relational histories in early life strongly suggests an association between childhood adversity and adult contact with CSC, shaped by intersecting social, economic and material factors. This affirms previous research with families living in deprived areas being more likely to have contact with CSC (Bywaters et al., 2018) and the link between childhood experiences of abuse, inequality and contact with CSC and DVA in adulthood (Broadhurst and Mason, 2020; Philip et al., 2020).

Duration of CSC involvement

The enduring nature of CSC involvement in families' lives is a significant finding, which has not been identified to the same extent in past studies on parental experiences of social work contact (Dale, 2004; Dumbrill, 2006; Ghaffar et al., 2012; Featherstone and Fraser, 2012a). Ten out of fifteen participants reported long standing involvement with CSC, fluctuating through their life course. Seven of the ten accounts reported at least two generations of CSC contact with interconnected difficulties relating to DVA, mental ill health, abuse, neglect, economic hardship and substance use. This is important because it situates the relationship between families and CSC over periods of up to fifty years for three families and at least thirty years for four other families. Thus, family histories are interwoven with CSC intervention and are a significant part of stories and practices for both families and CSC. While this was acknowledged in family accounts, this intergenerational involvement was rarely acknowledged in professional accounts in this study.

Studies on parental engagement with CSC often frame parental non-engagement as 'resistant,' 'difficult' or 'defensive' parents and/or families (Shemmings et al., 2012; Trotter, 2015) with non-engagement linked to early care-giver relationships,

development histories and adversity (Trevithick, 2011; Mason et al., 2020). While it is important to be curious about defensive behaviour, what is missing from this literature is an acknowledgement of how the impact of histories of CSC intervention into family life contribute to ongoing experiences of trauma and influence relationships with social workers and CSC more broadly.

Relationships with social workers – contradictions and tensions

There were mixed experiences of contact with social workers with many participants comparing 'good ones' with 'bad ones.' Consistent with Smithson and Gibson (2017) and Morris et al., (2018), families valued professionals that treated them humanely, showed genuine care, kindness and warmth, had a sense of humour, were punctual and provided practical help and access to other resources. Communication that was honest, respectful and empathetic was also valued. Positive experiences of contact with social workers were often attributed to individual characteristics rather than CSC overall as an organisation.

Fathers, in particular, reported social workers not taking the time to get to know them, not acknowledging their histories of abuse and neglect, and trying not to meet them alone and that this treatment was different to that for mothers. Mothers reported that previous histories of trauma and abuse were used to judge them and used as justification for increased scrutiny. Overall, parents felt that CSC saw them as deficit parents where there was DVA, did not acknowledge their strengths or consider wider causes of relationship conflict.

Poor experiences of social work contact were consistent with other studies where there was DVA and CSC involvement (Hughes et al., 2011; Philips et al., 2019; Stewart, 2019; Keeling and van Wormer, 2012) and linked to encounters that were shaming, judgemental and minimised family difficulties. Findings in this study highlight parental frustration with all difficulties being reduced to DVA and professionals ignoring the wider context of their lives. Where individual social workers may have acknowledged wider difficulties, the organisational focus on children's safety compounded feelings that CSC were not there to help them but focus on their deficits and change them. Furthermore, participants reported that there was a lack of time and

support to make changes that were needed (Hughes et al., 2016; Philips et al., 2019) that contributed to feelings of being ‘set up to fail’ by CSC.

The finding that the majority of mothers felt judged, responsible for the care of children and blamed for DVA is not new (Lapierre, 2008; Perel and Gil, 2011; Stewart, 2019). What is new, is that in a local authority aspiring to work restoratively with families where there is DVA, most mothers in this study continued to feel they alone carried the responsibility for the care of their children. This was particularly highlighted in accounts where women were living with or still had contact with partners that were abusive.

Mothers were more positive about social work encounters long after they had separated and were no longer in relationships where DVA featured. The accounts of Ashley, Becky, Faye and Kay illustrated a lack of support and understanding of the ‘terror’ of their DVA situations at the time, and they experienced social work interventions as punitive, all having had children removed from their care. However, following separation, therapeutic support from allied agencies for some, new relationships and subsequent pregnancies, all reported some positive encounters with CSC. This was in part due to their own journey of recovery from DVA and child separation, but also their determination to ‘keep’ their new baby and ‘get ahead of the game’ by pre-empting CSC ‘tick boxes’. All four women actively did this by informing health and social care services they were pregnant, complying with pre-birth assessments (even when they deemed this unnecessary because they were no longer in abusive relationships), attending all meetings, enrolling in parenting courses, preparing their homes and buying appropriate baby equipment. While mothers did not welcome the ongoing scrutiny into their lives, they were resigned to it and complied. As Kay reported, ‘I’ve been in the system all my life. I knew the only way what I could keep my baby was to do what they said before they said it.’

This study also heard about the lives of fathers that were not interviewed but featured in women’s accounts – current and ex-partners with past or current DVA in their relationship. While this was not a homogenous group of men, in line with previous research women’s accounts asserted that there was both a lack of engagement by CSC with resident and non-resident fathers (Scourfield, 2006; Gilligan et al., 2012; Laird et al., 2017) and avoidance of engagement by fathers themselves (Featherstone

and Fraser, 2012b) that led to a failure to hold men accountable for their abusive behaviour. Furthermore, fathers that were interviewed reported that their social worker had strongly suggested that they separate from their partner. Following separation there was limited contact with them by CSC, which again placed a greater burden of care on mothers and lack of support for fathers.

Fathers also reported that they were not being helped in the ways that they needed. This finding extended beyond current contact to previous contact with CSC, particularly for Charlie, Jake and Jon who all narrated traumatic childhood experiences of abuse and neglect and CSC involvement. Charlie was placed in out-of-home care, and Jake and Jon could not comprehend why they had not been. They perceived that 'everyone had given up' on them and expressed a sense of hopelessness for their current and imagined selves including regret about who they were, what they had wanted to be, and how the cumulative impact of abuse, lack of educational achievement, substance use, involvement in crime and mental health difficulties was limiting their lives at the ages of 22, 23 and 27 years, respectively.

These findings confirm previous research with fathers, where there was limited contact with men that were viewed as a threat to women and children (Baynes and Holland, 2012; Brandon et al., 2019; Critchley, 2021) and were treated with suspicion even where they had responsibility for the care of children (Baynes and Holland, 2012; Critchley, 2021), and a lack of consideration of their experiences of trauma (Philip et al., 2019).

The majority of participants recounted difficult relationship histories and wanted to have their previous experience of victimisation recognised by social workers. While relationship-based practice can contain emotions of anxiety, anger or distress (Turney, 2012), participants felt that these emotions could not be expressed in the restrictive emotional regime for fear of these emotions later being used against them (Quick and Scott, 2019). This finding calls for compassionate, emotionally competent and trauma-informed practice.

Barriers to building trusting relationships with CSC

In line with previous research, fear of CSC involvement limited participants' disclosure of DVA (Hughes, Chau and Vokri, 2011) and so compounded the potential for further

DVA and unsafety. Jess's account highlighted both fear and reassurance of CSC involvement. Having CSC involvement was identified as helpful by Jess because she felt that this kept her partner 'in check'. However, her fear of the potential for CSC to remove her children may have prevented her from disclosing DVA experiences earlier. In this way, the fear of CSC compounded risks for families rather than alleviating them.

In contrast, the threat of being separated from children prompted disclosure of the extent of DVA for some mothers, yet often only when the situation had escalated. A few women identified that the threat of having their children removed from their care had helped them to leave their abusive relationship. While this placed additional pressure on women, it helped some 'make a choice' (Faye) and was reported 'as the best thing' (Kay) because some had 'stopped feeling anything' (Ashley).

A social worker's age and gender was identified as a barrier to trusting professionals particularly by fathers in this study, but not exclusively. Some participants stated experienced workers, rather than 'young women', helped them to feel more confident about talking about their difficulties. Younger social workers were described as being 'out of their depth' (Sam) and 'not having enough experience of life' (Rodger) to help. This prevented some parents from engaging with workers. Experienced 'knowledgeable professionals not new fledglings'(Sam) helped parents to build trust in workers. Furthermore, some men preferred to have a male social worker and felt that they were potentially less likely to have assumptions made about them as 'bad men'. In this way, parental-social worker relationships reflected wider workings of unequal power relationships that were sustained through CSC.

Emotional regimes

The relevance of emotion in social work is well established (Morrison, 1997; Howe, 2008; Ruch et al., 2010; Warner, 2015) where social workers are exposed to the suffering of those that they work with (Turney, 2012; Cook, 2020). In these intensely emotional encounters, where social care processes can stigmatise parents in their own eyes and others' (Reich, 2005; Frost, 2021), the welfare of children is scrutinised and parents recounted trying to regulate affect and show compliance to deter shaming scrutiny (Dumbril, 2006; Quick and Scott, 2019).

Emotion is a discursive expression of feeling that is socially, historically, politically and culturally constructed (Reddy, 2001; Lupton, 2013). The process of affect becoming emotion and the boundaries of what is socially acceptable or unacceptable expression is dependent on context. Affect cannot be contained discursively because it is embodied, complex, conflicting and ambiguous too (Quick and Scott, 2019). Thus emotions in social work are constructed through practice encounters that are influenced by the wider moral, social and political context. Yet, consistent with Reich (2005) and Quick and Scott (2019), participants in this study report a lack of engagement by social workers with them as emotional beings, beyond focusing on their 'defensive' behaviours and communication.

Some participants reported not being able to tell their social worker how they felt. There were reports of needing to 'control' or 'hide' emotional expression from social workers, in particular feelings of anger and frustration, to limit judgemental encounters. Participants were managing how professionals perceived them (Dumbril, 2006). This was difficult in highly charged emotional and shaming encounters (Frost, 2021). There is a parallel between the practice encounters described and the DVA experience of mothers who report hiding their feelings from their abusive partner to limit conflict and DVA (Perel and Gil, 2011; Coy and Kelly, 2019). Additionally, men also recounted avoiding professionals so they did not have to confront their difficult feelings (Featherstone, Rivett and Scourfield, 2007) and be perceived negatively. Anxiety was expressed that showing emotion would incur punitive practice and require changes to self and others, without necessarily wanting to or having the support to do so.

Tension arose between narratives of pain and suffering and the reported inability of workers to be curious or respond appropriately. This lack of empathy confirms a restrictive emotional regime (Quick and Scott, 2019) where anxiety and complexity in social work are defended against through prescriptive managerialist processes (Munro, 2011). Participants noted their awareness of this restrictive regime through their experiences of 'not being seen as a person', a situation which led some to conceal emotions and limit social work encounters using a range of strategies that included avoidance, silence and choosing when and how to engage.

Defensive practice cultures in CP social work are accepted as a way to advance managerialist cultures (Munro, 2011; Lees et al., 2013) yet also maintains reductionist

explanations of family difficulties. As Cooper and Lees (2015) argue, the purpose of defences in social work organisations are 'to successfully disguise or obscure the threats, feeling states or fantasies to which they are then attempted to solution' (ibid, p.255). In this way, a rational, technocratic system attempts to defend against the very emotions and circumstances that participants wanted help with; thus creating practice encounters where genuine support and help are increasingly impossible.

Contesting family practices

Smart's (2007) concept of personal life builds on Morgan's (1996; 2011) family practices to offer a broader interconnected approach to thinking about 'the family'. Smart's (2007) approach accounts for the overlapping categories of biography, memory, imaginary, relationality and embeddedness, and contrasts with the theory of individualization (Giddens, 1992; Beck and Beck-Gernsheim 2002) asserting the significance of family relationships and histories rather than their decline. Smart's (2007) perspective stresses the need to see people in their 'web of relationships' because 'familial roots which locate a person emotionally, genetically and culturally are essential for ontological security and a sense of self' (Smart, 2007, p.81). Thus, it is important to keep 'the process of relating in focus, just as much as, if not more than, the individual or the self' (Mason, 2004, p.167). This was particularly relevant for understanding the trajectory of some participants' lives in this study, where every day social work encounters were impacted by family practices and previous CSC involvement, including family experiences of out-of-family care, the lived reality of families having recurrent separations of children into adoption, kinship care, foster care, but also, as Jake and Jon's accounts describe histories of a lack of care and protection from CSC.

Some participants' experiences can also be understood as 'contested family practices' (Fosberg, 2013). These are institutional practices that are 'special, difficult, considered to be ethically charged and conflict ridden for one reason or another, and for which there exist no clear-cut answers in advance' (Fosberg, 2013, 305). In this study, examples of contested family practices include families being required to separate, have restricted or supervised contact between each other or attend courses or parenting classes. Some of these actions are court mandated and social workers are responsible for monitoring and assessing parental modification of their family life. Thus, CSC make changes, contest and influence the way in which families do family.

For example, participant accounts of continuing relationships in the context of DVA where CSC had stipulated against this (Kim, Jake, Rhianna) is a contested family practice, yet there was little consideration by CSC of participants' desire for this as a 'normal' family practice for them. Further exploration of the boundaries of what are 'normal', exceptional and contested family practices, and the points of difference between family members, families and CSC, would support a greater understanding of how families perform family under the professional gaze.

Relationality is 'too risky'

Returning to the reality that the diversity of family relationships within which people are embedded cannot be assumed to be an 'a priori good thing' (Smart, 2007, p.137) and family accounts of DVA and childhood abuse illustrate this. A difficulty in remaining and leaving relationships caused harm, because participants were embedded through love and fear, children, hope for imagined future relationships and interdependencies of material resources, substance use and mental ill health. The majority of participants continued to have contact with their own families, despite childhood histories of abuse and neglect and family rupture. These difficulties were part of their experience of family life, how family was 'done'. Some participants stressed their need for ongoing connections, despite the context of family violence, abuse and adult DVA, as they found maintaining connections supported their sense of family.

Yet participant accounts report a failure of CSC to engage with the individual needs of their family, relying instead on the institutionalised gendered binary model in DVA (Ali et al., 2016) where men are seen as either risky or resourceful (Featherstone, 2013) and women as both made responsible for protecting children and perceived as `failing to protect (Lapierre, 2008; Wendt et al., 2015. Where couples wanted to stay together or maintain contact, participants recounted how there was a focus on risk to children, rather than working with them as a couple and supporting wider difficulties that caused stress. Yet even when specifically requesting this support as, for example, Jake, Kim and Rhianna did, there was a reluctance to see couples together because 'it was too risky'. The lack of support for couples who want to stay together has also been highlighted by other researchers (Stanley and Humphreys, 2017; Philip et al., 2020), confirming a default risk-focused position rather than a restorative approach in practice. This also confirms a lack of practitioner confidence and CSC more widely to

work relationally with couples and DVA (Sen et al., 2018; Olszowy et al., 2020) and provide the emotional support and help that is needed. .

Conclusion

This chapter has reported on the narratives of mothers and fathers in situations of DVA and contact with CSC. The chapter has shown that for the majority of the participants in this study, the intended restorative approach of working collaboratively, 'doing with', was not consistently evident. In fact, narratives suggest a greater experience of 'doing to' or 'not doing' that corresponds with authoritarian and neglectful practice. Participant narratives showed that CSC involvement across generations is significant to the ways in which 'the past is in the present' (Smart, 2007) and how participants perceived CSC intervention in their lives.

Due to the length of involvement in families' lives, positive experiences of social work practice were often limited in the midst of many changes of social worker and CSC involvement over the life course. Practitioner curiosity about how family practices are shaped by this history can provide greater understanding of parental-professional relationships and support more humane practice. Professional focus on DVA as a singular issue that impacts families currently ignores the complexity of participants' lived experiences, and also how DVA intersects with parental identities and adversity in everyday lives. Acknowledging family economic and social context is important to understand the constraints that shape family practices and how adversity and inequality can impact family capacity to 'do' family in the way that they want or indeed are required to by CSC contact.

Parents experienced CSC as a defensive organisation with a restrictive emotional regime that did not help in the way that they wanted. The prioritisation of child safety and welfare over the needs of parents and welfare of the whole family prolonged family struggles and contributed to parents feeling stigmatised by CSC. Participants' feelings and experiences were not addressed appropriately in social work encounters, and this is a challenge for relationship-based and restorative approaches. In the next chapter I will consider practitioner perspectives of working with families affected by DVA and child welfare concerns.

Chapter 6: Practitioner narratives on practice with families where there is DVA and child protection concerns.

> *More complex problems carry with them elements of ambiguity and uncertainty both with respect to their causes and potential solutions* (Khoo et al., 2020, p. 2102).

