

# Exploratory Study of Support Worker Perception of Child Depression in Refuge

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## ABSTRACT

The current study aims to encourage research into depression in children and adolescents who attend refuge to avoid domestic violence. A mixed-methods design involved analysis of refuge case files and a focus group of refuge workers (n=7). The latter explored the perception of depression in children and adolescents. File information, including child characteristics, symptoms, and standardized depression screening scores, was held on forty-two children (7-18 years). Quantitative data were analyzed using descriptive statistics and ANOVA. A quasi-qualitative approach was used to analyze focus group data, including frequency counts of statements and codes. Results indicated 40% of children (n=17) fitted the criteria for depression, four times the general child population. Refuge workers emphasized that agencies need to recognize the harm children experience, the resultant depression, and the need for support beyond medication. Research needs to explore child and adolescent depression before and after entering refuge and include the child's perspective.

**Keywords:** Youth; Mental health; Wellbeing; Support; Professional services

## INTRODUCTION

Due to the lack of empirical studies, the current paper presents a small-scale study, that aims to establish the proportion of children and adolescents in refuge who are clinically depressed as well as to seek refuge workers views on how to address child and adolescent depression within the refuge. The paper examines literature related to the complexity of the definition of Domestic Violence (DV) for children and adolescents, the extent and nature of exposure to DV for children in the community, and the resultant symptoms and risks, particularly depression. Refuge, as a place of safety, is also set within the wider context of mental health services.

Domestic violence has been conceptualized as a human rights violation and a public health problem [1]. Despite DV being associated with non-engagement of services and poorer outcomes, the identification of domestic violence by mental health professionals remains limited [1]. Perhaps one reason for this is the wide range of definitions that exist for DV in policy, practice, and research. Within definitions, there is uncertainty regarding the nature of DV exposure, whether witnessed or experienced by children [2]. Harms by mother and father, violence between partners as well as perpetrator and victim violence are increasingly included [3]. More recently intimate partner and feminist

definitions include gendered partner violence on a continuum of a single event to ongoing abuse [4]. Angus Women's Aid, the organization in this study, defines DV within the wider concept of domestic abuse, as defined by the Scottish Executive. The latter being the political and funding context for refuge services in Scotland. The Scottish Executive defines DV as "gendered based violence that can be perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviors), sexual abuse acts which degrade and humiliate women and are perpetrated against their will, including rape), and mental and emotional abuse such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behavior such as isolation from family and friend" [5]. This is the definition used for this study.

## Exposure to DV

Historically, most DV studies focused on women's experience of harm. Dobash RE and Dobash RP [6], in their seminal work, identified the prevalence and impact of DV on women to the exclusion of children. One in three women were found to experience DV resulting in long term health, social, and economic consequences. More recently, children's experience of DV is increasingly recognized. Global estimates suggest 275 million

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children are exposed to DV [7]. A UK study of nearly three-thousand adults found 26% witnessed DV as children [8] and 40% of children and adolescents who witnessed DV also reported experiencing violence [9]. Even where children do not witness DV they can be aware of it and experience the threatening atmosphere [10]. Further, children and adolescents experience disrupted routines and moves of school, and home [11]. Stark, however, believes it is daily coercive control of intimidation, degradations, and isolation, rather than overt acts of violence, that do most harm [12].

### Resultant symptoms

Not surprisingly, given the enduring nature of DV, a wide range of symptoms have been identified for children and adolescents [13]. These include problems with toileting, sleep, emotional distress [14]; underachievement in school [15]; aggression [16]; substance misuse [17]; bedwetting, depression, suicide [18]; and trauma symptoms [19,20]. Symptoms vary with young children displaying crying, withdrawal, and regression, and adolescents more likely to run away, misuse substances, and use violent dating behavior [21]. Young children appear to be more vulnerable to DV, and for some, symptoms decrease with age [16]. Only one study to date has explored signs of mental health for children in refuge. Webb, Shankleman, Evans, and Brooks, in a study of 148 children and adolescents under sixteen, found half presented with mental health difficulties. Depression, however, was not specifically identified [22].

Developmentally, the impact of DV can differ for adolescents compared to younger children. Adolescent males tend to act out more, use substances, and non-attend school whereas adolescent females may be more withdrawn and engage in self-harm [23]. In relation to depression, Pelcovitz, Kaplan, DeRosa, Mandel, and Salzinger [24] found that physically abused adolescents who lived with DV (n=57) were more vulnerable than those who did not live with DV (n=97). Gender wise, although results of studies are mixed, Evans, Davies, and DiLillo [25] in a meta-analytic study found girls who experienced DV were more likely to experience depressive symptoms than boys. Moylan and colleagues in a longitudinal study of 457 youth identified that children who experienced the dual exposure of DV and child abuse were at higher risk of developing depression [3].

When symptoms are not addressed in childhood mental health problems can develop in later life, including chronic physical illness, depression, and anxiety disorders [9]. Remarkably, over fifty percent of children are resilient and find ways to cope. Strategies include talking to friends, seeking help from a teacher, and putting effort into activities beyond the home [26]. For some, protecting the abused parent is also part of coping [10]. Children who have a good attachment with at least one caring adult tend to show more resilience.

### Depression in the child population

Studies that explore child depression in the general population are helpful in placing depression in children in refuge into perspective. In the general population, prevalence rates range from 2-8% showing a spectrum from sadness, to severe depression to bipolar symptoms [27]. Small et al., found distinct internalizing and externalizing co-morbid responses with depression in adolescents

with internalizing adolescents more impaired in psychomotor and cognitive functioning [28]. Child depression is also associated with a greater risk of suicide [29]. It is unknown how being in refuge impacts on this risk. Empirically-based treatments for depressed children are scarce with an over-reliance on medication from social and health services. This is concerning as Bridge and colleagues [30] meta-analysis of adult and child depression studies found antidepressants increased rather than reduced suicidal ideation.

### Adult depression studies and risks in childhood

Studies relevant to child depression in the refuge include adult studies where risk factors for adult depression are identified in childhood. Powers et al., found stress in childhood increased the risk of adult depression in females [31]. Choi et al., in a study of young adults who witnessed DV in childhood, discovered an increased risk of depression as a result of the neurological change in the fiber pathways for processing emotion, memory, and learning [32]. Vulnerability increased between the ages of seven and thirteen. A longitudinal study of child maltreatment in fifteen thousand adolescents revealed exposure to abuse in the first five years increased the risk of depression and suicidal ideation in young adults. Finally, a meta-analysis conducted by Nanni, Uher, and Danese of sixteen epidemiological studies found that childhood maltreatment predicted persistent depression and poorer treatment outcomes in adulthood [33]. The above studies highlight the need to identify and address risk factors in childhood. The current study explores whether depression may be a risk factor for children in refuge.

### Refuge as a place of safety

Refuges take different forms across the world. Refuges in Scotland are safe houses where women and children, who are victims of DV, can live without fear for as long as they need to. In the US, they are often referred to as domestic violence shelters. In contrast, in Germany, there exist many different refuges; for women and children who experience domestic violence; for maltreated children; for those sexually abused; for girls threatened by forced marriage; and victims of trafficking, refugees, etc. In Scotland, the location of refuge is kept confidential to the refuge and government services, and a woman is placed in a refuge a safe distance from the perpetrator. In Scotland, women can escape to refuge at any time. Interestingly, in comparison to statutory agencies, women tend to report refuge as more supportive. This may be because of the shared experience as refuges are often run by those who have experienced DV themselves [34-36].

Despite increased access for children with their mothers to refuges in Scotland [37], there has been little research on the benefits for children. The small number of studies conducted in Scotland have, rather, focused on the quality of refuge facilities [38], the rates of re-housing for women [39], and the identification of children's needs during rehousing [37]. In the latter study, children were found to struggle with the sudden unpredictability of moving, and multiple losses, such as belongings, schooling, friends, and pets. Factors that positively mediated children's reactions included: having someone to trust, ongoing friendships, and active support from a safe parent. Fitzparick et al., [38], in a study of women and children's perceptions of refuge facilities, children reported that they felt safe for themselves, and their parents. Workers, support

spaces, other children, and trips were specifically identified as supportive. Mullender who explored child perception of DV and support found children valued having a worker to speak to who could support them in managing feelings [40]. Further protective factors include supportive mothers and extended family, and the importance of having somewhere to escape to. Challenges, however, have also been found for children in refuge. For children these include sharing facilities and the disconnection from friends, whereas adolescents can feel embarrassed about being in the refuge, and report insufficient age-appropriate activities [38]. Overall being safe in refuge outweighed the day to day difficulties, compared to the violence at home [11].