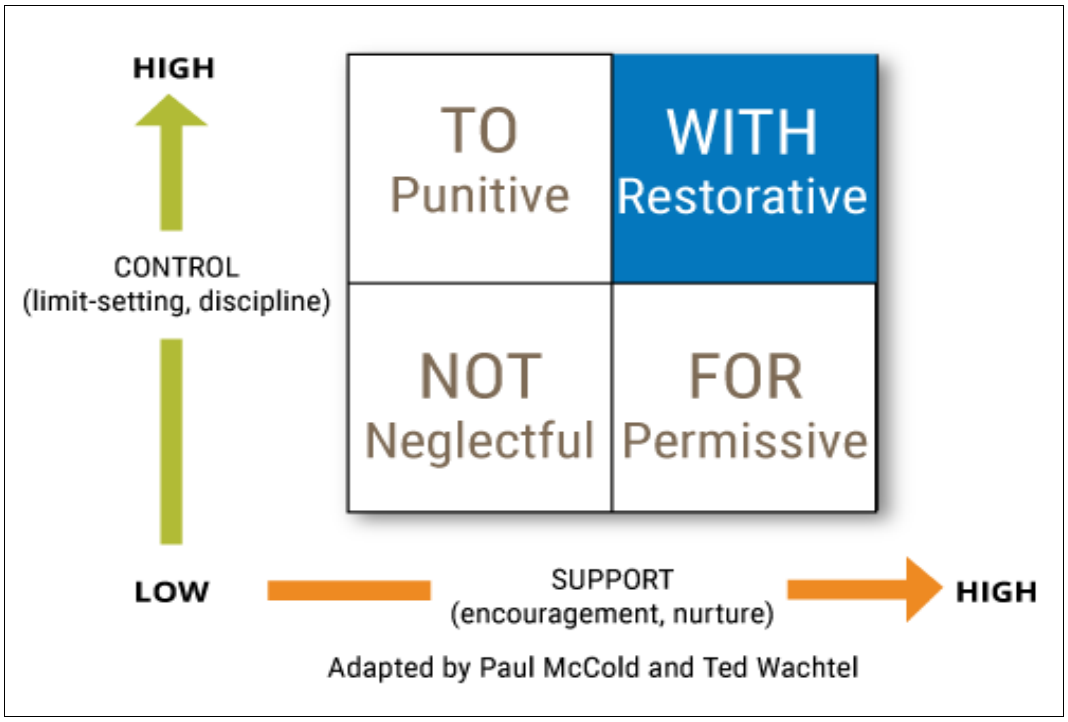
Introduction

This chapter focuses on practitioner perspectives of work with families and responds to the third research question: ***What are the opportunities and limitations of* RP *to support family resolution in the context of DVA*?** This is the final findings chapter and is structured in two parts. The first part will focus on the context of practice with families with a focus on complexity and how this is managed by practitioners through practice encounters. The second part of the chapter is focused on RP and explores how RP is performed in everyday practice, with a particular focus on family group conferencing (FGC) where there is DVA.

A longstanding critique of CP social work is that it fails to meet the diverse needs of families where there is DVA (Humphreys and Absler, 2011). Mothers have been the focus of intervention and made responsible for protecting their children and separation enforced, often regardless of abuse the mothers continue to suffer (Humphreys and Absler, 2011; Alaggia et al., 2015). Fathers that are abusive have traditionally been excluded from social work practice and framed through a binary risk/resource lens (Scourfield, 2006; Brown et al., 2009), contributing to further surveillance of mothers (Featherstone and Peckover, 2007). Assessing risk in situations of DVA has been the driving CSC service intervention, while contributory adverse structural factors that challenge families are not routinely considered in practice (Fahmy et al., 2016; Ferguson et al., 2020). As such, family difficulties are atomized and individual members become recipients of contradictory service responses.

It is against this backdrop that Northford reimagined a new approach to working with families living with DVA, through whole system change programme backed by considerable investment from the DfE (2014) Social Care Innovation Programme (Mason et al., 2017). This was an ambitious programme to embed RP across

Northford's CSC and included the expansion of the FGC service to families experiencing DVA. There was also the establishment of a Daily Domestic Violence Meeting (DDVM) to replace the Multi-Agency Risk Assessment Conference (MARAC) in a bid for a timelier multiagency response to high risk DVA cases and the establishment of a new Duty and Assessment Team that would be located in multiagency setting (the front door safeguarding hub) (Mason et al., 2017). These developments were supported through workforce development predicated on RP and the social discipline window (Wachtel and McCold, 2001) (see below) utilising the concept of high support/ high challenge (HSHC) behaviours to drive innovation and championing a `doing with, not to' model of practice.



The Social Discipline Window

Practitioner participants

One-to-one semi-structured interviews were conducted with six practitioners:
(3 FGCC, 3 SW practitioners of which one was a Caring Dads' team practitioner). In addition, there were two focus group interviews: The first at the start of the fieldwork and the second, six months later towards the end of fieldwork. Ten practitioners were involved in the focus group interviews (five FGCC and 5 SW).The same practitioners were involved in both focus groups.

All practitioners had undertaken training on the use of restorative approaches with DVA in practice, within the last year. One social work team had received additional DVA training as part of a pilot project (due to be rolled out across the city) with a specific focus on the barriers and challenges for practice change in this area. A practitioner from this team was interviewed individually and was also part of the focus groups.

Part One. Practitioner constructions of family life

To situate practice with families in this chapter, it is important to consider how practitioners construct family and who the focus of concern is for CSC intervention. This section will set the context for practice discourse on work with families and consider practitioner perspectives on working with families where there is DVA and child welfare concerns.

The `family` in practice

There is recognition of the shifting definitions and understanding of the` family` in CSC practice, where 'family' is used interchangeably with 'parent' (Churchill, 2011) and practice with individual family members is referred to as work with families (Morris et al., 2015). Moreover, 'parent' and 'parenting' have meant 'mothers' rather than mothers and fathers in policy and practice (Gillies, 2005). In this study, at the point of service delivery practitioners described the `family` as important people that lived with and had responsibility for caring for the child. There were accounts that elucidated the diversity of families they worked with and how this informed their understanding of 'family' in practice. While practitioners articulated diversification in family forms, applied understandings of the family in practice were based on traditional heteronormative constructions. Yet simultaneously practitioners acknowledged that there were few 'typical' nuclear family forms that they came across. Notably, there was a focus on mothers as the key point of contact in families.

> I try and contact mum's first, especially in DVA cases. It's important to hear their story first as the victim cos that helps to give us a picture of the risks (Carol FGCC).

While it is crucial to 'hear their story' of all those involved and gather information from different family members, prioritising mothers first was routine practice at the point of

service delivery. This was more so in `DVA cases` where children and mothers were identified as victims of DVA and to support consideration of the risks to victims. It can be argued that meeting with fathers first would also provide an assessment of the safety and protection needs for all family members, yet this was not the reported practice and confirms fathers as 'secondary clients' (O'Hagan, 1997). The focus on mothers reinforced gendered occupational construction of women as primary carers in CP work (Scourfield, 2001) and more so in the context of DVA.

Practitioner constructions of family oscillated between general accounts of practice with broad networks of kin and non-kin members (as reported mostly by FGC practitioners), and accounts where the family were narrowly defined as parents and children living in one household (predominant in social work practice accounts). Accounts revealed a distinction between practice with the whole family, a separation between work with parents, mothers, fathers and work with children. This exemplified individualised practice with family members and conceptualisations of children as distinct entities from their parents (Gopfert et al., 2010), with divergent needs and identities, rather than being mutually constituted through interdependent relationships.

Different family forms were reported where broad networks consisted of new and old relationships that had been made through relationships ending, new partners, their children and extended family relations. The normative nuclear family rarely featured in generic descriptions, however, many of the practice examples shared, exemplified smaller networks, consisting of mothers, fathers and maternal grandmothers. Although families were conceptualised as diverse in practitioner narratives exemplified traditional gendered constructions of normative family forms.

Working with complexity

Complexity in CP social work practice is widely recognised because practice sits at the interface of structural inequality, complex family dynamics and needs, risk-focused organisational cultures and ever decreasing resources and austerity (Lawler and Bilson, 2009; Rogowski, 2012, 2020; Hood, 2014). Complexity and uncertainty are recognised as part of statutory CP practice (Munro, 2011; Jenkins et al., 2017) and specifically part of DVA and CP practice (Featherstone and Trinder, 1997; Devaney 2008; Hughes and Chau, 2013; Harris and Hodges, 2019). A clear definition of complexity within CP settings is lacking; however, complexity in practice with families

is most often linked to multiple needs that create complex situations challenging child safety and well-being. For instance, parental difficulties, including mental health, problematic substance use and DVA coalesce (Devaney and Spratt, 2009). More recently, research has confirmed complexity in practice at the intersection of ethnicity, poverty and child welfare intervention too (Webb et al., 2020). It is in this context that practitioners have to make sense of everyday practice with families.

The overarching theme in practitioner narratives of working with DVA and CP with families was complexity. Complexity was typified through different practice settings where family needs interacted with structural factors, organisational constraints and wider social and political discourses about `family' (Khoo et al., 2020). Data from the study evidenced that practitioners showed understanding of the structural challenges that created difficulties for the families they worked with where material, economic and social deprivation, histories of abuse and few opportunities for changing their social circumstances were reported. Practitioner narratives highlighted precarious family situations where there were imminent crises as detailed below.

> There is high stress because you're living with domestic abuse you don't know when the next incidents going to be. And you're living on tenterhooks all the time. Quite often the neighbours get involved, because they don't like the noise … they become agitated … it all escalates and rolls into one (Erin SW).

> In some families there is a constant state of the threat of domestic violence, so it's triggered by alcohol, by financial worries, by drugs. In terms of us managing, it's difficult and because it's a shifting situation, it's also difficult for families to manage (Jaswinder SW).

There were nuanced understandings of how DVA was linked to wider structural factors and created flashpoints for violence and abuse within the home and community. These situations were identified as 'difficult to manage' for both families and practitioners and speak to the complexity of responding to DVA through CSC systems.

Challenging social and economic circumstances

Practitioners recognised adverse social and economic circumstances contributed to complexity for families and practice. Economic difficulties constrained family practices and decentred DVA as the most significant issue impacting families. This was recognised by practitioners in different ways as highlighted below.

> I think a wider narrative needs to emerge about what's going on in the family. I think it's important that we do think about poverty and because you're aware and ask questions, those narratives will emerge when you go out and do your assessments … Because if that's not acknowledged, and all we talk about is domestic violence, we're overshadowing so many of the struggles that families are having (Simon FGCC).

> I think the structural issues we know are not just about Northford, it's bigger, its national, and you do put things to the back of your mind. It's good to bring it to the forefront and talk to people about the material reality of the lives. And yes, it's good to acknowledge … but you also have to deal with that you're not going to be able to change it for them individually, and you still have to be a social worker and prioritise and, in a way, look past it (Erin SW).

There was a clear link made between austerity, welfare reform (in particular Universal Credit) and the escalation of DVA for some families contributing to family stress and DVA. Repeated attempts to secure scarce resources and reinstate welfare benefit payments when they were inexplicably stopped, thwarted practitioners efforts to provide support to families. Practitioners' expressed frustration at the lack of co-operative working across different departments within the local authority particularly the housing department's inability to provide safe housing options at key points in practice; namely, when women wanted to leave relationships, or families needed larger properties to ease overcrowding. These accounts illustrated how precarity increased difficulties for families, especially for mothers, as housing and welfare challenges were often borne by women (Porter, 2019) highlighting the gendered and classed nature of welfare austerity.

The consequences of austerity reverberated through practitioner accounts of working with families and DVA, providing nuanced understandings of family lived experience. The lack of provision to adequately respond to family needs created difficult working environments and ethical dilemmas as practitioners could not always provide the help that they recognised was needed in response to families' social and economic circumstances. Not being able to meet needs for safe housing, material and financial resources also undermined practitioner confidence and acceptance of work with families as being `good enough' (Saltiel, 2013).

> It's like a dot-to-dot drawing, you know where the dots are, you can see what the drawing is meant to be, but you can't always join the dots together. You do what you can because that's better than doing nothing (Kate SW).

Families social and economic circumstances were sometimes constructed as background issues in order to manage complexity within the day-to-day 'doing' of social work. This involved a separating out of what was manageable and what some considered the 'main job'; to secure children's safety and protection. In this way, structural inequality, despite being a significant root cause of family difficulties (Fahmy et al., 2016), was disconnected from practice which perpetuated an individualised focus on family members.

DVA is a complex problem

There was awareness amongst practitioners in the study that DVA was not a singular problem for families or for their practice with families. While referrals to CSC alerted DVA and child welfare concerns, other difficulties that might contribute to family lives were most often not included in professional referrals. Practitioner accounts exemplified how concurring individual difficulties coalesced to create complexity especially where individual and family needs were long standing and often exacerbated by newer challenges as illustrated in Simon (FGCC) and Jaswinder's (SW) accounts below.

> In just one household you can have many layers of difficulties. I'm working with a family where the circumstances are so complex. You have a young man pending prosecution, Mum's a care leaver has lots

> of support, but Dad has had childhood difficulties and his siblings had all been taken into care part from him, so he experienced most of the trauma that they had but without the support as a young adult. There's financial difficulties, drugs, alcohol, another child of Dad's that he has no contact with lots of complex relationships. There's housing issues too and all this has emerged from one conversation with a young man of twenty-three (Simon FGCC).

> I'm working with a family where there is DVA but also substance misuse and I'm trying to get the mother to accept that she needs to go into rehab. The two are linked. Her needs are really complex and then she has a disabled child and dad has mental health difficulties. I am one worker; I could spend all my time on that family (Jaswinder SW).

There are 'many layers of difficulties' that bring complexity to practice from the range of differing individual needs in any one family, mediate through structural inequalities, impacting both intra-familial relationships and relationships with practitioners. Complexity recounted here is helped by An intersectional framing (Sokoloff and Dupont, 2005; Nixon and Humphreys, 2010, Ferguson et al., 2020) helps to consider complexity recounted here where identifiers such as `race`, class, (dis)ability and sexuality further exacerbate experiences of inequality. This framing challenges the reductionist dominant DVA story (Loeske, 2001) that CSC service provision has traditionally responded to in practice: with fixed binaries of victim/perpetrator and where experiences of DVA are abstracted from the structural conditions of people's lives. Thus, the categorisation of DVA as a singular problem, as a 'DVA case', belies the complexity of lived experience and practice. Organisational attempts to distil DVA into a single issue or case, which was then assigned to practitioners, gave the impression that the problem is both manageable and being addressed (Bacchi, 1999; Ferguson et al., 2020). There were a lack of service responses to this complexity in practice. The next section will focus on separation as a service response to complexity before moving on to focus on how practitioners sought to manage complexity in practice.

Separation as a routine response

Without appropriate alternative ways to achieve safety in families, separation has been a routinised statutory response to managing DVA risk, primarily to children, by enforcing the separation of the couple, often regardless of parental circumstances. Separation as a CP response to DVA has been critiqued due to the punitive scrutiny on mothers that are living with abuse and for not taking into account that some partners may want to stay together (Stanley and Humphreys, 2017) and seek different solutions for their difficulties.

Practitioner narratives confirmed the continued use of separation, along with written agreements to reinforce this as a service response to DVA in Northford.

> Some workers still use working agreements because they don't have enough tools to work with families in a different way. It's a stick for professional purposes (Kate SW).

Written agreements are written expectations where parents are asked to agree to behaviours and actions that are considered necessary by CSC to protect children's safety. In DVA cases, this has often required couples to separate and places unrealistic burdens on women to protect themselves and their children while suffering DVA. Moreover, these agreements do not address an abusive partner's behaviour and serious case reviews continue to note that written agreements have proven to have 'no value in keeping children safe but only give false assurances' (NSPCC, 2019, p. 29).

Furthermore, written agreements were identified as state 'proof' of holding families to account in court proceedings with parents, so that breeches in agreements could be more clearly evidenced. This pressure reportedly came from the wider professional network too, as detailed below.

> When we go to court, we know it's not worth the paper it's written on, we`re grilled by the solicitor who says did you write it down, was it agreed? So, then you've been pulled in a way and being pulled in a

> different way. There's other factors at play and then we are forced to put on families too in a way (Jaswinder SW).

Jaswinder shares the dilemmas of working in a culture where she is 'forced to put on families' that are struggling with DVA, aware that it perpetuates a blame culture (Leigh, 2017). Furthermore, such an approach was known to overburden mothers and threaten families with potential child removal if they did not adhere to agreements. This practice was recognised as deterring families from accessing alternative ways of resolving difficulties through FGCs.

> Yeah, social workers still use written agreements. Often because they [CSC] need to enforce something. Sometimes an FGC is offered after the social worker has assessed the family, if family don't want to take it up because the social worker has already put a working agreement in place and they may not have kept to it, so family don't trust being given an opportunity to make their own plans (Mo FGCC).