### Challenges for mental health services

Currently, the value of universal screening of women for domestic violence is being debated across mental health services in Scotland. As far as the authors are aware, no such debate exists for screening children. International guidance does suggest that women should be routinely asked about domestic violence, but again there is no mention of screening children and adolescents [41,42]. The relationship between screening and outcomes is, however, uncertain. Challenges also exist in enabling mental health professionals to acknowledge the nature and extent of violence against women. There is some evidence to suggest professionals can (i) fail to understand the power dynamics of abuse; (ii) know how to respond appropriately to disclosures; and (iii) know how to address the abuse itself [43,44]. Survivors, on the other hand want their experiences acknowledged and responded to [45]. Training in DV issues, however, appears to be insufficient to change mental health professionals' practice [46]. More promisingly, Read, Sampson, and Critchley's in a small-scale community health teams' study in the UK, found that the inclusion of DV prevention advocates within mental health teams did positively influence practice [47,48]. While these issues have begun to be explored for women receiving mental health services, this appears not to be the case for children and adolescents.

### The current study

Depression is a significant mental health risk for children in the short and long term. This is particularly so for children who experience the dual adversity of DV and child abuse. Although many studies have explored DV and child mental health, no studies have explored depression in children in refuge. Indeed, studies into refuge in Scotland are sparse. The current study sought to identify the extent of depression in children in one Scottish refuge and explore refuge worker perception of child depression for future research. The role of refuge workers in relation to mental health services is also considered.

## METHODS

### Research design

Mixed methods were used to explore depression in children in refuge. The refuge was located in a small Scottish coastal town. Analysis of organizational files included child characteristics including age, gender, home location, diagnosis of mental illness, and disability (the latter two factors were self-report by child or adult); family contexts; the nature of support work with children;

and scores from a standardized measure of depression. A focus group was held with refuge workers to assess their perceptions of depression in children. A quasi-qualitative analysis was applied to data to identify and rank order codes, and themes. Ethics permission was granted from a university research ethics committee requiring active informed consent.

### Organization

Angus Women's Aid (AWA), formed in 1978, has independent charity status. The service covers Angus's geographic area offering outreach services and temporary accommodation to women and children who experience DV. The majority of funding is provided by the Scottish Government. AWA's mission is to "make Angus a safer place to live so that women and children can realize their full potential" [49]. To achieve this, a wide variety of activities, refuge, and partnership working are provided. The organization comprises a Chief Executive Office, office manager, 9 paid workers, and 8 volunteers. The refuge operates seven apartments, with five for families of up to three children.

### Organizational files

Files included an electronic case management system with information on child characteristics and family contexts, and paper case files with information on support work. All information was anonymous. A framework for analysis was developed from five files that pre-dated the study. The framework included: an identifying number; child characteristics (age; gender; geographical location; mental illness; disability); the presenting problem (the reason for referral; reported symptoms) and standardized depression scores. Files also included the nature of violence experienced and by whom, however, this data was not utilized in the current study.

### Depression

The Burleson Depression Self Rating (DSRS) was a measure routinely used by AWA to identify potential depression and inform support [50]. Workers were not diagnosing depression, rather they were assessing whether a referral for depression was necessary. Workers considered depression to be a significant factor in children's responsiveness to treatment and wanted to utilize a measure to explore their perceptions in order to better respond to children's needs. Children were administered the DSRS by their support worker during the initial assessment meeting between worker and child. As far as the authors are aware this is the first study that has used this measure with children who have experienced domestic violence. The DSRS assesses depression from 8-14 years on 18 items over a 3-point scale (mostly, sometimes, and never). A cut-off of 15 and over signifies the likelihood of a diagnosis of depression. The DSRS has good internal validity with a Cronbach's alpha of 0.86 [51]. No other standardized measure was used and reported in files by AWA.

### Focus group

A focus group was conducted by the researcher, digitally recorded, and transcribed by a transcription company. The researcher checked the transcription for accuracy. Only paid workers with direct contact with children participated (n=7). Workers were from a range of social care backgrounds, with a child-care certificate,

diploma, or degree qualification. Not all refugees in Scotland have children's workers. This focus group was all experienced workers with at least 5 years experience in the refuge. Workers supported children of all ages and mothers, bearing witness to their experiences, offering emotional support, facilitating peer support, and helping mothers and children identify their needs holistically and problem-solve difficulties with their unique solutions. Workers also delivered personal safety and non-violent parenting programs. The focus group lasted 90 minutes. The focus group utilized a semi-structured interview format. Questions were generated from gaps in the literature and checked with Women's Aid CEO for relevance to practice. Workers were asked how they define depression; the challenges of depression; reasons for depression; how depression is assessed; the short and long-term consequences; how big the problem is; how children cope; and how workers help children cope?