Written agreements signify a reductionist approach and an organisational attempt to control, complex and uncertain DVA situations by imposing organisational frames for risk management. Even though there was a reported marked decrease in their use, practitioners were aware of their continued use and negative impact on building working relationships and undermined family engagement. Ironically, those in need of support were least likely to be helped in alternative ways due to default punitive DVA service responses. Enforcing separation through working agreements was reported as negatively impacting family take up of the alternative RP approaches that Northford was championing, particularly family group conferences. This created contradictions in practice for practitioners and families, limiting the potential for finding family resolution.

Making sense of complexity

This section will focus on how practitioners manage tensions arising from complexity in practice. Concurring needs in families created complexity and uncertainty in practice that was difficult to manage at times. Managerialist cultures, workload pressures and scarce resources prevented practitioners responding in the way that they would like

(Munro, 2011). This led to shortcuts in practice and attempts to make the unmanageable manageable, by sorting and prioritising needs (Gümüscü et al., 2020).

> The system, legislation, risk focus is to address the incident and DVA and try and work with the other issues, but there isn't the time always and so you prioritise the DVA and even then, it's the risks to children you're really focusing on (Sue SW).

> It's not right, but its simpler to do the things you have to do. Bottom line is children. You have to do what is safest for the children (Kate SW).

These quotes reflected the views of many practitioners reporting how they managed complexity in practice with families by narrowing the focus on risks posed to children. Doing this aligned with the legislative and organisational focus to bring a 'simpler', more manageable focus to multidimensional problems and was legitimised by restating 'the child's needs are paramount'. This also led to tension in practice, separating the child's needs from the family, with professional culture perpetuating a child-risk focus (Humphreys, 2007). This was recognised as problematic and led to some querying the 'fit' between DVA and CP.

> I don't think we're best placed to do that work. We'll do an assessment, we get told certain things and if we don't really think it's happening, if things seem ok, it's hard to keep the case open and we close it, and it comes in again, and there could be lots of assessments and then we think, there's been six assessments we better go to child protection. I don't think we're best placed to deal with DVA (Erin SW).

Here, routinised approaches are described and contribute to the stop-start response to DVA (Stanley et al., 2010). This staccato approach does not foster trust for building relationships, to support families or for families to confide difficulties with practitioners (Stanley et al., 2010). These practice responses were recognised as inadequate and having significant implications for the safety and protection needs of family members and for the management of risk in families.

Additionally, there were nuanced reflections about the challenges of working with families and DVA, and the need to build trust as a profession to alleviate families' fears of CP processes that result in children being removed from their care.

> I think DV is about relationships and patterns of relationships, and we're not best placed to do the work, I think that we go in and it would be better if there was family support work, where you build relationships and can chip away at it […] I think for social workers, we must respond to injury or chronic neglect, violence, we need to respond. I think where there's DV and CP its right we're involved, but I don't think the statutory going in is helping because how do you separate the DV and CP issues? I think a lot of the work is helping families to regulate and manage life and I don't think we are the right people to do that. We have a statutory role and the building relationships, we can do some of that, but people are scared because they think we're going to take their children away (Freya SW).

There is recognition in Freya's account about the need for relational practice but this is made distinct from the statutory social worker role. Working relationally over a period of time with families is identified as incompatible with ensuring children's safety, giving rise to contradictions in CP practice in situations of DVA. Humphreys and Absler (2001) have identified these tensions and also called for the development and resourcing of service pathways that provide relationally focused ways to build trust and manage risks more effectively, as Northford were attempting, through the expansion of FGCs and workforce development on RP. Yet, these tensions remain in every day social work practice with families.

Where complexity in CP was identified practice was concerned with the immediate presenting risks for children as other problems may be seen as background issues and also not so easily resolved (Devaney and Spratt, 2009). In this study, practitioners sought to manage complexity by prioritising risk. All practitioners agreed that the initial focus of their work was to address risk and safety issues, trying to ascertain what needed immediate attention. This was often the prioritisation of risks to children, as narrated by one practitioner below.

> It can be very overwhelming, and we've got more and more families having lots of different problems that have different professionals involved. I have to keep my focus on the child and work with the professional network to try and ensure that the child is safe (Freya SW).

While all considered child safety to be apriority, there was a different emphasis from FGCC's where meeting with the family and gaining an understanding of the perceptions of all family members was prioritised. There were attempts to speak to as wide a family network as possible in preparation for the FGC meetings. In contrast, social work practitioner accounts illustrated how they prioritised what problems to focus on, resources available and their professional judgement which involved a process of prioritising what was manageable based on the immediate concern for children's welfare. Tensions between a child-focus and wider family focus in practice were exemplified in focus group discussions as illustrated in the short extract below.

> Sue (SW) The children are the most vulnerable in that situation and focusing on them steers my work, obviously that means helping parents but that can be very difficult.
>
> Jo (FGCC) Yes, but if you only focus on the child … what about the parents? The parents need help so they can help the child better. (FGC)

Individualising family troubles pitted children's safety and welfare against their parent's needs, where decisions based on 'the best interests of the child' trumped 'what about the parents?' Practitioner narratives revealed differing perceptions of competing needs and vulnerabilities between children and parents rather than whole family considerations of safety and protection. These were familiar themes across practitioners and not exclusively separated between social work and FGC practitioners. This will be explored further in part two of this chapter in the section on family group conference practice.

Complexity in CP practice has been described as a 'wicked' problem (Devaney and Spratt, 2009) and characterised by uncertainty, where both the cause and solution are

indeterminate. While practitioners recognised the multidimensional nature of complexity, in everyday practice, the focus on determining risks posed to children, rather than the safety and protection needs of all the family provided clarity in practice for some. Practitioners compartmentalised work with families, prioritising the problem(s), or risks, which were easiest to address within the organisational culture. This created a practice context that made problems more manageable (Ferguson et al., 2020; Gümüscü et al, 2020). Focusing on risk and specifically child safety and welfare provided a 'clearer' singular focus to practice, despite this siloed approach to DVA long being critiqued (Hester, 2011; Humphreys and Absler, 2011).

In summary, scare resources and a lack of service responses to support families encouraged a reliance on the default separation response to DVA. Austerity, lack of broader provision and resources to support family needs and the use of working agreements also narrowed possibilities for family resolution and contributed to the prioritisation of immediate concerns in CP by managing DVA by focusing on 'what is possible' and 'keeps children safe' in the situation. The complexity of concurrent and competing individual family needs was recounted as overwhelming at times because practitioners lacked time, training, support, and resources to respond in the way that they would have liked. This reinforced an individualised focus on family members as a way of managing complexity. I turn next to practitioner constructions of working with mothers where there is DVA and CP concerns. This is followed by consideration of failure to protect discourse in Northford.

'Being pulled' - work with mothers

Practitioner understandings of women's experiences of DVA and CP intervention were not always made explicit. However, there was generalised acknowledgement of women's circumstances, different relational pressures on mothers and how social work intervention increased pressures.

> There's something about trying to make it work. I mean that they're trying to make it work for social workers, trying to make it work for the kids, trying to make it work for the person being abusive. I think it's a constant being pulled and tugged and not really knowing what to do

> for the best, hoping it will go away and it doesn't, but they're stuck in that cycle of managing that every day (Kate SW).

Mothering in the context of DVA was understood by practitioners as `being pulled and tugged' due to relational expectations and responsibilities as mothers and also being the focus of service scrutiny, often from different agencies. This was recognised critically and uncritically through social worker accounts. There was also recognition that women were 'pulled' within the worker-mother relationship, and how this could impact the helping relationship, creating tension and contradictions, as illustrated below.

> I think there's pressure to minimise what's happening to us, cos they'll see us and say why have you got a problem with it because I don't have a problem with it (Kate SW).

> Some mums see us as confidants and tell us things but then feel uncomfortable because they might have overshared, and they want to go back on what they told us because they might have changed their mind, or the situation has changed, and they make a different decision. I think they want to tell us but not sure about telling us things (Erin SW).

There has been criticism of social work practice for not understanding the difficulties that mothers face in DVA and CP situations (Keeling and van Wormer, 2012), however, these accounts illustrate practitioner knowledge of the challenges and contradictions that mothers face trying to mediate help from CSC. This is in contrast with Lapierre's (2008) findings and demonstrates practitioner understanding in Northford of the intra-familial and interpersonal difficulties women faced.

While there was acknowledgement by some practitioners that CP practice was mother focused, others stressed that this needed to be the case as mothers were seen as the legitimate first point of contact, as demonstrated below.

> We work with mothers because they're the ones around, and we have to have a parent that's responsible for the children to work with (Freya SW).

This practice was so embedded that there was limited problematisation of this in some accounts. Mothers were seen as a means to an end: the end being a child-focused risk assessment and safety planning and resonates with Gordon (1989), confirming how social work practitioners often mapped `the problem' onto the parent that was present and influenceable. This makes women the focus of service scrutiny, while fathers that cause harm are not engaged with in the same way and their role is under problematised.

Failure to protect discourse

Mother-blaming in situations of DVA has been a longstanding phenomenon in CP services (Gordan, 1988; Scourfield and Coffey, 2002; Humphreys and Absler, 2011) with gendered discourse and practice manifesting in failure to protect discourse. Failure to protect (FTP) is grounded in the moral assertion that mothers are responsible for the protection of their children from avoidable harm and those that fail to do this are responsible for the resulting harm or risk to their children (Azzopardi, 2022). In situations of DVA, blame is attributed to mothers that 'fail to protect' their children by choosing to remain in an abusive relationship (Stanley and Humphreys, 2017). Implicit in FTP discourse are gendered assumptions about 'good' mothering, and expectations that women perform idealised constructions of mothering, even when they are experiencing DVA. Failure to meet idealised expectation feeds judgements of FTP that generate shame towards mothers (Frost, 2021) that are already marginalised, legitimising labelling at a state, social group and individual level.

The majority of practitioners confirmed that FTP thinking was systemic and difficult to challenge in situations of DVA, where the focus was often on immediate concerns for the safety and welfare of children. Case notes and referrals were reported to contain FTP language and embedded in work with families in CSC and allied agencies. While recognised as punitive this was also justified by practitioners as exemplified in the following extract from a focus group discussion

Jo (FGCC) I think the language of FTP doesn't necessarily come from a bad place I think it's people that are genuinely trying to help. Although it is punishing language especially when you are the mum hearing it. It's hard because you're trying to balance and support people to change and make them understand, and I'm not sure as practitioners that we have the skills yet that we need to do that in a way that isn't black-and-white. It's more complex than that and I think we're trained in a black-and-white way. This is wrong, this is right, he's a perpetrator, she's a victim. We're trained to do that. I don't think professionals always mean to degrade women when they say that.

Erin (SW) I agree with that but then I've also been in a number of situations where you are in care proceedings and you try and do everything you can for a victim that is in a domestic violence relationship and it does become that you have to prioritise the safety of the children and you're not able to do it. I wouldn't use that language but you do have to prioritise the children sometimes and for the best will in the world you want either parent to be able to do that but then they haven't then you have to act, and you have to say some things about parents not being able to prioritise the kids knowing that they are a victim, but you're still having to do that. And it's not sat comfortably with me. That's in situations where couples have decided to carry on with their relationship and you know there is domestic violence.

There are contradictions in these accounts with FTP discourse constructed as both 'punitive' and 'necessary'. While there is acknowledgement that mothers living with DVA will struggle to protect their children from the same partner that is abusing them, FTP discourse belies the complexity of mothering in situations of DVA by suggesting that there are clear-cut `good` and `bad` choices that can be made (Coy and Kelly, 2019) and FTP discourse is justified to 'make' (coerce) mothers make 'good choices'. Hence, while acknowledging that situations were more complex than the language of FTP suggests, rather than engage with the complexity of mothering in these contexts, a mother blaming discourse was often adopted to make practice more manageable.

This confirmed once more, for the need for more nuanced approaches that aligned with the lived experiences of family lives, rather than individualised stigmatising constructions of lived experience. I turn next to practitioner experiences of working with fathers.

`I try and work with dads`

Extant literature on social work practice with men in CP settings has consistently identified gendered constructions of men as 'risk' or 'resource' (Scourfield, 2001; Featherstone and Fraser, 2012b; Laird et al., 2017), where men have not routinely been contacted or engaged with in CP interventions (Featherstone and Fraser 2012b; Nygren et al., 2019). Furthermore, low levels of social work engagement have been reported with fathers that perpetrate DVA (Baynes and Holland, 2010; Alaggia et al., 2015). Northford sought to address this by establishing a Caring Dads service for fathers that are abusive and promoting the need to work restoratively with fathers in CP practice. Several practitioners described their practice with fathers, recounting attempts to locate and engage with men. However, there were few accounts of direct work with men beyond FGC practice where practice directly addressed their abusive behaviour and support needs in the context of DVA.

The challenges of engaging fathers were attributed a range of factors as illustrated in the extract below.

Sheila I try and work with dads where I can and it is hard because sometimes Dad's not on the scene and we try and engage him but where there's DV, it's much harder to track dads down. They don't want to engage, so I think it does fall back on mums and because we know that I try harder to make contact with dads, but I'm not always successful [laughs].

Permala Why do you think that is?

Sheila It really varies, some dads don't want to work with us, its threatening and I get that, but trying to track them down takes up so much time, and then when you do, it takes time to try and

> build rapport so that you can convey that you are someone to be trusted. Time is a big issue.

Fathers were constructed as not wanting to engage with social workers or be scrutinised and were difficult to 'track down'. Fathers, it was acknowledged, felt threatened by CSC involvement and building relationships in this context could take time. Organisational pressures on time and heavy workloads limited practitioner persistence to locate and engage with men. These combined factors meant that practice remained mother-focused.

A focus on men's fathering role has been recognised as motivating change around the use of harmful behaviours (Scott and Lishak, 2012; Stanley et al., 2012) and this will be the focus of the next section.

There were limited narratives of individual practice with fathers in the focus groups. Much of the discussion on engaging men was focused on the only service in CSC for fathers that were abusive in their family relationships. Caring Dads (Scott, Crooks and Francis, 2006) is a 16 week fathering programme that aims to hold men accountable for their abusive behaviour and improve their parenting by motivating change through relationships between fathers and their children. Evaluations of the programme have found that motivating men, to seek to improve their father-child relationship, has led to improvements in communication and respect with children's mothers too (Hood et al., 2015; McConnell et al., 2017). Engagement with fathers provides increased opportunities to motivate change where there was a focus on their fathering role (Maxwell et al., 2012; Stanley et al., 2012; Strega et al., 2008). Practitioners also identified opportunities to engage fathers by motivating desire to change by emphasising the benefits for improved father-child relationship as detailed below.

> I've found it easier with those dads that live with mums and want to have a relationship with their kids. The kids are often a hook for them, and I do see dads engaging where there's more of a focus on the relationships with their kids (Jaswinder SW).

In contrast to the traditional separation approach to DVA, Jaswinder noted that partners living together provided an opportunity to engage fathers, emphasising

relatedness and motivating fathering behaviours. This was noted most often where fathers were resident with partners and children, rather than non-resident fathers.

Caring Dads was a relatively new service in the Northford and was seen as a positive development in the city. However, practitioners (and fathers in this study) noted the length of the programme (16 weeks) for fathers was a barrier to participation. Yet, fathers were routinely referred to the service even where men had stated they did not want to attend (stated by Charlie, Jon and Sam in this study). Referrals were most often made by professionals rather than directly by men and take up by fathers was reported to be low. Though all social workers in the focus group had referred fathers, no practitioner interviewed was aware of any man they had referred that had completed all the programme. The lack of services for men in Northford, either in need of support and/or to address their harmful behaviour, meant that the Caring Dads service was the only service for practitioners to refer men in situations of DVA and as such, had become a routinised point of referral point.

However, the service had provided an opportunity for fathers to work with other professionals in CSC, beyond the allocated family social worker, which was usually with a male practitioner. This was welcomed because it widened opportunities for support for fathers and addressed the tension in practice, where women practitioners recognised their gender bias in practice.

> I do think I often affiliate with the female partner and that it's quite good that you have a different figure within the professional network that the male partner can go to. This has tended to work really well. That might be a bigger picture about responsibility because the social worker and the female partner are both female. I don't solicit this is right, but this is where we are (Erin SW).

Further discussion evidenced wider acknowledgement that women workers found it 'easier' to work with women rather than men in situations of DVA constructing work with men as requiring different skills and training and that this should be someone other than the social worker. The statement above, 'I don't solicit that this is right` uncritically reinforces routinised practices with mothers and letting fathers 'get away with it' (Featherstone and Peckover, 2007). This default practice approach does not

support fathers to be accountable for their abusive behaviour or seek support to change which was the very practice that Northford had sought to challenge through its innovation programme yet confirms that gendered practice is very much part of social work, even where there are attempts to innovate (Ferguson et al., 2020).

Positive reports from mothers, fathers and practitioners about the course. In particular, practical strategies for de-escalating conflict with partners and children, talking to other men and being able to share their story without judgement were cited as helpful.
While valued, the Caring Dads provision was limited by its programme structure and was precarious due to temporary funding. There were positive suggestions for a befriending service and less structured support for men to meet their help seeking requests but being tied to the Caring Dads franchise, limited opportunities for flexibility in the service, something that fathers and practitioners in this study asserted was needed.

Practitioner fear and lack of confidence to work with men

There were varied accounts about engagement with fathers across social work and FGC. Practitioners reported that restorative approaches were positive because they facilitated more father inclusive practice at an individual and organisational level. There was acknowledgement of RP operationalising greater efforts to work relationally with fathers' and reflect on work with fathers more too, as explained below.

> It's still early days. FGC co-ordinators talk to each family member – immediate and wider members and engage all dads where they can. It's less so in SW service, men are sometimes an afterthought, and the work is still predominantly work with women. The service is structured around daytime visits and if men are in prison, if they're out of sight, or if they live a little distance, they're not necessarily engaged (Jo FGC).

> I think we are working with men much better … we don't have many services, but it is still giving us room to work with them and more than anything with getting men opening up a lot more. You can go and sit

> and have a coffee with a man now who will start telling you about their childhood life (Freya SW).

There was recognition of the different ways in which fathers were engaged across the FGC and social work teams that signalled early attempts to think creatively about engagement with men. However, these positive moves were affected by practitioner lack of confidence about working with men as detailed below.

> I think I'm more confident in my practice about doing the direct work with the children and domestic abuse, but not as confident to do the domestic abuse work directly with men (Sheena SW).

> I think it's coming along a lot better, but the only thing is that we're not the best at just yet is engaging with men. We've got Caring Dads […] but a lot of men will turn round and say, 'that isn't for me'. `I don't want to go to group` and a lot of workers will take on that work themselves as a one-to-one and that's really positive, but a lot of workers might not feel confident to do that and I don't think it's fair on some workers to put them in that position, to make them do the work when they don't feel confident to do that work (Erin SW).

Work with men continues to be inconsistent as some practitioners feel more confident than others to do the one-to-one work. The assertion that 'it's not fair on some workers […] to make them do the work when they don't feel confident' is also likely to be linked to fear for personal safety of working with men that are violent and abusive, particularly by women practitioners (Humphreys and Absler, 2012). There were generalised accounts about a lack of confidence and fear of men and even being able to state this as illustrated below,

> I don't think workers want to say they're scared of violent men, but we need to have those conversations. It doesn't help that they go two 'ed up [in two's]. That gets men's backs up. (Leanne FGCC)

Yet in a restorative authority, practitioners shared that there was little training to support direct work with fathers that perpetrate DVA, making it more difficult to work relationally and/or have opportunities for discussing these issues with other practitioners. This ultimately hinders support for families that are struggling with DVA.

Although there were no direct accounts of fear of men in practice this was implied in accounts as a lack of confidence of working relationally with men, the challenges of working with men that caused harm were repeated in several accounts. These challenges were at an organisational and practitioner level. My own embodied experiences of hearing stories in homes where DVA was possibly ongoing and being immersed in family participants stories of intergenerational violence and suffering, brought fear for me at times too. There needs to be an acceptance and acknowledgement that fear is a valid response in this area of practice and to acknowledge the presence of fear in work with DVA is a starting point that needs to be addressed organisationally, so that practitioners can be supported to articulate this too and sup[ported to help families more effectively.

These findings strongly suggest that practitioners *know* that they need to engage fathers more meaningfully in practice, but are held back by individual, organisational and systemic constraints (Olszowy et al., 2020). Without opportunities to reflect on practice with men, it is possible that practitioners fear leads to defensive practice that further alienates men and potentially produces the very reactions that were feared by practitioners (Trevithick, 2012). However, research with men indicates that early engagement, active listening, and the use of motivational interviewing approaches help build relationships (Maxwell et al. 2012; Brandon et al., 2017; Philip et al., 2020). While practitioners in this study endorsed the need to engage with fathers, how to do this in practice was hampered by a lack of support, training, confidence and fear due to organisational constraints around time and opportunities for learning and development.

Working with complex family circumstances in CP settings has been described as stressful and frightening (Saltiel, 2013). Practitioners were fearful of their personal safety when working with DVA and men that are abusive (Humphreys and Absler, 2011). However, even in an authority where there has been considerable investment in workforce development for more inclusive practice with family members, many

practitioners were not confident about working with men in DVA situations. As such, practice with fathers was constructed as discretionary and specialist rather than being integral to their role with families. The failure of services to provide effective and appropriate support for men that sufficiently hold them accountable for their abusive behaviour was ultimately carried by mothers. The focus on risk was mapped onto mothers who were left to deal with DVA without support, even when men were seeking support for their abusive behaviour.

Summary of Part One

In summary, the first part of this chapter has considered the context of practice from practitioner perspectives. Complexity in practice was recognised at individual, organisational and structural levels. Firstly, there was recognition of the impact of structural inequality in the lives of families affected by DVA and limited service responses to address these factors in practice due to austerity and cuts in services. Thus, complexity from the broader context and interface with DVA and CP concerns, was managed in everyday practice through an individualised risk focus on individual family members, where the needs of children were prioritised. This in turn reinforced a focus on mothers. While there have been positive attempts to support fathers, engagement is still limited due to a lack of clear policy and practice developments to prioritise father -inclusive practice.

Part Two. Restorative Practice with Families

The second part of this chapter will focus on practitioner narratives on restorative approaches in Northford with a focus on high-support-high-challenge and family group conferences to address the third research question outlined at the start of the chapter.

High Support, High Challenge (HSHC) supporting practice

RP was operationalised through the social window of discipline model (Wachtel and McCold, 2001) and concept of high support high challenge, fostering a `doing with, not to` relational ethos in practice. HSHC was reported as providing a hook to shift thinking on DVA practice. This was implemented through generic workforce development opportunities and additional DVA training that was delivered as pilots to some area SW and FGC teams. The specific whole team training focus on DVA and RP was welcomed by practitioners as noted below.

> I know my area especially, we've attended a DV pilot and all of us would say how it's really developed our thinking, our way of working, our ability to reflect more. Because it [DVA] does become draining and the work can become monotonous. People were very honest, they were able to say they felt quite worn down by DV, because they didn't know how to change their thinking around it and was really helping to move that on and we've had better results. We are thinking about how we can work more restoratively (Freya SW).

Workforce development gave opportunities to name the impact of working with DVA for practitioners and identify barriers in practice.

and challenge thinking to support gave space for practitioners to name individual working with DVA and HSHC was also credited with challenging the reliance on separation ultimatums as routine practice and rethinking risk assessments for some.

> We've really got rid of practice that states the man must immediately leave, and I think now because we know that we're going in, knowing that these two are going to be seeing each other. So, we're thinking about how we can assess differently but safely. But there are situations where they must leave because it is too high risk. But I think it's the fact that people are now actually *thinking* about that and weighing up rather than that being automatic practice, to give a deadline and that was it, he had to be out (Jaswinder SW).

RP offered alternative practice with DVA and was acknowledged as challenging the routine use of separation in practice. There was generalisation that RP helped to reframe practice yet limited detail on how exactly this translated into everyday work with families. Data suggests that while there were the beginnings of thinking differently about DVA practice, this was more challenging where couples remained in a relationship.

While all practitioners interviewed asserted their commitment to RP without being prompted, challenges were readily acknowledged. RP had brought a change in culture, with a focus on building relationships and attempts to shift adversarial practice

by aligning with families. Yet this was constrained in the existing risk oriented CP system. Time constraints and high workloads were identified by some as limiting capacity to work restoratively in the way that they wanted to.

> To be restorative you need time. Restorative working isn't an event that happens, it's not just the FGC, it's all the little conversations that happen on the way that are really important and that needs time (Carol FGCC).

> There is a tension between being frantically busy and restorative practice. You can't build relationships and treat families as partners if you don't see them enough (Erin SW).

High workloads and trying to balance visits to families with multi-agency communication, trying to secure resources and recording demands: these constraints have been identified as being part of contemporary social work practice (Broadhurst al., 2010; Munro 2011; Morris et al., 2018). Thus, there is a need for implementation of innovative practices to address the extent to which organisational constraints facilitate or limit new ways of working.

Family Group Conferencing (FGC) and DVA

FGC practice represented a keystone of the implementation of restorative approaches in Northford. The expansion and offering of FGCs to more families affected by DVA was part of Northford's Family Valued programme (Mason et al., 2017). However, at the time of the research fieldwork, the dedicated FGC team working with DVA (the Innovations Team) had been dissolved and practitioners had been absorbed into existing FGC area teams. FGC co-ordinators from different teams took it in turns to attend the Daily Domestic Violence Meeting (DDVM) to assess DVA police referrals, and referrals for FGC were then allocated across the three area teams. Thus, there was no specific team focused on DVA and FGC during the research period.

There was no statistical data on FGCs where DVA featured as a significant factor for the current year 2018-2019. Annual data reported for 2017-2018 through service statistics showed 685 FGC referrals were received and there were 160 FGC family

plans recorded for the same year. Explanation for the low conversion rate reported in interviews and focus groups was given as a combination of the following:

- professional discretion about offering FGC
- lack of clarity if FGC was an entitlement or an approach
- low use of the referral pathway for FGC prior to an initial CP conference (ICPC) hence a default to traditional systems for CP decision-making
- the timing of FGCs where other (business as usual) CP meetings were prioritised
- time taken to bring families together for FGC
- family decision not to proceed

There was a lack of statistical analysis about the low numbers of FGCs in situations of DVA. This impacted on data about the use of FGCs in these circumstances.

Typology of FGC in DVA cases

The specific use of FGCs in situations of DVA will be explored through the typology of FGCs developed by Sen et al., (2018). The typology of FGCs for DVA outlines three types of FGC as outlined in Table 5 below.

Pragmatic	This type of FGC focuses on identifying and bringing together a support network for the survivor of DVA, often the mother. This FGC is commonly used in situations where there are concerns about children's welfare, usually following parental separation. The focus of pragmatic FGCs is to support the care and safety needs of the mother and children. There is rarely paternal involvement in pragmatic FGCs and therefore, limited in terms of making fathers accountable for their behaviour or providing resolution or restorative.
Resolution focused	This type of FGC focuses on working towards resolving disagreements or practical issues relating to the care and welfare of children between the mother and father and their wider family networks. These tended to be held in the aftermath of DVA and post-separation around family arrangements, particularly to resolve disagreements to facilitate children's contact with fathers and paternal networks.

Restorative FGCs	This type of FGC aims to involve maternal and paternal networks, including the father as the perpetrator of DVA, where it is safe. The FGC acknowledges the harm caused by the DVA, providing an opportunity for the father to acknowledge and accept the harm caused and put a plan in place that supports the care and well-being of the mother and children, and address support for the father to support a change in his abusive behaviour.

Table 5: Typology of FGC for DVA cases. Adapted from Sen et al., 2018.

This section will consider practitioner narratives of FGC practice against this typology. The most common FGC reported by practitioners in this study was pragmatic, followed by resolution focused, with very few narratives outlining restorative FGCs and correspond with earlier findings (Sen et al., 2018) on the use of FGCs with DVA.

Despite the positive endorsement of FGCs, data highlighted uncertainty and risk averse practice where there was DVA and emphasises the challenges of implementing participative family engagement within contexts where organisational culture reinforces risk focused professional knowledge and skills (Holland et al., 2005; Barnsdale and Walker, 2007, Ney et al., 2013). The expansion of the FGC service specifically for families affected by DVA challenged the dominant organisational focus on individualised risk practice and brought tensions in practice. Using the typology to map practice helps to highlight some of these tensions.

Pragmatic and Resolution focused FGCs

Significant in practitioner accounts was the tension of managing risk and restorative approaches in situations of DVA. While endorsement of FGCs occurred, the possibilities were challenged by risk averse practice culture (Holland et al., 2005; Barnsdale and Walker, 2007), as practitioners tried to balance a participative, family-led process with the care and safety needs of the child, sometimes leading to uneasy tensions. There were accounts from social workers and FGCC about how they tried to manage tension in practice.

> It's a very complex situation. From personal experience I've had some very positive, successful family group conferences where there was

> safety planning for Mum where there was a separation that either had already happened or was on the way and the focus was on safety planning in the FGC, to rally Mum's troops and reinforce Mum and give her a sense that she can do this, you can manage this and that there is a support network here for you to do it. [pause] I've also had a few where I wasn't happy at all with the feel or the outcome. They were joint FGCs between mums and dads. Sadly, the ones that I experienced, it was a bit of a case of Dad reinforcing the status quo, reinforcing the fact that he hadn't done anything wrong and finger-pointing at Mum and Mum not necessarily having enough support network or courage to stand up to that. So, from that I learnt to be *much, much more careful* and since then I've not actually had an FGC where both parties have been involved, where both parties have worked together to come up with a safety plan together. I've attempted that a few times, but it's not gone past that, *is this safe* stage, and the answers been, no, actually it's not safe (Carol FGC).

In this extract, the FGCC recounts having positive pragmatic FGCs that have supported the mother and children. In contrast, her experience of 'a few' joint FGCs have been where fathers did not take responsibility for the harm they caused and mothers not having enough support in the family network. This points to a need for further clarity about the process and pre-conditions for having FGCs where maternal and paternal networks come together in situations of DVA. The FGCC is applying her professional experience of 'unsafe' conferences as a blanket approach to justify not holding joint conferences together at all families, despite the uniqueness of family circumstances and relationships. Not holding FGCs with paternal and maternal family networks together means that opportunities for RP that address men's abusive behaviour are curtailed and not considered alongside attending to the safety and protection needs of women and children. As such, FGCs with maternal and paternal networks where there is DVA are constructed as a discretionary intervention rather than an entitlement. Conversely, a number of FGCCs reported 'very good', 'positive' and 'successful' pragmatic and resolution focused FGCs with women and children, again, where there was separation. Practitioners reported how women and children were empowered in these FGC process with the support of their networks to make and sustain safety plans.

Restorative FGCs

Restorative FGCs can be most challenging because they include maternal and paternal networks. This type of FGC focuses on acknowledging the DVA and harm caused, planning for the safety and support of the mother and child(ren) and for the father to address his abusive behaviour and commit to changing this through support. Data were limited on restorative FGCs with FGC and SW practitioners reported that very low numbers of restorative FGCs had been convened. Where they were reported there was a pragmatic, rather than a restorative approach described. As exemplified below,

> I've had quite a few FGCs where it's the blending of the families I suppose quite a few where actually Mum and Dad have said, 'we're not separating, we`re staying together'. So, it's like been like, 'Okay fine, what you going to do about that? What's life going to look like? How are the children not going to be exposed to domestic abuse? Because it's not okay for them to be exposed to it. And how are your family going to help that?' (Jo FGC).

The extract implies a judgement about the couple staying together. There is a pragmatic child focus rather than a resolution or restorative focus with an approach that appears to limit children's exposure to DVA and ensure there is a plan in place to support this. A singular child focus, rather than a restorative approach to address all harms in the family were evident in examples of joint FGCs where couples have stayed together. Applying the FGC typology helps to show the contrast between types and practitioners understanding of their approach in practice. Interestingly, although Sen et al., (2018) identified that pragmatic FGCs in their research rarely involved fathers and paternal networks, the findings in this study illustrate a pragmatic focus on how the couple will manage the consequences of staying together, 'okay fine, what are you going to do about that?' and a solution-focused approach that is framed by the risks to children. This illustrates an emphasis on pragmatic FGCs by practitioners as a mechanism for paternal and maternal networks to come together to address harm caused and work towards resolution. While this was noted in the focus group discussion, it is not evident how practitioners actually endorsed offers of FGC.

Likewise, little discussion arose in the focus groups on how fathers were supported to address abusive behaviour in joint or separate FGCs or how harms were addressed, beyond children's safety and protection needs. However, some individual FGC practitioner interviews did emphasise the challenges of balancing risk with restorative approaches, as detailed below.

> There's got to be a balance of risk and compassion. There's got to be that to have dads in the room. Bringing the whole family together makes mums very vulnerable and so you have to do a lot of work to get to that point. That takes time, where Mum's self-esteem is shattered and then she's in the room with Dad and he's messed up often and vulnerable too. There's got to be attention to how fragile the conference can be and try and work through what's in the room. (Simon FGC)

This is challenging work with skilled practice involved to draw out and contain intense emotions (Connolly, 2006) and work through family members challenging each other and practitioners challenging family. Where joint FGCs were described, practitioners recounted that there were difficult emotional conversations between family members.

Where there were FGCs reported with maternal and paternal networks were also where there was separation as confirmed below.