### Analysis

Descriptive statistics involved collating the number of children, the population's age range, mean, and standard deviation, the proportion of male/females, and the frequency count and percentages of home location (rural/town) and self-reported mental illness and disability. The number of children likely to be clinically depressed, that is above the cut-off score, is reported in both number and percentage. Analysis of the standardized measure also involved ANOVA to assess the significance of moderating factors. Focus group data were analyzed using a quasi-qualitative approach developed by Bruan and Clark [52]. This involved a six-step process: familiarization of data; identification of codes from statements; review of statements and formation of codes; review and frequency count of statements, and codes, identification of themes; and rank ordering of codes. Report writing enabled finalization of codes and themes. Codes are reported using workers words and quotes are provided to exemplify the theme. Themes were identified from the data rather than theory-driven. Codes were labeled and reported in order of frequency of occurrence to evidence how often the issue was raised in comparison with other codes. Frequency counts, however, are not a measure of how important an issue (code) might be for the focus group. Inter-rater reliability was conducted by independent analysis and ratings by the principal investigator, a Professor in Trauma Studies, and the co-researcher, the Women's Aid CEO. The latter had extensive experience, over 20 years, in the refuge.

## RESULTS

### Sample characteristics

AWA files covered sixteen months. Data were available for 42 children equating to 2-3 children in refuge per month (Table 1). The average age was  $m=12.6$  ( $SD=2.81$ ), ranging from 7-18 years. Eight participants were aged 13(19%) and 11 years (19%), and 5 were 14 years (11.9%). There were 26 girls (61.9%) and 16 boys (38.1%). All were Scottish. Socio-economic status was not recorded. Five home locations were identified from files: one city, and four towns. Fourteen children had a self-reported but unspecified mental health difficulty (33.3%) and five (11.9%) had an unspecified disability.

### Extent of depression

The number of children who met the criteria for a potential diagnosis of depression was  $n=17$  (40%). The mean score was 11.76 ( $SD=6.16$ ), with a wide range of scores, 3-24. Children who did not spontaneously report symptoms at the initial AWA interview had significantly higher levels of depression  $F(6,35)=4.829$ ,  $p<0.01$ . No difference was found in depression for age  $F(11,30)=1.882$ ,  $p=0.83$ ; gender  $F(1,40)=0.021$ ,  $p=0.887$ ; geographical location  $F(4,37)=1.012$ ,  $p=0.414$ ; and disability  $F(1,40)=0.019$ ,  $p=0.891$ . There was no difference in depression whether a child was recorded as having a mental illness or not  $F(1,40)=1.701$ ,  $p=0.200$ .

### Defining depression

Inter-rater reliability of focus group data was high at 0.91. In making sense of depression, 11 codes were identified from 49 worker statements (Table 2). In order of frequency, codes indicated AWA workers perceived differences between agencies, not only in their recognition of depression ( $n=6$ ); but also their response ( $n=6$ ). On the one hand DV was seen as leading to loss of identity for children ( $n=6$ ), whereas other children were reported as not thinking they were depressed because daily violence was normal ( $n=6$ ). Workers were unsure of how children define depression ( $n=5$ ) and noticed that children struggled to trust and share experiences ( $n=5$ ). Poor child hygiene was frequently observed ( $n=5$ ) and children missed school and appointments ( $n=4$ ). Workers were concerned with professionals' over-use of medication ( $n=3$ ) and children's risky behavior ( $n=2$ ). In short refuge workers viewed "depression as difficult to define" ( $n=1$ ).

The theme identified was: uncertainty of what depression is for refuge workers, children, and professionals. Exemplar quotes include "A child's feeling quite low, and nurses are saying 'it's depression, and they need medication,' and that's the answer. I don't think that's fair."; "With abuse you lose yourself, you don't know who you are" and "I don't know how kids define depression; maybe they don't know what depression is, maybe they would define it as feeling sad."