> Most of the FGC where there have been DVA have been where couple are separated or about to, we've had some amazing FGCs. We have also had some that were more restorative, bringing mum and dad together. Few. When they went well, very powerful. Getting someone in a room to talk about their harmful behaviour and being able to say to that person you've hurt me, and it has to stop. Very powerful! But very few (Mo FGC).

However, when discussion moved to joint FGCs there was considerable number of practitioners stating that meetings were not safe where couples were brought together. This practice resonates with some CP conferences in situations of DVA, where fathers experienced social worker reluctance to bring couples together during initial CP

conferences and also holding split conferences to manage risk (Philip et al., 2019). Hence, this approach reinforces mother-focused and father-exclusionary practice.

The majority of FGC practice shared by practitioners involved work with women and the maternal network, with limited recounting of work with fathers. Where fathers and paternal network were shared, there was greater relational complexity noted in the family network and practitioner - father relationship. For example,

> Having joint FGCs are hard work especially when couples want to stay together. People have had difficult lives and little support and you start doing the prep and talking to people on a one on one and it all comes tumbling out of them, the hurt, trauma, abuse and so when you get people together to talk about how they're treating each other, there's layers of abuse you have to get through. It's not just a case of DVA. Yeah, those FGCs … you're only touching the surface. Once people have said things, they're out in the open, I've seen families thinking about how they want it to be different, but that all takes a very long time (Simon FGC).

Practitioner confidence across SW and FGC co-ordinators was mixed in relation to FGCs where there was DVA and CP concerns. This was specifically in cases where couples were in ongoing relationships and living together. There was practitioner reluctance and lack of confidence to bring wider family networks together and evidence that both social work and FGCC made decisions that reduced opportunities for family engagement. This is despite some families living together and the risks that practitioners were concerned about, were ongoing in families and therefore responsibility was co-opted to families from the state, responsibilising mothers for managing DVA situations, even where there was state awareness of DVA.

In their study on the use of FGCs with families experiencing DVA, Sen et al., (2018) FGCC described social work practice of excluding men they thought posed a risk without giving them an opportunity to engage men around their DVA behaviour. This study reveals that men were excluded from practice by both social work and FGC practitioners where professionals thought that they posed a risk. This practice

highlights the persistence of a separation focused approach to DVA and the challenges of implementing restorative approaches.

There has been concern that the use of restorative approaches with DVA present high risk to women and children (Brown, 2007; Stubbs 2002, 2010). This was also a factor in Northford and legitimised father exclusion from FGCs at times. Practitioners across the board identified working with couples that had separated easier following pragmatic FGCs and greater complexity in resolution FGCs (Sen et al., 2018). Not having joint FGCs limited the opportunity for families to come together and engage in family focused resolution and decision-making and therefore made it more likely that families will be subject to CP processes.

Summary of Part Two

In summary, pragmatic and resolution focused FGCs were more common and very few restorative FGCs were reported in interviews. Therefore FGC practice was more focused on ensuring support was in place for mothers and maternal networks in the first instance with less potential to hold men accountable for their abusive behaviour and provide support for the father to address his behaviour. This highlights social workers earlier assertions of gendered practice, where most often women social workers align with women and children in situations of DVA. Additionally, practitioner lack of confidence to work with men generally and specifically men that used harmful behaviours, limited family focused practice and engagement with broader family networks. This confirms that FGC was most often constructed as an intervention rather than an entitlement, co-opted into a risk averse setting and limiting opportunities for restorative resolution in situations of DVA.

Discussion

Practitioners showed awareness of the impact of structural factors and in particular, the cumulative impact of austerity and service cuts that depleted family material, social and economic resources. This was linked to the triggering and escalation of DVA for some families and confirming earlier interconnection between poverty and DVA (Fahmy et al., 2016) and exacerbating difficulties for women wanting to leave abusive partners, where a lack of safe housing options and welfare cuts coalesced to embed women further in abusive relationships (Porter 2019). While practitioners recognised

this complexity there was a lack of resources and service responses to addressing the impact of structural inequality in families lives, alongside DVA. As such, everyday practice defaulted to DVA being conceptualised as a singular problem affecting families. Without organisational support practitioners attempted to manage complexity through compliance that fitted the organisational risk frame (Juhila et al., 2017; Ferguson et al., 2020) and prevented family problems from being conceptualised beyond individuals (Featherstone et al., 2014, 2018). This reinforced an intra-familial and interpersonal focus that further legitimised individualised risk focused practice.

Professional discretion

As public service workers at the interface between state and people that use statutory social care services, social work practitioners have been described as 'street level bureaucrats' (Lipsky 1980). As such, social workers implement legislation and policy, and make decisions about access to state resources, within the constraints of their role (time, resources, policy, etc.) and have to balance this with individual ethics and values, within risk focused organisational conversations
s. This can cause tension between balancing policy and practice with personal and professional values in everyday practice and lead to heuristic practices (Broadhurst et al., 2010) that aim to reduce complexity and are operationalised through individual professional discretion and informal sense-making. Broadhurst et al., 2010 identified that `excessive rigidity' within organisational culture and practice, can lead professional discretion to become defensive rather than innovative (Broadhurst et al., 2010) due to ethical dilemmas arising from an organisational focus on risk and concern for professional accountability (Sundell et al., 2001). Heuristic practices were evident in this study where FGCs with parental and maternal networks were identified as being 'too risky'. Hence, FGCs with paternal and maternal networks together were limited , so much so, that some practitioners actively challenged the rationale and values underpinning restorative FGCs in DVA situations. Limiting opportunities for FGCs, limited family participative mechanism for decision making and cemented the orthodox individualising practice framework.

There have been valid concerns raised about the use of restorative approaches in the context of DVA, because of the potential for revictimisation (Stubbs, 2002, 2007) where there is likely to be ongoing contact with fathers and the possibility of mothers

being coerced to reconcile with their abusive partner (Pennell et al., 2020). Practitioners in this study raised concerns about ongoing abuse in FGCs where maternal and paternal networks were coming together and included social work and FGC practitioners.

Uncertainty about holding FGCs in situations of DVA was reflected in interviews and focus group discussions. These findings illustrate that there is greater acceptance of pursuing pragmatic FGCs, followed by resolution FGCs. However, there is resistance to hosting restorative FGCs, where harm is addressed, and men are held accountable for their abusive behaviour and supported to address this. Implicit in practitioner accounts was the belief that restorative FGCs were 'too risky'. This view was often implied in interviews and discussions. In contrast, counter views also arose predominantly from FGCC, for the need to explore opportunities for restorative FGCs and support family-led decision-making. The lack of restorative FGCs indicates continued mother-focused practice with limited opportunity to address men's abuse and supporting families to seek resolution through family-led processes. Further work is needed to develop progressive FGC practice and unpick what is 'too risky' and 'is this safe?' especially when families (usually mothers) are often left to manage these situations.

The numbers of FGCs were generally low in Northford and particularly in situations of DVA. Team mangers identified that numbers of referrals for FGC across the board, differed across locality teams and were also linked to the different professional relationships held between the FGC team and the locality SW teams. With stronger working relationships and co-location of FGC and SW teams in one building, also resulting in more referrals. This requires further enquiry about referral pathways so that family access to family-led decision-making does not depend so much on defensive professional judgment and working relationships. The lack of restorative FGCs means that risk-focused, mother-focused practice prevails. Yet previous research (Pennell and Burford, 2000) identifies that RP in DVA situations can provide hope and those causing harm can be helped.

Father inclusive practice?

Despite recognition of the significance of fathers for children's well-being and development (Lamb, 2010), this study has found that CSC were slow to routinely

involve fathers in their work with families. This has been a common finding in CSC research (Scourfield, 2006; Maxwell et al., 2012; Brandon et al., 2017; Philip et al., 2020) and was revealed through practitioner accounts, where mothers were repeatedly prioritised at the point of service delivery and ongoing engagement and fathers was secondary to maternal engagement. RP was credited in practice with altering thinking about work with men and led to greater attempts to engage men. This was notable through referral to Caring Dads, an outsourcing of the work with men on their harmful behaviour and support needs. While this service was valued by practitioners, fathers and mothers, frustration persisted that all men referred did not engage with the only service available, and this referral practice did not signal increased everyday practice with men.

Evidence arose of ideologically motivated practice legitimising disengagement with men and work with couples who wanted to remain in relationships. Some practitioners struggled to include fathers in their practice, identifying their role as being primarily to support children and mothers. There had been incidences of men `reinforcing their abusive power` through CP meetings and FGCs, and this experience became practice wisdom, reinforcing a practice mantra that avoided bringing parents together to safeguard children and mothers. This was despite the uniqueness of families, their dynamics and circumstances. Thus, practitioners continued to be challenged by how to work with men to address both their support needs and the risks that their abusive behaviours posed to their families.

While there were examples of efforts to engage fathers, there was not a clear policy framework for improving service responses to men. Having HSHC aspirations without corresponding training to equip practitioners to build skills and confidence and name their fears in this area of practice, meant that the ambition to improve the safety and protection needs of mothers and children remained an aspiration. By constructing men as ‘community outsiders’ (Kuskoff et al, 2022), focusing on their harmful behaviour, men that were already marginalised, facing significant barriers from seeking support, were further isolated and deterred from practice. Some men lack the social resources to help them make the changes to cease their abusive behaviours on their own. Yet practitioners were also constrained by a lack of tools to draw on to enable a family focus in practice where there was DVA. Despite attempts to innovate practice in this area (Stanley and Humphreys, 2017; Sen et al., 2018), this study has also found that

father inclusive and whole family practice is limited, reinforcing mother-centric practice focus.

In order for practice to become less mother blaming there is a need for practitioners to routinely engage men. The findings from this study emphasise that while there had been significant workforce development on RP, there was a need for specialist training and confidence building in this area to better support practitioners. Again, these findings have been replicated in other research (Stanley and Humphreys, 2017) and there is evidence that specialist training can help better equip practitioners to work with men (Heward-Belle et al., 2019; SafeLives ,2020; Wild, 2021). It is imperative that practitioners are adequately resourced and supported to work with men.

Idealised motherhood

The data evidenced that enduring constructions of ideal motherhood were embedded in CP practice, as mothers remained the relentless focus of service interventions. Gendered discourse and practice identified mothers as the first point of contact while fathers were not routinely engaged or held accountable for their parenting and abusive behaviour, thus, replicating deeply embedded mother-centric practices in CP with families where there is DVA.

FTP discourse was acknowledged as punitive and stigmatising, yet some practitioners defended the term, where mothers and fathers were deemed to be 'failing'. In this way, parents were caught in conflicting practice expectations, where they were both responsible for care of their children and also positioned as failing to care (Morris and Featherstone, 2010). This response played into reductionist narratives of deficit mothers, where individual inadequacies were attributed to perceived FTP children. To move away from shaming FTP discourse, requires practice to engage with the individual lived experiences of mothers. An intersectional approach would support more nuanced understandings of how structural factors intersect with women's lives and how this might impact mothering through DVA.

Individualised risk focus – the predominant perspective

The findings indicate a predominant child focus, where the best interests of the child are assessed against the capacity of mothers to protect children from DVA. This is the

dominant framing of practice with families. CSC practitioners as agents of the state (Lipsky, 2010) intervene with an individualised focus in their work with families, where children are constructed as distinct family members, separated from the interdependencies of family relationships. This framing of children as separate is predicated on a risk discourse, with CP eclipsing family support needs.

A child focus overshadowed the lived experiences of other family members, in particular mothers, who were over responsibilised for the care and protection of children, required to make changes as outlined in CP plans and were fearful of children being removed. These experiences are well known (Alaggia et al., 2007; Lapierre, 2010; Keeling and van Wormer, 2012) to stigmatise and deter women from seeking support or being open about contact with abusive partners. Decentring an individualised risk focus on family members demands practice responses that prioritise the safety and protection needs of the whole family that are only possible through organisational cultural change and investment in workforce development.

This chapter has highlighted how statutory policy obligations placed the needs of children in tension with those of their mothers. The best interests of the child were stipulated as primary consideration in all social welfare actions concerning children and were recounted by practitioners as guiding their practice. It is imperative to uphold best interests as a guiding principle in practice where it is rigidly applied it can work against the interests of marginalised families (Philip et al., 2020). This practice challenges reductionist discourses that individualise family troubles where the whole family may require support to meet safety and resolution for all family members.

More nuanced training

DVA training is critical to increasing skills, knowledge, and confidence for practitioners (Button and Payne, 2009). With ongoing training being important for understanding the complexity of DVA and risk assessment and safety planning (Stanley and Humphreys, 2017). There was a lack of ongoing training on DVA to adequately support practitioners to practice with families. A small number of practitioners had received pilot DVA training (this was planned to be rolled out across social worker teams) with positive evaluation, for locating practitioner feelings about DVA practice and for disrupting mother-focused interventions by foregrounding men’s engagement. While

practitioners could recognise the challenges in their practice with families and the difficulties that families experienced, there was not enough of the 'right kind' of training to support more nuanced DVA practice. Though acknowledged as problematic, practice was predicated on a risk culture, where there was a victim/perpetrator discourse that held back more nuanced understandings of the nature of DVA in relationships and families.

There is a need for more specialist training and the development of specialist services/roles to work with men and further training on the complexity of kin relationships where there is DVA. Some social work practitioners had received additional training in their teams as part of a pilot in Northford and were able to share their experiences of working with DVA and challenges for them, such as 'don't know what to do' moments providing an opportunity to explore practice that was more attentive to the needs of families.

Conclusion

In conclusion, this chapter has considered the opportunities and limitations of RP to support family resolution in DVA and CP situations, from practitioner perspectives. Northford offers an example of whole system change including the introduction of models of practice that are conceptually significant. RP and HSHC aim to support less punitive practice that is situated in restorative partnership working with families. Practitioners expressed feeling positive and hopeful about working in Northford with HSHC identified as providing a common language to support relational practice, help to advocate for families and challenge management decisions at times. However, data substantiates that adoption of these approaches is hampered by ongoing reductionist approaches to DVA that are predicated on a mother-focused/limited-father inclusion, risk averse context. As such, the challenges identified by individual practitioners need to be contextualised within organisational cultures that are preoccupied with risk management and systemic resource constraints that reduce practitioner capacity to offer relational and restorative focused practice. The aspiration and ambition of HSHC and RP have offered opportunities to shift practice with families by encouraging father inclusive practice, with the Caring Dads service noted as an additional resource and one that needs to be offered more flexibly. While practitioners and families have noted positive outcomes, nevertheless there was a lack of detailed evidence about how the

ambition of RP translated into practice. In order for RP, and family led engagement to become a realistic possibility, highly gendered practice and discourse needs to be an actively and meaningfully challenged as part of a renewed whole system change.

Chapter 7: Conclusion

Introduction

This study builds insight into family practices and state responses in the context of DVA and child welfare concerns. The knowledge presented here makes the case for listening to families and extending restorative family led decision-making so that care and protection needs are met more humanely by the state. In doing so I have considered the interrelated narratives of mothers, fathers and practitioners utilising family practices (Morgan 1996, 2011; Smart, 2007) as a conceptual lens. These voices have been foregrounded to challenge the dominant discourse of deficit parenting in CSC (Reich, 2005; Ney et al., 2013; Baginsky, 2023) and to do justice to the plurality of stories shared with me. Analysis of these narratives highlights the orthodoxy of risk focused professional agendas and gendered practice, whilst simultaneously revealing opportunities for reimagining practice with families in the context of DVA and child welfare concerns.

This concluding chapter considers family and practitioner narratives to explore key findings in relation to the research questions and to consider their wider significance. To begin, I will revisit the research rationale followed by discussion of the key findings in respect of the research questions. This will be followed by reflection on the methods used, the implications of my findings for policy and practice, limitations of the study and the possibilities for future research.

This collaborative study stemmed from the rationale that little is known academically and in applied social work practice about the interconnection of family practices and restorative approaches in the context of DVA and child protection (CP) concerns in a UK setting. As such, the study has aimed to:

- Further understanding of how families `do` family where there is DVA and contact with statutory CP services.
- Explore restorative practices with families where there is DVA and CP concerns.

The research setting of Northford CSC provided a unique opportunity for researching this dual focus due to being the first statutory CSC service in England supported to implement RP through whole system change (Mason et al., 2017). This included

specific expansion of their FGC service to work restoratively with families where there was DVA and CP concerns. In chapters one and two (introduction and literature review), I provided an overview of the context for the study. This highlighted the historical policy contexts that have shaped dominant discourses of DVA within a child welfare setting in England. This discourse reinforced the construction of DVA as a gendered social problem and justified the use of separation responses to families experiencing DVA. As such women were being made responsible for managing DVA and men that were abusive were neither supported to change nor held to account for their abusive behaviours. As discussed in chapter three (methodology), the study utilised a post structuralist intersectional feminist approach. Semi-structured interviews, focus groups and observations of practice produced rich data that were thematically analysed. Chapter four, five and six were the findings and discussion chapters and respectively corresponded with the three research questions. The overarching key findings will be discussed below and address each research question in turn. By framing the findings in this way I hope to make my contribution more evident.

Key Findings

Research question 1. What family practices are described by families in the context of DVA? (How do families `do` family in the context of DVA?)

This study has used family practices (Morgan, 1996, 2011) as a framework for exploring how families affected by DVA and contact with CP services live their everyday lives, including family relationships of care and support. This has provided an opportunity to disrupt narrow individualised risk focused conceptualisations of family beyond CSC framings.

This study confirms the importance of Smart's (2007) concepts of relationality and embeddedness for families in the context of DVA and state intervention. Data revealed the importance of maintaining relationships and close ties with kin and non-kin family, and the challenges of doing this in the context of DVA. There were accounts of mothers remaining in relationships where there was DVA to meet their own and societal expectations of idealised `normal` family. For example, some mothers seeking to avoid

lone motherhood stigmatisation and continuing relationships because their children had the same biological father, unlike many of their peers.

Additionally, family rupture and separation from children (through relationships ending and/or state ordered separation of children) revealed feelings of shame and yearning for closeness to children for mothers and fathers. State removal of children did not signify an end to relationships and mothers embodied relationships through family display. This included practices of remembrance such as celebrating birthdays for children that were not physically with them, having tattoos of their children and through the telling of stories. Similar to Morriss (2018) and Broadhurst and Mason (2017) these findings illustrate pain, loss and the enduring impact of DVA and child removal long after the abusive relationship(s) had ended.

The concept of embeddedness framed the need for family members to be located within their family history and connections across time, recognising the enduring quality of family ties and CSC involvement. Family practices sometimes across generations illustrated experiences of intergenerational trauma located both in histories of abuse from family members and state practices for some families. Family narratives also connected traumatic past CSC interventions to present CSC encounters where there was state ordered separation of children sometimes across generations. Thus the enduring involvement of CSC in family lives highlighted ongoing challenges in participants ability to remove themselves from the web of state intervention in their lives (Smart, 2007, Gabb, 2009). Key family practices connected to the desire for `normal` family and `good` mothering and fathering are outlined below.

The desire for a `normal family`

The desire for a `normal` family was significant across mothering and fathering accounts. Being a `normal` family was subjectively and culturally defined with participant accounts revealing a focus on forms and relational practices indicating an idealised heteronormative family model. `Normal` was depicted as a family household where parents lived together with their children and performed practices of care of the children together, such as routines of putting children to bed, reading to children and leisure time together. There was also a desire for wider family networks of support that included participants ongoing connections with their own parents and siblings, despite experiences, for some, of earlier abuse and harm from them. Thus constructions of

`normal` family transcended participant experiences of difficult family relationships and underscored the embedded nature of kin and non-kin relationships across generations.

What was identified as a `normal` family moved between past, present and future constructions and between family participants own experiences. For example, violence and abuse were constructed as `normal` family practice for some, through narratives of experiencing parental DVA, childhood abuse and DVA from partners into adult relationships. While familiar and normalised through lived experience in this way, there was also hope of moving beyond these practices and experiences to an imagined `normal`, where there was emphasis on finding resolution.

Most mothers in this study wanted fathers to have contact with their children and be involved in CP processes too. This was linked to the desire for healthier family functioning, cessation of DVA and safer relationships to support co-parenting practices. For example, to `get on`, 'sort out problems`, 'stop the violence' and `be at a CP meeting without shouting at each other in front of other people`. Thus constructions of `normal family` emphasised performing and displaying family to convey practices of care and safety of children. The strong desire towards resolution of difficulties emphasised finding ways of *becoming* `normal`, rather than 'normal' being an end in itself. In this way a more fluid sense of family practices was imagined by family participants that challenged the rigid binary constructions of victim/perpetrator in practice.

Fathers also narrated a desire for `normal` family, especially non-resident fathers where there was increased contact with their children and fathering was performed in the way they imagined resident fathers might do. Fathers wanted to perform routine everyday care routines, have physical proximity and positive relationships with their children despite the context of DVA. These narratives of `good` fathering practices were disjointed form fathering practices of harm and abuse, corroborating earlier research (Perel and Peled, 2008; Zanoni et al., 2013: Philip et al., 2019).

Fathering practices

This study has demonstrated that men's constructions of masculinity and their own perceptions of fathering were multifaceted and challenge the `good dad/bad dad`

binary that frames social work practice with men (Haworth and Sobo-Allen, 2020). The majority of men in the study had experienced abuse from their own fathers/father figures and constructed their fathering as different from their own `bad` experiences of being fathered and did not want to replicate these `bad` fathering practices. However, this was in tension with fathering accounts of DVA as learned behaviour from parental relationships. Fathers emphasised that they were not harming partners or children in the same way that they had experienced harm as children thus depicting themselves as `better` than their own abusive fathers. In this way, fathering constructions of `good` fathering for the majority were set against their own abusive experiences of being fathered and contributed significantly to the social and emotional meanings that informed their own moral and social identity as good enough fathers.

Men's narratives on explanations of DVA behaviours were limited in this study and where expressed, DVA behaviours were attributed to their own moral and social constructions of masculinity linked to learned behaviours, such as 'I was being a man' and psychologically constructed as, `I lost control`. Being under the influence of alcohol and substances contributed to having reduced awareness of both DVA and the impact on children confirming earlier research with fathers (Heward-Belle, 2015) and highlighting a lack of control as justification for abusive behaviours. Fathering accounts of care and protection of children during DVA were also limited and where fathers acknowledged the presence of children during escalation of DVA, there was emphasis on how they sought to create physical distance from children in an attempt to prevent children's direct exposure to DVA. Furthermore, men's acknowledgement of harmful practices were interwoven with narratives of mental health difficulties exacerbated by difficult economic and material circumstances, ongoing difficult familial relationships and a lack of social support.

Fathers in this study ascribed different meanings to their fathering practices which were located in their social, economic and cultural context. An intersectional analysis of fathering practices revealed more nuanced understandings of how everyday tensions, violence and abusive behaviours were interwoven with depleted material, social and emotional resources to support their fathering. Most men in the study identified with the traditional aspect of fathering and the breadwinner role even when fulfilling this role was challenging due to the lack of opportunities and employment. Working fathers emphasised their role as provider for the family whilst working in

precarious, low paid circumstances and fathers that were unemployed were keen to display their provider role through stories on pooling welfare payments with partners, visiting food banks, seeking material household items through community resources and some also reporting engaging in petty crime to support their family.

Mothering practices through DVA

Mothering in the context of DVA exemplified multiple practices where women sought to prevent DVA and protect children. This included attempts to create physical distance from the abuser during escalation of DVA, appeasing, distracting and acting as a buffer. In this way mothers identified their mothering as `good` and normative of their own and societal expectations of care and recounted how their attempts to protect their children were often unacknowledged within professional encounters. Mothers recounted being blamed for managing DVA which corresponded with practitioner `failure to protect` discourse and where the needs of children were set in contrast to their own. These findings corroborate previous studies (Lapierre, 2008, 2010; Keeling and van Wormer, 2012; Wendt et al., 2015) and highlight the persistence of gendered practice and responsibilisation of mothers who experience DVA.

This study asserts the need for practice to move away from mother-blaming so that the challenges of living with DVA and care and safety of children can be explored through a family practices lens. This would facilitate a focus on mothering practices of care alongside the challenges of mothering through DVA. Without this dual focus the care and protection of children will continue to be appropriated by state agencies (Humphreys, 2010) and children continue to be positioned as passive victims (Katz, 2015; Callaghan et al., 2019). There is a need to focus on family practices that recognise everyday care and protection practices and desire for resolution.

Research question 2. What are the family narratives of DVA and contact with Children's Social Care services?

This study evidences that there was longstanding CSC involvement in families lives with the majority of participants first having contact with CSC due to abuse and maltreatment in their own childhoods. The data substantiated that some family participants experienced intergenerational CSC contact spanning three and four

generations. There were family histories of rupture, being separated from children and out of home placements due to histories of child abuse, parental DVA and mental health difficulties that contributed to interpersonal difficulties into adulthood for some. Data histories of cumulative disadvantage and psychological difficulties that corresponded with experiences of complex trauma (Herman, 1992).

The extent of CSC involvement in families lives across generations provided rich data on family experiences and contextualised mistrust of CSC. This is where there had been recurrent child removal and stories of not been helped in the way that families wanted at various points across the life course. Although some participants expressed being helped by CSC by being removed from abusive family situations, subsequent experiences of a lack of care in out of home placements and a lack of support as care leavers contributed to cumulative experiences of traumatic state harms. In this way, past experiences of CSC, often across generations were imbued in present day interactions with CSC and signify the embedded nature of state intervention into families lives across generations in this study.

These findings resonate with Quick and Scott (2019), Philip et al., (2019, 2020) and Mason et al., (2020) to confirm a connection between the co-occurrence of DVA, childhood abuse, mental health difficulties and CP intervention, and illustrating how structural inequalities and state intervention further compounded experiences of complex trauma. This is not to suggest that all CSC involvement in childhood was experienced negatively, however, the majority of experiences narrated the devasting impact of previous intergenerational contact with CSC and further suffering.
The findings evidence that there was great variation in the way CSC engaged with mothers and fathers. Mothers described being the focus of CSC interventions, being made responsible for the care of children and blamed for DVA and putting their children at risk. Fathering narratives emphasised limited contact from CSC that was often focused on their deficits and the risks they posed.

There was commonality in parental accounts of fear of CSC involvement due to the threat of children being removed similar to earlier research with mothers and fathers (Lapierre, 2008, 2010; Keeling and van Wormer, 2012; Brandon et al., 2017; Philip et al., 2019, 2020). The threat of child removal led to a reluctance to engage with CSC and avoidance of professional encounters.

Mothers were routinely seen as the first point of contact where there were CP concerns and constructed as primary carers and protectors. Most often mothers felt they were made responsible for managing abusive situations, separation and care and protection of children (Gordon, 1998; Lapierre, 2008, 2010; Humphreys and Absler, 2011; Keeling and van Wormer, 2012). Data also substantiated that mothers were also contacted first where fathers had reported being victims of DVA from their partner. These gendered practice experiences from CSC confirmed the persistence of mother-focused practice in Northford in the context of DVA and child welfare concerns.

Mothers that had experienced court ordered separation of their children in this study narrated their struggle to cope at the time with managing DVA, CSC intervention and the lack of support available to deal with this. Whilst this study corroborates the enduring traumatic consequences of court ordered separation of their children (Broadhurst and Mason, 2017, 2020; Morriss, 2018; Wild, 2022) and it also contributes evidence of mothers' attempts to rebuild their lives and enact agency in the aftermath of separation. There were practices of informing CSC of subsequent pregnancies to take back control and pre-empt hostile CSC intervention first, engaging with CSC and other support to prepare for birth and new babies, caring for children and in many ways thriving by doing family and mothering. This was not to suggest that mothers were no longer impacted by earlier child separation but that everyday family practices of remembering children they were separated from, having subsequent children in their care and being able to mother again, all helped women that had experienced state ordered separation of their children in this study to move on with their lives.

Fathers in this study wanted to be involved in children's lives but did not want to be the focus of CSC interventions. Fathers shared feeling threatened by CSC involvement due to past negative experiences and emphasised limited support and contact from CSC that was often focused on their deficits and the risks they posed (Maxwell et al., 2012a; Scourfield, 2014). The potential surveillance of their fathering acted as a barrier to engagement with fathers avoiding and delaying contact with social workers (Featherstone and Peckover, 2007; Featherstone and Fraser, 2012b). This finding contributes to the long standing critique of CP practice avoiding men and not sufficiently engaging fathers or holding fathers that are abusive accountable for their

behaviour (Humphreys and Absler, 2011). This lack of engagement with fathers in the context of DVA further exacerbates mother-focused practice.

In addition, many family participants indicated how CSC enforced participation onto courses that were targeted at improving their parenting skills as part of CP plans. This included attendance on the Caring Dads programme for fathers. Enforcing course attendance was an oversimplified, routinised response to DVA and child welfare concerns that did not adequately respond to family needs and experiences. While it can be argued that mandating fathers to attend the Caring Dads programme to address their fathering role and abusive behaviours towards children and partners, signalled an attempt to readdress mother focused practice, it represented a siloed response due to the lack of resource for working relationally with the whole family. It was also a challenge for men to attend all sessions due to work commitments and no father in this study had completed the sixteen week programme. There were positive experiences shared by fathers about learning new strategies to support fathering and recognising their own emotions and taking steps to deescalate a situation. However, the majority of fathers that attended had significant histories of abuse and trauma and Caring Dads could not adequately support fathers to address their abusive behaviour and their need for support with unresolved trauma experiences.

An absence of help

A significant finding across family participants was the unavailability of appropriate help at different points in their lives. There were accounts of how help at the `right time` as children and younger people from earlier CSC involvement, school and as care leavers could have helped to change life trajectories, averting the escalation of difficulties and cumulative experiences of abuse and even family rupture. Fathering accounts in particular noted the absence of early support and not being able to make sense of childhood abusive experiences at the time, resulting in a lack of trust in professionals and services to provide support (Maxwell et al., 2012a; 2012b) While research evidence shows that young men struggle to seek help in situations of DVA (Fox et al., 2015), this is in contrast to men's retrospective narratives in this study where fathers asserted a request for help earlier in life. These findings correspond with earlier research where professional curiosity and empathy, care and listening to their story were cited as the support they needed as younger men and has been identified

in previous research (Featherstone et al., 2014; Fox et al., 2014a; 2014b; Callaghan et al., 2019).

These findings have facilitated an exploration of family practices and personal lives that challenge the individualised risk focus on family members. This calls for consideration of the embedded nature of state intervention and its impact on families in applied understandings of families living with DVA and other adversities. Despite participants highlighting a lack of appropriate help at key points in their lives, there were also practices that demonstrated how challenges were overcome, the importance of relationality and families seeking resolution of DVA and child welfare concerns.

Research question 3. What are the opportunities and limitations of restorative practices to support family resolution in the context of DVA?

There is empirical evidence that FGCs can support family resolution and the care and safety needs of adults and children in situations of DVA (Pennell and Burford, 2000). This is where men are held accountable for their abusive behaviours and supported to change alongside attention to the safety and protection needs of mothers and children. Utilising Sen et al., (2018) typology of FGCs in situations of DVA a key aspect of restorative FGCs in situations of DVA is the inclusion, where it is safe, of men that are abusive to support the cessation of DVA and protect children and mothers by supporting fathers to accept responsibility for their abusive behaviour and commit to change this.

Family participants that had contact with the FGC service described positive encounters where they felt respected and listened to. Additionally, the process of preparing for and attending meetings and private family time helped some mothers to feel in control of safety planning and also strengthened their wider support networks. These positive experiences of FGC in the context of DVA and CP have been noted in other FGC studies too (Pennell and Burford, 2000; Sen et al., 2018) and indicated the commitment, experience and skill evident within the FGC service in Northford and potential for restorative FGCs. However, data substantiated that the most common FGCs were pragmatic and resolution focused FGCs (Sen, et al., 2018), where the practical safety needs of children and mothers and contact arrangements with paternal

networks were the focus of the FGC. Thus confirming earlier findings of the low number of restorative FGCs (Mason et al., 2017; Sen et al., 2018) and where opportunities for the care and protection of mothers and children were addressed alongside support for fathers to accept and change their abusive behaviours.

This study confirms that RP was limited by organisational and practitioner confidence in FGC practice across social work and family group conference settings. Practitioner and family participant narratives highlighted the struggle to bring maternal and paternal networks together in situations where DVA was a factor. There was a fear that doing this would increase risks to the mother and children. At times, some professionals were tokenistically acknowledging the need for 'letting families take responsibility', and simultaneously limiting opportunities for FGC, even when families requested a family meeting (for example, as Rhianna's quote 'what we need is a big family meeting' illustrated in the introduction). Organisational and practitioner uncertainty about trusting families to make plans and decisions in the context of DVA underscored a common theme, that DVA was deemed 'too risky' for FGC practice. This highlights continued tensions between participative family engagement processes and traditional risk-focused professional agendas in CSC (Brown, 2003; Connolly, 2006; Holland et al., 2005; Morris, 2006). As such, these findings corroborate the ongoing challenge to 'mainstream the practice into child welfare with fidelity to its core principles' (Pennell and Burford, 2008; 6) of participative family engagement.