### Challenges with depression

Eleven codes were identified from 50 statements indicated a wide diversity of challenges. These were: inappropriate service responses ( $n=8$ ); missed appointments for children because of lack of parental support ( $n=7$ ); the impact of DV all aspects of a child's life ( $n=6$ ); a professional over-focused on the mother's safety and as a consequence missing a child's mental health difficulties ( $n=5$ ); and children being blamed for the situation they're living in ( $n=5$ ). Worryingly, families who are geographically distant from services are being de-registered ( $n=5$ ).

Depression, within DV, is seen by the child and mother as normal ( $n=3$ ) and/or children are unaware they're depressed because they're

Table 1: Child characteristics.

No.	Mean age (SD)	Gender	Location	Mental illness	Disability
42	12.6 (SD=2.81)	26F (61.9%) 16M (38.1%)	1 City 4 Towns	14 (33.3%)	5 (11.9%)

F: Female; M: Male



Table 2: Worker perception of depression in children in refuge.

Question	Themes	Exemplar statement
Defining depression	Uncertainty for refuge workers and different professional views in defining depression.	"They're feeling quite low and they're not depressed, the nurses are saying it's depression, and they need to get medication and that's the answer. I don't think that's fair."
Challenges with depression	Invisibility of child depression leading to insufficient services' response.	"Because of how busy they are (medics) they're quite strict. If they're not able to attend their appointments because they've not got a structure, they're left in that same situation again."
Reasons for child depression	Pervasiveness of DV on every aspect of life.	"DV effects every aspect of life. Children are constantly thinking of it and worrying about it, and what they can do as well to help."
Assessing depression	A process involving child-led goals, needs and risks.	"It's giving them that choice. Something they've probably never had before. To think about what they're needing and wanting. Can be huge to focus on themselves and think."
Short term consequences	Depression is part of a cycle of harm that can have greater consequences after the abuse.	"It's continuous. They can be fine and then it gets to the point where something happens at home and they crash right down again. They've got no control over it because it's someone else's behavior."
Long term consequences	Lower self-esteem, increased vulnerability, lack of education, poor mental and physical health, and over-use of medication by services.	"Relationships in later life, we're talking about trust that's dented. Adults as well as children are impacted, from health professionals to school teachers, anybody."
Size of the problem (depression)	Huge problem and bigger than services appear to acknowledge.	"Bigger than health services would like to admit. It's a huge problem. There's a problem with education and mental health. There's not enough services."
How children cope with depression	Problem behavior is often children's way of coping.	"Self-harm, that is a huge one. They punch themselves in the head because they're so unhappy, and they're recognizing that's what they're doing as a way of coping."
How workers help children cope	Physically and emotionally safe relationships with choice and control.	"And if you want to tell you can, but it's giving that platform if they want to, they know. I think that's important to hand back some of that control, and some of that decision making to them."

so concerned for their parent (n=3). Workers thought refuge could refer more quickly to medical services (n=3) and that teachers are insufficiently aware that DV impacts school work (n=2). Workers were concerned that children experience alack control in DV (n=2) and a lack of services (n=1).

The theme identified was: the invisibility of child depression leading to insufficient service response. Exemplar quotes are "Children were not aware that they're depressed, because they're living with abuse so it becomes part of life"; "Because medics are strict, and children are not able to attend appointments because they've no structure from parents, they're left in that situation again"; and "Children could be doing everything to help themselves with depression but they're going back into what's causing the depression."

### Reasons for depression

The reasons for depression were captured in 11 codes were from 42 statements. Codes were: children experience multiple losses in life (n=9) as well as dissonance of not trusting, what is caring workers in the refuge (n=13). Children find themselves parentified looking after their mother and/or siblings (n=4) and worried about their safety (n=4). Agencies, on the other hand can over-focused on the parent and the child becomes invisible (n=4) whereas the children are entrapped in DV (n=2) with little control of what's happening (n=2). Children often hide DV (n=1) and can be psychologically in parts (n=1); lose their self-worth (n=1); with a sense that DV is endless (n=1).

The theme identified was: Pervasiveness of DV on every aspect of life. Exemplar quotes included "DV affects every aspect of life. Children are constantly worrying about it, and what they can do to help."; "They've got to hide everything, to be two different people and the loss of self-worth. You get to the point where you don't

know who you are"; "Young people who take on that caring role when dad leaves, they become adult, looking after siblings, and worry about safety."

### Assessing depression

Twelve codes were identified from 47 statements in relation to identifying depression: Firstly, workers find it difficult to judge if a child is depressed because of the lack of child and adult awareness (n=8). This is one of the reasons why a screening tool for depression and mental health is asked about safety plans (n=7). AWA, however, utilizes a needs-led assessment, not a diagnosis model (n=5); Review meetings raise awareness about depression and we aim to give children choice about what they can do (n=5). Children are asked indirectly about depression (n=4) as it's a challenge for children to trust and share (n=4). AWA support is about child-led goals (n=3); and what services children want (n=3). Refuge can contribute to professional understandings (n=3). For example, we now explicitly ask if a child is suicidal (n=2) and our review meetings help uncover depression (n=2), that is, signs of depression emerge over time (n=1).

The identified theme was: Assessment involves a process involving child-led goals, needs, and risks. Quotes included "Our support focuses on children and what they want with plans and feeling scales"; "On risk assessments, we speak about low moods, depression, suicidal thoughts, and self-harm"; and "It's giving them choice, something they've never had before, to think about what they need. It can be huge to focus on themselves."

### Short-term consequences

Five codes were identified from 47 statements highlighting workers perceptions of short term consequences of domestic violence and

depression [53]. Depression was seen as part of a cycle of harm that can have greater consequences after the abuse stops (n=14). Consequences were perceived to be severe, especially where a child is used to abuse the other parent (n=13). These consequences are also complex and not easy for workers to understand (n=10). Signs often include posttraumatic stress (n=7) and depression can appear to impact every aspect of life (n=3).

The theme was identified as “Depression is part of a cycle of harm that can have greater consequences after the abuse stops. Exemplar quotes include “Children don't want to go to school, they lack personal hygiene, isolate themselves, self-harm, have suicidal thoughts, engage in risk-taking, have flashbacks, bedwetting, and nightmares, and don't attend appointments”; “For younger kids, not wanting to leave mum, no life in them, no spark”; “It's continuous, they can be fine, and doing much work, and something happens at home, and they crash down again. Depression, they've no control because it's someone else's behavior that's impacting on them.”

### Long-term consequences

Twelve codes were identified from 103 statements referring to the long-term consequences of domestic violence and depression. The long-term consequences of depression were seen as pervasive. Codes were: often hearing reports that DV worsened with pregnancy (n=19) and that there is a lack of services and over-use of medication (n=15). Children get into a cycle of questioning and self-blame (n=14) and workers sense of a child's vulnerability (n=9). Children's education suffers (n=9), relationships are difficult to sustain (n=8) and the problems increase with age (n=7). There is a need for services to understand that lack of emotion is part of depression and a normal response to DV (n=7). Teenagers can too easily become dependent on medication (n=6); have poor mental health (n=5); and engage in risky behavior in young adulthood (n=3). Services need to focus more on the cause of problem, DV (n=1).

The theme was: Lower self-esteem, increased vulnerability, lack of education, poor mental health, and over-use of medication by services. Quotes included “Trust is dented with adults, children, and health professionals to school teachers. They become dependent on medication”; “For refuge, they've got a new school, and it takes a long time to settle. They might drop out, through no fault of their own.”; “As they get older it gets worse because they're chasing that high, it's more of everything, including abusive relationships. They blame themselves which impacts on confidence.”

### Size of the problem

Eighteen codes were identified from a high number of statements (n=124). The problem was seen as “huge.” Codes were categorized by stakeholder: Service's attitudes were seen to stigmatize and service responses were seen to get in the way of children seeking help (n=15). DV was perceived to be bigger than agencies admit (n=12) resulting in agencies failing to explore abuse, and instead focusing on symptoms (n=8). Agencies were reported as providing short-term responses (n=6) with symptoms being dismissed as age-related (n=3).

Parents were experienced as gate-keepers who could block support for a child (n=14). Parents were also described as presenting their own concerns first (n=11). Concern for workers was that children

under 12 years of age can't self-refer, so issues are often seen through the parents lens (n=8) and some parents' take risks with their child's mental health (n=6). Other parents abuse power (n=4) including not giving children a choice (n=2). Some parents avoid seeking help for their children (n=1) and can be more of a friend rather than a parent (n=1).

Children's depression was often noticed to kick in after they have moved out of the home (n=11), when children experience multiple losses (n=6); and then returned to an abusive situation (n=2).