An additional element to Northford's workforce development programme included change to shift attitudes and practice towards restorative approaches with families. Using a high-challenge-high-support (HSHC) approach (Wachtel and McCloud, 2001) that struck a chord with practitioners in this study recounting attitudinal change and relational practice was evident. However, shifting practice from a mother-centric to a family engagement focus, or even father inclusive focus was not evidenced. The foundational work of disrupting and dismantling risk averse practice cultures had not been undertaken in preparation for implementation of restorative approaches. So while Northford had implemented whole system change towards RP, this was not whole system change to target and challenge individualised risk focused gendered practice which is integral for providing restorative possibilities for family safety and resolution. As such, working within traditional CP processes with risk averse, routinised,

procedural decision-making cultures restricted the implementation of innovation in relation to FGCs.

Restorative practice was further hampered by practitioner delays in locating and engaging with fathers. This resonates with fathering experiences of contact with CSC (Brandon et al., 2017; 2019) where work with fathers was deemed as secondary to the core business of work with mothers and children. Workload pressures meant that some practitioners gave up trying to make contact and meet organisational timescales, confirming previous research Where fathers that caused harm also avoided contact with CP services (Featherstone and Peckover, 2007; Heward- Belle, 2015; Brandon et al., 2017; Philip et al., 2019; 2020). Together this led to the default gendered, mother-focused practice.

Complexity in practice

This study evidenced complexity in practice where there was DVA and CP concerns. Similar to Olszowy et al., (2020) practitioner accounts confirmed complexity coalescing at individual, organisational and systemic levels. DVA was recognised by practitioners as a multidimensional problem, where families they worked with were impacted by poverty, mental health difficulties, substance use alongside DVA experiences. The lack of resources and training to adequately respond to the co-occurrence of individual and whole family needs. However, evident across practitioner data was also the recognition that austerity and cuts to services impacted families and practice in this area. For example, there was a lack of support services for men who used DVA behaviours and also reduced access to safe refuge and housing to help support mothers to leave an abusive partner (Porter, 2019). This narrowed options for practice too and led to a default to the `core business` of CP (Ferguson et al., 2020) where complexity was rationalised by breaking down needs into tasks so that work with families could be managed more easily. In doing so, DVA was conceptualised as a singular problem in everyday practice that was most often met with an orthodox CP practice framing that limited opportunities for family resolution.

Barriers to working restoratively with families.

That the orthodoxy of child protection processes created barriers for whole family approaches and family led decision making is not a new finding (Brown, 2003; Morris, 2006; Ashley and Nixon, 2007), these barriers are summarised below for this study.

- Gendered discourse and practice evidenced in mother focused practice creating practice encounters that blamed and shamed women and led to a lack of engagement with fathers.
- Families' lack of trust in CSC due to previous contact and child removal.
- Lack of practitioner time for relationship-based practice with family networks.
- Practitioner fear of working with men that were abusive, low confidence, lack of knowledge and skills in relation to DVA and whole family practice.
- Lack of clear policy, practice guidance and practice tools on the use of FGC in situations of DVA to inform working across the social work and FGC service interface. Specifically, a lack of clarity about who could call an FGC and how families could use their entitlement to an FGC.
- Lack of service infrastructure to support the needs of families for all members to be safe and protected. The lack of safe housing options for mothers and lack of services for men to change their abusive behaviours and attend to their experiences of victimhood and trauma.

These factors highlight the barriers to working restoratively with families that were rooted in systemic, organisational and practitioner limitations.

Reflection on the methods

This thesis has contributed to understandings of family practices that occur where there is DVA and attempts at resolution through CSC involvement. The concept of family practices, how families `do` family and the meanings attached to these practices have been the focus of this study. In order to do this a qualitative mixed methods approach was undertaken to support participants to tell their stories in the manner of their choosing. This allowed mothers and fathers to construct their own understanding of their experiences and focus on their everyday lives, generating data that gave insight into family practices at the intersection of state intervention.

The multifaceted nature of the qualitative data collection identified in chapter two brought complexity to the methodology. Rich data were produced through interviews with family participants and practitioners, focus groups with practitioners and observations of practice. The volume of data produced was challenging to manage because of the different aspects and varied themes generated across the key areas

of focus, family practices, RP, DVA and CP practice. I felt overwhelmed at times, seeking to do justice to the stories of all participants, mindful to balance this with addressing the research questions and simultaneously seeking to make a positive contribution to knowledge, practice, and policy in this area.

Applying a narrative orientated approach to the semi-structured interviews generated substantial rich data and many themes that were beyond the specific focus of this study. In hindsight a more structured interview process may have produced less data and limited the free flow narrative of the telling of life stories and practice reflections. However, given the marginalisation of families in CSC (Reich, 2005; Munro, 2011; Baginsky, 2023) and the lack of research with families impacted by DVA and child welfare concerns it was imperative that I facilitated the privileging of family participant voices. Therefore, the qualitative interview format was ultimately an effective methodological approach for this study.

Additionally, the sensitive nature of the research generated stories of abuse and trauma that were difficult to hear at times. These were not isolated incidents but ran through the life course for many participants and through their narratives too. The cumulative impact of hearing these stories across all family participants was distressing at times. My professional experiences and training, working in DVA and post abuse therapeutic services supported me to process the detailed stories of abuse and adopt self-care strategies. However, this was challenging again when revisiting the interviews and hearing participants voices repeatedly through transcription and analysis and recalling their voices when I was writing up my thesis findings. The impact of this has been identified as secondary trauma on the researcher (Kiyimba and O'Reilly, 2016) and was managed through pacing research activities, accessing supervision and maintaining a reflective journal to process my thoughts and feelings.

As outlined in chapter three, consultation with the Friends and Family Advisory group (FAFAs) at the start and end of the research collection period was invaluable for considering the research design and checking the scope of my findings against the groups own experiences of contact with CSC in Northford. This helped to reinforce the validity of my findings with similar themes and experiences noted between family participants and FAFA group members, even though the FAFA members contact with CSC had occurred many years earlier. Risk focused, gendered practice, hostile

professional encounters, trauma associated with intergenerational state ordered removal of children, recurrent contact with CSC and a lack of opportunity to tell their story and be heard were prevalent themes and corroborated by the group.

Implications for policy and practice

The aims of this study included understanding practice and policy responses to families from CSC in the context of DVA and making recommendations for services to respond more humanely to families. This section outlines the implications for policy and practice generated from the study findings by highlighting the key areas.

This study substantiated that CSC practice continues to be mother centric and needs to be challenged through the promotion of father inclusive practice. Shifting to this requires father focused approaches that are firmly rooted in policy and practice, engage fathers and hold abusive partners accountable for their behaviour. Engaging with fathers as a priority from the outset as a practice norm rather than optional practice means a shift in responsibility from mothers to a focus on harmful behaviours and safety and protection needs of all the family. This means working with fathers to hold them to accountable, providing support to change through building relationships and being curious about their lives (Featherstone, 2013). This requires additional resources and a cultural shift on the part of services so that gendered expectations are challenged at a service, practitioner and societal level too.

While there was practitioner consensus of the importance of engagement with fathers where there was DVA and child welfare concerns, there was reluctance from some practitioners to prioritise engagement with men whether they used DVA behaviours in their intimate relationships or not. There was also variation in practitioner confidence, knowledge, skills and attitudes to work effectively with men who perpetrated violence and abuse. This study also substantiated FGC co-ordinator reluctance to engage fathers in FGCs where there was DVA (Sen et al., 2018). The lack of engagement with fathers that perpetrate DVA across CSC ultimately reinforces mother focused practice and limits opportunities for RP. As evidenced in this study, there were CP conference chairs that struggled to effectively engage with fathers in practice which highlights the need to target professionals at all levels in the organisation to challenge practice that reinforces mothers' responsibilisation and sanctions fathers' disengagement. Providing training and skills to support confidence to work effectively with families in

particular men who are abusive would support change in practice (Maxwell et al., 2012). This requires organisational policy and resources to identify services for work with men and to address the training needs of practitioners so that the needs of families affected by DVA and other adversities can be met more effectively.

In order to address gendered practice in DVA and CSC, it has to be recognised and named in the first instance at a macro (systemic and organisational) and micro (practice) levels. This requires critical reflection at an organisational and individual practitioner level of the conscious and unconscious biases regarding societal gendered stereotypes and how they are replicated through their work with families. Reframing practice to a family and father focus, rather than defaulting to mothers can be transformative, by facilitating opportunities for the discussion of care and protection needs with the family and father rather than solely with mothers.

While Northford undertook whole system change and implemented RP through high-support-high-challenge approaches, how the service would implement RP with families that had recurrent generational experiences of family rupture and state removal of children needs further consideration at micro (everyday practice) and macro (policy) levels. To do this professional understanding of the legacy of intergenerational CSC involvement in families lives and intergenerational state order separation needs to be recognised more fully at a systemic, organisational and everyday practice level through relationship building practices. Failure to do this impacts current relationships and potential for families to seek help to support their care and protection.

Experiences of trauma, mental health difficulties and substance use were a feature in the lives of those that caused DVA harm in this study and have been evidenced in previous research too (Hester et al., 2017; Lilley- Walker et al., 2018). Similarly, the mental health needs of those that cause harm have not been adequately addressed by services yet have been a significant feature in domestic homicide reviews in England and Wales (Oram et al., 2013; Chantler et al., 2020). Furthermore, fathers that experienced recurrent CP care proceedings often presented with poor mental health (Philip et al., 2021) which was borne out in this study too. These factors highlight the need for policy and practice to address the concurrent nature of mental health and substance use and ensure effective multi-agency working to support opportunities for

recognising this link and reducing risks to support the safety and protection of those that are likely to be harmed.

For there to be increased opportunities for families to come together and speak about DVA and be supported to consider the safety and protection needs of their families. The data in this study confirms that mothers and fathers want to be involved in their children's lives. Responding relationally to families and mothers and fathers as people in their own right, with their own needs and concerns would support more effective engagement. To facilitate this would require systemic and organisational commitment to support practitioner training and confidence to work relationally with whole family groups and to secure long-term resources that support pathways to services that can help in the way that families want and need. Thus a whole family approach to working with families in the context of DVA requires clear policy guidance that prioritises working with wider family networks that encourage participative family engagement and decision making to help support families to care and protect their children.

There needs to be further analysis of CSC practices that create barriers to participative family decision making. This requires attention to how CP policy and processes interact with FGC services and facilitate family led engagement through a system that is not configured for family led engagement (Brown, 2003). This analysis has the potential to inform specific policy and guidance about FGCs in situations of DVA and RP. By reframing practice to a whole family focus would be transformative and also means a shift in responsibility from mothers to a focus on the harmful behaviours of abusive partners whilst holding the safety, protection and support needs of all the family.

Humphreys and Absler (2011) assert that the responsibility for practice change cannot be held solely by practitioners. Indeed, it is easy to transfer mother blaming onto worker blaming in CP DVA practice in the context of neo-liberal managerialist cultures in CSC. However, this study has highlighted the complexity of DVA and underlying structural inequalities that bring additional adversity for families. Practice was constrained by the lack of a service infrastructure to effectively support family engagement. This requires organisational and systemic resources to provide effective preventative domestic abuse services, pathways to support those that use DVA behaviours and services to address underlying structural inequalities that exacerbate

DVA (Fahmy et al., 2016). Additionally, workforce development that disrupts gendered practice alongside strategies for supporting practitioner supervision, training, knowledge, skills and tools for working with whole families where there is DVA, trauma and conflict is required. Practitioners need to be resourced to undertake this work confidently so that the prevailing default risk focused, mother centric practice is effectively challenged. Therefore, the implications for policy and practice outlined here reassert the need to address barriers at the systemic, organisational and individual levels.

Limitations of the study

This study was located in one English local authority CSC service, during one data collection period. The participant size (21 interviews and 4 focus groups) was small in scale and does not suggest that the findings can be generalised to all families impacted by DVA and CP involvement or indeed all CSC services and practitioners.

The study set out to engage family networks to include parents, children, family friends, grandparents, etc. and this was not possible as I predominantly interviewed individual family members. This was in tension with the critique of individualised practice discourse in statutory CP services where service development and research fail to capture whole families' views, relying more on the outcome and experiences of individual family members (Morris, 2012). Recognising the individualising gaze of CSC involvement in situations of DVA (Ferguson et al., 2020), I set out to mitigate against this, however discovered that speaking to family networks would be ethically challenging in this context due to the sensitive nature of the research (Holland and Shaw, 2014). Where I did interview more than one family member this was two couples and in both instances after completing the first interview, despite attempts, it was a challenge to arrange a face-to -face interview with the partner. Therefore, these second partner interviews were undertaken as telephone interviews and were the only telephone interviews within the study. As such, talking to wider family networks was a limitation of this research that is also a recognised challenge in researching family relationships (Gabb, 2008; 2009) more generally.

Another limitation of this study was the degree of diversity across family participants and practitioners. The majority of participants identified as White British across family and practitioner participants and all family participants narrated experiences of DVA in

heterosexual relationships hence other types of relationships were not evidenced in this study. Additionally, despite attempts, children's voices were largely absent from the study and their experiences were constructed through parental and practitioner accounts.

A final limitation was the lack of restorative FGC practice evident in an authority that had invested significantly to innovate and provide opportunities for restorative resolution for families. I had hoped to interview families that had experience of a restorative FGCs (Sen et al., 2018). Whilst I spoke to participants and practitioners involved in pragmatic and resolution FGCs, I did not have contact with family members that had had a restorative FGC experience. This also underscored the limited observation of direct social work and FGC practice with families and therefore a reliance on constructions of practice from the perspectives of family and practitioner participants. Despite these limitations the findings are significant and relevant nationally and internationally to consider family practices and the implementation of restorative approaches in the context Of DVA with families in statutory CSC settings.

Future research areas

There is a need for further research that can extend understanding of complex trauma to include the interconnection between childhood abuse, DVA, mental health, structural inequality and the impact of intergenerational contact with state CP services into families lives. In doing so, curiosity about families histories can support broader understanding of how state intervention and structural inequalities interrelate with family practices to challenge the focus on individualised family risks and consider more broadly, the roots of family difficulties. Further research in this area would facilitate greater understanding of family practices and support thinking for transforming practice so that CSC can build relational repair through restorative approaches.

There were narratives of the co-occurrence of DVA, substance use and mental health difficulties narrated by mothers and fathers. While this has been explored previously (Gadd et al., 2019; Radcliffe et al., 2021), the intersection with CSC is needed. Therefore, further research of family practices in the context of these needs and dependencies and contact with CP services warrant further attention. Further research into the contested nature of family practices where there is state intervention would

help to further explore how families mediate state intervention and make decisions about what state mandated family practices are adopted, adjusted and/or resisted in the context of CP interventions.

This study also contributes to RP in particular, family group conference practice to evidence how CSC practice with families limits the opportunities for resolution through FGC practice. DVA was conceptualised as `too risky` for participative family decision making processes as evidenced by the low numbers of restorative FGCs, as identified in the typology of FGC by Sen et al., (2018). Therefore, research that can engage in the direct observation of family group conferences and processes in situations of DVA would support insights into family engagement and decision making that could further practice in this area.

This study makes a contribution to the study of family practices and restorative practices that are situated across the disciplines of sociology, social work and DVA. My contribution argues for a broader understanding of family practices that builds on Morgan's work (1996; 1999; 2011) to address violence and abuse imbued within everyday practices by making a contribution that gives voice to those experiencing DVA. A family practices lens facilitated an understanding of how practices were compounded by CSC organisational practice and policy; specifically, how gender role stereotypes were reinforced through mother focused practice.

Additionally, building on Forsberg's (2013) concept of contested family practices helped to broaden the scope of family practices to bring insights into the contested nature of family practices, where state intervention sought to change family practices and family structures and how families mediated this in the context of DVA and CP concerns. Participant narratives substantiated the contested nature of family practices where, for example, CSC enforced separation, mandated attendance on courses to change their parenting and performance of relationality. This provided a broader framework for thinking about how family practices intersect and are constrained by state intervention.

Concluding Thoughts

In concluding this thesis I want to emphasise the importance of listening to families and creating spaces for family engagement and family led decision-making to support

resolution of care and protection needs. Family participants wanted to be involved in this study to share their stories, to inform change and support other families that have contact with CSC. While the focus of this study has been on DVA and experiences of CSC, curiosity about families' everyday lives and family practices also generated stories of love, care and hope. Thus, families in this study are not defined by their DVA and CP experiences alone but also their strength and determination to resist challenges in their lives.

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Appendices

Appendix 1. Family Participant Table

	Pseudonym	Age	Ethnicity	Care experience	Children and ages	Family information	DVA current	FGC mtg	Open CP case	Interview details
1	Anita	34	African Caribbean and White British	Yes	3 children 9 ,13 and 15 years	Anita lives with her children in a lone parent household.	No	Yes	Yes	In person at family home. 1hr35min
2	Ashley	38	White British	Yes	4 children 2, 13, 18 and 20 years	Ashley lives on her own with her youngest child in a lone parent household. She was separated from her three older children. 1 child lives in a long-term foster placement (no current contact). 2 children were adopted. Both have subsequently returned to the city and Ashley has contact with both children.	No	No	Yes	In person at family home. 1hr50min
3	Becky	27	White British	Yes	3 children 18 months, 6 and 9 years	Becky lives alone with two children in a lone parent household. She was separated from her two eldest children who were placed in care. One child was returned to her care and her eldest child was placed in kinship care. She has regular contact with her.	No	Yes	Yes	In person at family home 2x interview 45 + 50 min
4	Faye	27	White British	Yes	3 children 7 months, 3 and 5 years	Faye lives with her partner and their child. She has two older children from a previous relationship that she is separated from. They are both adopted.	No	Yes	Yes	In person at family home 2x interview 1h 30min 1hr10min
5	Jess	30	White British	No	3 children 8 months, 8 and 10 yrs.	Jess lives with her partner (Charlie) and their child (8 moths) and her two older children from previous relationships.	Yes Partner	Yes	Yes	In person at family home. 50min
6	Kay	34	White British	Yes	2 children 3 and 5 yrs.	Kay lives with one child in a lone parent household. She is separated from her older child that is adopted.	No	Yes	Yes	In person at family home 1hr30min

	Pseudonym	Age	Ethnicity	Care experience	Children and ages	Family information	DVA current	FGC mtg	Open CP case	Interview details
7	Meena	49	Indian	No	2 children 14 and 16 yrs.	Meena lives with her husband (father of the children) and two children	Yes Partner	No	No	In person at family home. 50min
8	Rihanna	21	White British	No	1 child 18 months	Rihanna lives with her child in a lone parent household.	Yes ex-partner	No	Yes	In person at friend's house 1hr20min
9	Kim	23	White British	Yes	2 children 10 months and 6 years	Kim lives with her children and also stays regularly with her partner (Jake) at his mother's house with their child (10 months old) and her older child from a previous relationship. The family alternate living between Kim and Jake's mother's house.	Yes Partner	Yes	Yes	Telephone interview 35min
10	Charlie	20	White British	Yes	1 child 8 months	Charlie lives with his partner Jess (above) and their child (8 months) and her two children from two different previous relationships.	Yes	Yes	Yes	Telephone interview 40min
11	Jake	23	White British	No	2 children 10 months 2 years	Jake recently separated from Kim (above). He lives at his mother's house and has weekly contact with Kim and their child (10 months) and her child from a previous relationship. The family alternate living between Kim and Jake's mother's house. Jake has a second child that he has no contact with from a previous relationship.	Yes	Yes	Yes	In person at Mothers house 1hr20min
12	Jon	30	White British	Yes	3 children 1, 4, and 3 years	Jon lives alone with his son from a previous relationship. He is in a relationship with his partner who lives on her own with her child from a previous relationship and their two children. There is daily contact between the two households.	No	No	Yes	In person at family home 1hr10min

	Pseudonym	Age	Ethnicity	Care experience	Children and ages	Family information	DVA current	FGC mtg	Open CP case	Interview details
13	Mark	49	African Caribbean	No	2 children 9 and 3 yrs.	Mark lives with his mother. He has regular contact with his two children from a previous relationship.	No	No	No	In person in private room at community centre close to his home
14	Sam	33	White British	No	2 children 4 and 6 yrs.	Sam lives with his mother and children. He is the primary carer for his two children from a previous relationship.	No	No	Yes	In person at Sam's Mother's home 1hr40min
15	Rodger	47	White British	No	3 children 17, 20, 24 years	Rodger is married and lives alone. He previous lived with his wife and her younger daughter from a previous marriage. He has daily contact with his wife and stepdaughter. Rodger has two children from a previous relationship that he has no contact with.	No	No	No	In person at his partners home 1hr10min

Appendix 2. Practitioner Participant Information

Table of one to one in person interviews.

	Practitioner - pseudonym	Role *
1	Erin	SW
2	Leanne	FGCTM
3	Mo	FGCTM
4	Pete	SW Caring Dads
5	Sheila	SW
6	Simon	FGCC

Appendix 3. Focus Group Practitioner Information

	Practitioner - pseudonym	Role *
1	Anne	FGCC
2	Carol	FGCC
3	Erin	SW
4	Freya	SW
5	Kate	SW
6	Jaswinder	SW
7	Jo	FGCC
8	Scarlet	SW
9	Simon	FGCC
10	Sue	SW

* SW: Social Worker

FGCC: Family Group Conference Co-ordinator

FGCTM: Family Group Conference Team manager

Appendix 4. Interview Schedule (flexible)

Interview Question Schedules

Semi structured Interview Schedule with Family Participants

- Can you tell me a bit about yourself? How would you describe yourself? Your family?
- How would you describe everyday life for you? and your family? What's a typical day?
- What's good right now? What's not so good?
- Can you tell me about how social services became involved in your life?
- What was helpful? What wasn't helpful?
- Can you tell me about your experiences of DVA?
- Were you offered a family group conference? Did you accept the offer?
- Can you tell me about your experience of the family group conference?
- Is there anything else you'd like me to know?
- What are your hopes for yourself? and your family?

Semi-structured Interview Schedule with Practitioners and Focus group

- What did you think when you heard about this research study?
- Can you tell me about your work with families where there's DVA?
- Can you tell me how you've used restorative approaches in your work with families where there is DVA? How do you think they've helped/ hindered your work?
- Can you tell me about your work with fathers in the context of DVA, and/or where fathers are violent and abusive?
- What do you think you need to work more effectively with families where there's DVA?
- What do you think are the priorities for the service to work more effectively with families and DVA?
- Is there anything else that you think is important and want me to know?

Appendix 5. Family Information Leaflet

Researcher: Permala Sehmar
[redacted]
Telephone [redacted]
Department of Sociological Studi
University of Sheffield
Northumberland Road
Sheffield S10 2TU

Family Information Leaflet

Letting Families Speak:
How best can families be supported when there are situations of domestic violence and child welfare concerns?

My name is Permala Sehmar, and I am a researcher with the University of Sheffield. I would like to invite you to take part in a research project that aims to understand families' views and experiences. This leaflet tells you about the project and what taking part will involve.

What is the research about?
More and more families affected by domestic violence are being referred to child protection services. This project is interested in giving families an opportunity to share their views and experiences of how best they can be supported in these situations. I think it is important to hear directly from families about the difficulties they face to try to improve understanding and support for families.

Why are you being asked to be involved?
You are being asked to take part in this research project because you and your family may have had an experience of domestic violence and been involved with Children's Services. What you have to say about this is important and can help other families too.

What does taking part in the research mean?
If you decide to take part, I will interview you about your situation and your experiences of how Children's Social Care have worked with you. You do not have to talk about anything you do not want to. I'm hoping to talk to mothers, fathers, and children (aged 9-16 years) in families and do a family interview too if this is agreed. It will be up to you to decide if you want to ask your children about taking part.

I would be happy to come and have a chat with you or your children and answer any questions you may have before you decide whether you want take part.

Do I have to take part?
No, you don't have to take part. Also, if you decide to take part and change your mind you can withdraw at any time without having to give a reason why.

If you withdraw from the project, then the information that has been collected so far may still be used in the research.

What information will you be collecting?
I will be collecting information from you and other family members through interviews. I will write notes, make audio recordings, and possibly take photographs of any work you've made (artwork) during the project, with your permission.

Will taking part in the project be kept confidential?
All information collected during the project will be kept strictly confidential. All notes will be anonymised. This means that participants will be invited to choose a fake name which I will use instead of your real name. All Information you give me will not be used in any way that could identify you because I will use your fake name and places will be changed too. I will be happy to talk about any concerns you may have around keeping your identity safe.

The only time that I might not be able to keep information confidential is if you told me something that made me concerned about your safety or the safety of another person. If this happened, I would talk to you first, where possible, and tell you that I was concerned and needed to share this with my Research Link Person to decide how best to deal with the safety concerns.

What will happen with the information that you and your family give?
All notes and recordings of interviews will be deleted once they have been written up and anonymised. This research is part of my university doctoral degree. I will use the anonymised information I have collected to write up my research findings and present key messages to professionals and policy makers through meetings published articles and reports. This is to try and support others to help families get better help in the future. With your permission, short quotes from the interviews may be used in reports and presentations to help others understand your experiences. Any quotes shared will be confidential and your identity will be protected.

Who will have access to the information collected?
All the information will be held securely at the University of Sheffield during the project and only I will have access to my notes, hear the recordings and see transcripts. After the project has ended, I will keep the transcribed documents in a password protected file for 3 years after which time they will be destroyed.

What if you want to speak to someone else about the project?
If at any time you are worried about this project, want to make a complaint, or have any concerns about how you have been approached or treated during the research please contact my supervisors: Professor Kate Morris katemorris@sheffield.ac.uk, or Robin Sen rsen@sheffield.ac.uk

What do I do if I am interested in taking part?
I would be happy to have a chat with you and any other family members to answer any questions you may have before taking part.

If you are interested in taking part, please text or call me on [redacted] or email me at [redacted]

To thank you for your time, each participant will receive a £10 gift voucher at the end the research project.

Many thanks

Permala Sehmar

Appendix 6. Practitioner Information Leaflet

Researcher: Permala Sehmar
Email [redacted]
Department of Sociological Studies
University of Sheffield
Northumberland Road
Sheffield S10 2TU

Information for Professionals

Families Speaking:
How best can families be supported when there are situations of domestic violence, and child welfare concerns?

My name is Permala Sehmar and I am a researcher with the University of Sheffield. I would like to invite you to take part in this research study, which is a partnership between [redacted] and the University of Sheffield. This leaflet will give you information about the research to help you decide if you want to take part.

Background to the research

Domestic Violence and Abuse (DVA) was the most common factor (51%) identified in referrals to statutory children's services in England in 2018, an increase of 3% since 2016 (DfE 2018). Service responses to DVA and child welfare concerns are delivered through a risk management approach to families, where a child's safety is prioritised sometimes by enforcing the separation of partners. This practice can make mothers separation from an abusive partner a pre-condition for the continued care of their children, regardless of the mother's circumstances. Women in these situations can be revictimized; by being blamed for a `failure to protect` their children if they remain with their partner and simultaneously being made responsible for the protection of their children whilst suffering DVA. Fathers have traditionally been excluded from social work practice, thereby neither held accountable for their behaviour nor asked to meet their parenting responsibilities. This approach to working with families can exacerbate unsafe situations, isolate families and contribute to family's distrust in services. .

Innovation in DVA practice that engages families has started to emerge. [redacted] have introduced system wide innovation through restorative practice and extended their use of Family Group Conferences (FGC) to families experiencing DVA. Here, there are restorative practice conversations with families and FGCs are convened as a family-led decision-making forum that seeks to engage a wider family network to plan for the safety and welfare of women and children and engage men in the aftermath of violence.

Research aims.

This study aims to give families an opportunity to share their experiences of service responses in this context to help explore and understand what support families say would be most helpful. The research aims to include the voices of families that have

accepted an offer of an FGC and those that haven not. I am interested in hearing practitioners' experiences of working with families in this context too.
The research has been ethically approved by the University of Sheffield and [redacted]

As part of the research, I would like to talk to practitioners to;
Shadow practice to understand work with families in this context. Get help to recruit families that might be interested in being involved in the research.
Invite practitioners to be interviewed through a focus group setting (6-8 practitioners).

Eligibility criteria for family participants
Families are eligible to participate in the research where there has been an acknowledgement of DVA in the relationship, a commitment to stopping and relatively stable at current time.
Individual family members (parents aged 16 years and older and children aged from 9 – 18 years old) that have had contact with Children's Services where DVA has been identified as a factor.
Families affected by DVA that have accepted an offer of Family Group Conferencing (FGC)
Families affected by DVA that have not accepted the offer of FGC meeting and have had contact traditional child protection processes.
Participants with mental health difficulties where mental health symptoms are stable at the time of engagement with the research and have capacity to give informed consent.
Participants with substance use difficulties where there is a degree of stability and participants are not under the influence of alcohol or drugs or during a scheduled interview/ meeting and have capacity to give informed consent.
Inclusive of above and participants that have good standard of spoken English, Punjabi, or Hindi in order to communicate with the researcher and engage in the research.

Practitioner Focus Group
If you decide to take part, there will be two focus groups (1 hour) approximately three months apart; at the beginning and end of the research process. I'm hoping to talk to family group co-ordinators and social workers. I would be happy to have a chat with you to answer any questions you may have before you decide whether you want to take part.

With your permission, I would like to tape record focus group meetings. Only I will have access to the recording. I will transcribe the focus group interviews myself and they will be erased at the end of the study. All information collected will be kept strictly confidential and all notes and transcripts will be anonymised. You will not be identified in any subsequent written work or publications.

If you are interested in taking part and know of a family that might be interested in being approached to be involved, please contact me:
Email [redacted] **Mobile :** [redacted]

If you want to speak to someone else about the project or if you have any concerns about any aspect of this research, please contact my supervisors: Kate Morris or Robin Sen ([redacted]

Thank you for taking the time to read this information.

Appendix 7. Family Participant Consent form

Researcher: Permala Sehmar
Email: psehmar@sheffield.ac.uk
Telephone: 07568293064
University of Sheffield.
Elmfield, Northumberland Road
Sheffield S10 2TU

Families Speaking Project Consent Form

I have read and understand the information sheet.	*Yes* □	*No* □
I have been given the chance to ask questions about the project.	*Yes* □	*No* □
I agree to take part in the project.	*Yes* □	*No* □
I understand that my participation is voluntary. I am free to withdraw at any time without giving a reason. If I withdraw from the research, any information collected up to that point will still be used by the researcher.	*Yes* □	*No* □
I understand that there will be a £10 gift voucher for my involvement, to be given at the end of the interviews.	*Yes* □	*No* □
How my information will be used during the project		
I understand my personal details such as name, phone number and email address will not be passed onto to anyone other than the researcher, Permala Sehmar and supervisors (see below).	*Yes* □	*No* □
I understand that all information collected about me will be anonymised so that my identity will remain confidential. All audio recordings will be deleted once they have been typed up as anonymised transcripts.	*Yes* □	*No* □
I understand that my anonymised words and any visual work may be quoted and shown in reports, articles, presentations, and other research.	*Yes* □	*No* □
How my information will be used after the project I agree that only the anonymised data collected from me can be used in future reports, articles, web pages, presentations, and other research.	*Yes* □	*No* □
The data produced during this study will be stored and used in accordance with the Data Protection Act (2018), the Human Rights Act, as well as the University of Sheffield code of practice on Data Protection.	*Yes* □	*No* □

Name of participant *[PRINTED]*	*Signature*	*Date*
Name of researcher *[PRINTED]*	*Signature*	*Date*

If you would prefer to speak to someone other than me regarding this project, please contact my supervisor: Kate Morris kate.morris@sheffield.ac.uk or Robin Sen rsen.sheffield.ac.uk 01142226400

Appendix 8. Practitioner Consent form

The University Of Sheffield.

Researcher: Permala Sehmar
Email: psehmar@sheffield.ac.uk
Telephone: 07568293064
University of Sheffield.
Elmfield, Northumberland Road
Sheffield S10 2TU

Practitioner Consent Form

I have read and understand the information sheet.	*Yes* □	*No* □
I have been given the chance to ask questions about the project.	*Yes* □	*No* □
I agree to take part in the project.	*Yes* □	*No* □
I understand that my participation is voluntary. I am free to withdraw at any time without giving a reason. If I withdraw from the research, any information collected up to that point will still be used by the researcher.	*Yes* □	*No* □
How my information will be used during the project		
I understand my personal details such as name, phone number and email address will not be passed onto to anyone other than the researcher, Permala Sehmar and supervisors (see below).	*Yes* □	*No* □
I understand that all information collected will be anonymised so that my identity will remain confidential. All audio recordings will be deleted once they have been typed up as anonymised transcripts.	*Yes* □	*No* □
I understand that my anonymised words and any visual work may be quoted and shown in reports, articles, presentations, and other research.	*Yes* □	*No* □
How my information will be used after the project I agree that only the anonymised data collected from me can be used in future reports, articles, web pages, presentations and other research	*Yes* □	*No* □
The data produced during this study will be stored and used in accordance with The Data Protection Act (2018), the Human Rights Act and the University of Sheffield code of practice on Data Protection.	*Yes* □	*No* □

_____	_____	_____
Name of participant *[PRINTED]*	*Signature*	*Date*
_____	_____	_____
Name of researcher *[PRINTED]*	*Signature*	*Date*

If you would prefer to speak to someone other than me regarding this project, please contact my supervisor: Kate Morris kate.morris@sheffield.ac.uk or Robin Sen rsen.sheffield.ac.uk 01142226400