Schools were seen as targeting the universal population, rather than providing specific support for individuals with depression (n=14). Schools were also seen as taking a short rather than long-term perspective on the problem of child depression (n=10).

The theme was: Depression is a huge problem and bigger than services acknowledge. Quotes included “Bigger than agencies would like to admit. It is a huge problem. There are not enough services”; “Medication's not tackling the reasons why it's happening. There are not long-term solutions”; “When they get out of that situation, that's when depression kicks in because there's no routine.”; “It's that stigma, ‘what have you got to be depressed about?’ How is the child supposed to recognize it and deal with depression, if it's unspoken.”

### How children cope

Thirteen codes were identified from 83 statements in response to being asked how children coped with depression from DV. A wide range of strategies were identified including: talking (n=13); art (n=10); bullying (n=9); self-harm (n=7); over-eating (n=7); playing on the computer (n=7); using feeling boxes to express emotions (n=7); avoidance of activities, people and places (n=7); soiling (n=5); sleeping (n=4); music (n=4); aggression (n=2); and substance use (n=1).

The theme was: problem behavior is often children's way of coping. Quotes included “A five-year-old admitted they punched themselves because they're so unhappy. They're recognizing when you're asking: ‘do you hurt yourself?’ that's what they're doing as a way of coping”; “Bullying, they want kids to hurt as much as they hurt.”; “A little girl, will do the toilet in her pants and hide it, as a control thing.”; “Avoidance, a girl makes animal noises to deflect questions”; and “Computer, which is dangerous, because they're making friends with inappropriate people. Avoiding reality. You can be who you want to be online.”

### Helping children cope

Eight codes were identified from 40 statements in relation to worker perception of how best to help children cope. Codes were: creating a safe space (n=9); giving permission to disclose and stay in control (n=8); being honest, working things through, and giving choices (n=6); preparing children for AWA activities (n=5); providing need-led support and activities (n=3); asking children what they want (n=3); building trust through confidentiality (n=3); and helping children think in different ways (n=3). The theme identified was: Physically and emotionally safe relationships with choice, and control. Quotes included “Some children may not have anyone they trust. They can't speak to family and they don't want to talk to friends as they might be seen in a different light”; “If

you want to tell you can. It's important to hand back control and decision making"; and "It's making sure they're ready for telling."

## DISCUSSION

The current study was the first in Scotland to identify the extent of potential depression in children in the refuge (from services data records) and explore worker perception of child depression from DV. Compared to community samples, the percentage of children recorded in refuge with depression was four times higher than in the general population [27]. If this is the pattern and if it occurs nationally, substantial numbers of children in refuge require support. It would appear then, there is a need for research to robustly measure the extent of depression in children in refuge in local and national contexts.

Records indicated depression rates could be similar for males and females, regardless of age. Previous studies, however, indicate that depression is higher in adolescence, and particularly for girls [54]. A gender factor was, however, identified with twice as many girls as boys in the refuge. Furniss [55] suggests women who have daughters seek refuge because they perceive girls to be at greater risk of sexual harm and boys may be less likely to want to be in refuge in the same way males avoid support services [56]. Future research therefore needs to assess (i) whether there is a differential impact on males and females who attend refuge; (ii) how this relates to child age and (iii) the reasons for more girls than boys in refuge.

Records also indicated three times as many children in refuge had mental health difficulties compared to the general population [57]. Similarly, one in ten children in the refuge was recorded as having a disability compared to one in twenty in the general population [58]. Although the lack of recorded information on mental health and disabilities limited analysis, it would appear depression may present within a cluster of symptoms. The validity and reliability of these tentative findings need to be tested.

Workers highlighted the uncertainty of what depression is, for children and refuge workers, as well as how different agencies hold different definitions, an issue mirrored in child depression studies [2]. Workers also perceived a lack of understanding for children in the relationship between DV and depression. For example, depressive feelings were perceived to become normalized as a consequence of living with violence, making it difficult for children to know whether they are depressed. Further, because of the coercive nature of DV, children were perceived to have little control over decision-making, and as a consequence did not have the sense of belief to be able to change their situation [12]. Future research needs to explore the challenges of definition for the multiple stakeholders involved in DV, refuge, and child depression.

Children's risky behavior and distrust of adults were perceived by workers to mask depression and inhibit children's disclosure of symptoms to professionals. In turn, perceived professional denial of DV and childhood depression was described as "double jeopardy of created vulnerability." Such perspectives were supported in another Scottish study where children were ambivalent and critical of statutory agencies [34].

Medical services, on the other hand, were felt to "like the label of depression" and were perceived to over-use medication. In this regard, workers were concerned about a superficial focus on

symptoms and "quick fix" solutions. For children in the refuge, the confusion around the signs of depression, the use of medication, and the identification of child protection issues are challenges that need to be addressed, especially if children are to feel safe in refuge [38]. As with the wider literature on DV, workers observed that medical and other agencies focused on the mother's rather than the child's mental health [2].

In addition to the problems of definition, professional attitude and response, structural issues for agencies were reported to create challenges in recognizing and addressing depression. The lack of available services, lengthy waiting times, and uncertain referral pathways were all mentioned, and seen as "greater in a rural context". The lack of flexibility of agencies to adapt to families' chaotic lifestyles, such as children not being able to attend appointments resulting in children's de-registration, was seen to "further compounding the situation." De-registration involved children's names being removed from medical support service lists resulting in no access to service provision. As previous DV studies have tended to focus on women's, rather than children's, the experience of health care professionals, the perceived differences in refuge worker and professional understandings of DV, depression, and appropriate responses for children need further examination [59,60].

Workers described the process of assessment with refuge as relational, contextual, shared, and over time. Workers did not see their role as a diagnosis. Rather, depression was seen as a tentative concept, set within assessment for a purpose with the child, and worker learning together. Child choice and control appeared to be embedded into decision-making, and workers believed "Assessment tools had a positive impact on children's mental health." Workers also highlighted the importance of focusing on what had happened to children and not just the symptoms, an issue echoed in child depression and trauma literature [61,62].

Refuge workers viewed depression as a "huge problem, bigger than health care, and social workers want to admit," and as a long-term problem. The complexity of responding to depression was highlighted through workers' perceiving an increase in the risk of depression following a child's "escape from violence." Cumulative losses were perceived to underpin this reaction. The familiarity of home; school and friends; self-worth, and loss of identity were identified. Although there is research on the consequences of DV on children's mental health [3], the specific pattern of depression in response to escaping to refuge has yet to be studied. Finally, workers perceived that problem behavior was often children's way of coping, a finding apparent in juvenile justice studies [62]. Children were observed to use positive coping strategies including talking to a trusted adult or peer. Further, social support was underlined by workers emphasizing caring relationships and choice as part of creating physically and emotionally safe environments [61]. Research therefore needs to focus on both the function of challenging behavior as a way of coping with DV as well as children's effective use of supports.

## LIMITATIONS

The current study focused on one refuge in a Scottish town. Findings from refuges in cities and rural settings may be different. The study focused on worker perceptions from one focus group, rather than

measured child behavior, that provided a group rather than an individual perspective. The analysis of records was limited by what data was available. The depression measure was not administered under research conditions and therefore questions are raised about the fidelity of administration and the reliability of the results. With only one measure, the comparison of mental health markers was not possible. As there was no adult standardized measure, no comparison was possible between child and adult symptom reports.

## CONCLUSION

The current study highlights the need for research into children and adolescents who may present in refuge with depression. Workers raised a complex of issues in seeking to understand the interactions between DV, depression, and the consequences of perceived limited responses from statutory services. In line with women's studies, a range of professional barriers to the identification of DV and depression were reported indicating a discrepancy between refuge worker mindsets and agency responses. Finally, the dynamics of DV and child depression were perceived to bring significant challenges for refuge workers in delivering effective services for children. Issues included child trust, lack of family structure and support, and children continuing to live in an abusive context.

## RECOMMENDATIONS FOR PRACTICE AND RESEARCH

Refuge may be a context to identify signs of child depression and other mental health markers in order to refer children onto services for help. Future research needs to focus on: the extent of child and adolescent depression before and after entering refuge; vulnerabilities that may be created by professional responses and parental behaviors; and the moderating factors of disability and mental health. Rigorous quantitative research designs are needed including large sample sizes and multiple standardized measures to compare depression with other symptoms. The inclusion of adult measures would provide a comparison with child reports. The unique child perspective should be included in qualitative studies and longitudinal evaluation would enable tracing of depression over time. Finally, evaluation is needed on the efficacy of refuge for child depression.

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