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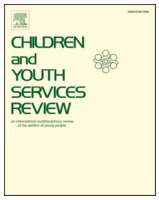

The impact of the healing together programme for children and young people affected by domestic abuse

Katie Cunneen [a,*], Asha Patel [b], Claire Fox [c]

[a] School of Psychology, University of Birmingham, Edgbaston, Birmingham, United Kingdom
[b] Innovating Minds CIC, Saint Nicholas Place, 81 The Green, Birmingham, United Kingdom
[c] School of Education, University of Bristol, Bristol, United Kingdom

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ABSTRACT

Background: Children affected by domestic abuse have a heightened risk of later mental health related difficulties due to their traumatic experiences. Development of trauma-informed support programmes which aim to develop a child's emotional understanding could offer an effective early intervention approach.
Objectives: The aim was to measure the impact of a trauma-informed intervention for children affected by domestic abuse. Intervention effectiveness was measured by tracking changes in emotional awareness at pre and post-test. Focus was placed on any interaction effects of delivery-method and age-of-child.
Participants and Setting.
In total, 327 children from the U.K. aged between 5–16 years who were involved in the Healing Together programme participated in the study. The programme took place within schools, youth organisations and early intervention services, between the dates of June 2021-June 2023.
Methods: The children completed the Emotional Awareness Questionnaire to measure Differentiating Emotions, Verbal Sharing of Emotions and Not Hiding Emotions before and after the programme.
Results: Immediately post-intervention, the Healing Together programme significantly increased children's ability to differentiate emotions, not hide emotions, and verbally share emotions. In addition, the effectiveness varied by age, and whether the intervention was delivered on a 1–1 or group-basis. The intervention appeared to be more effective on a 1–1 basis and for 5–10-year-olds.
Conclusions: The Healing Together programme was effective in increasing children's emotional awareness. This may have been due to the trauma-informed elements which allowed for a safe and co-regulating relationship to be established and the children to develop an awareness of how their body and brain work together when they are feeling unsafe.

1. Introduction

'Trauma-informed', although lacking a single definition, generally refers to any policy, intervention, or way of working which follows set principles known as the four R's (Bargerman et al., 2021; Wilson et al., 2017). These stand for, 'Realising' the widespread impact of trauma, 'Recognising' the signs and symptoms of trauma in clients/staff, 'Responding' by integrating knowledge about trauma into policies/practices, and 'Resisting re-traumatisation' (SAMSHA, 2014; Wilson et al., 2013). The Substance Abuse and Mental Health Services Administration (SAMSHA, 2014) also outlines six key-principles to conducting trauma-informed care (TIC): Safety; Trustworthiness; Peer-support; Mutuality and collaboration; Empowerment, voice, and choice; and Cultural, historical, and gender issues. When creating trauma-informed interventions, these principles act as a guide. TIC adopts various existing philosophies like the person-centred approach and quality-of-life theories, but extends beyond the helpee, to the helper and organisation (Keesler, 2014). The goal of TIC is to impart an understanding about trauma at a systemic, service level (Huckshorn & LeBel, 2013).

1.1. Domestic Abuse, Childhood, and Trauma-Informed care

Domestic abuse (DA) comes in many forms, including psychological, physical, sexual, financial, and emotional (United Nations, 2022).

* Corresponding author.
E-mail addresses: Katie.Cunneen@warwick.ac.uk (K. Cunneen), Asha@innovatingmindscic.co.uk (A. Patel), claire.fox@bristol.ac.uk (C. Fox).

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According to recent global studies and the World Health Organization (2022) it is estimated that up to 1 billion children aged between 2–17 years have experienced some form of domestic abuse within the past year (Hills et al., 2016). Exposure to abuse at a young-age is a risk-factor for multiple mental health disorders, such as depression, anxiety, and complex PTSD (Chandan et al., 2019; Cloitre et al., 2010; Springer et al., 2003). Early intervention is therefore pertinent to improve one's quality-of-life, enhance coping-skills, and potentially ending the cycle-of-trauma (Bartlett & Smith, 2019).

DA services typically revolved around empowerment and restoring a sense of choice, but concerns arose about the actual implementation of these goals (Goodman et al., 2015; Kulkarni et al., 2012; Kasturirangan, 2008). It was observed that some DA programmes moved from survivor-centred towards a more service-driven model, where support was constrained by predetermined criteria for success, and other shelters were observed to replicate coercive patterns of abuse such as strict curfews (Glenn & Goodman, 2015; Davies & Lyon, 2013; Goodman & Epstein, 2008). A renewed call for survivor focused services led to the adoption of TIC (Wilson et al., 2015; Goodman & Epstein, 2008; Kulkarni et al., 2012; Warshaw et al., 2003). Prior components, such as empowerment and peer-support, were reframed and new concepts of historical trauma and psychoeducation were integrated (Wilson et al., 2015). From this, three clusters of advances emerged: the promotion of emotional support, restoring choice/control, and facilitating connection (Wilson et al., 2015).

There has been a steadily growing body of literature depicting the effectiveness of TIC for child survivors of abuse. For example, a systematic review by Romano et al. (2019) pinpoints several effective trauma-informed therapeutic strategies, such as play therapy, child-parent psychotherapy, and psychoeducation, in tackling children's internalising and externalising behavioural symptoms (The National Child Traumatic Stress Network, 2025; Parker et al., 2021; SAMSHA, 2014). Another review by Howarth et al (2018) notes some successful methods to encourage readiness to engage in support, such as developing an understanding and identifying that abuse has occurred, as well as developing methods to articulate experiences, factors aligned with TIC methods (SAMSHA, 2014). Other reviews have noted the general effectiveness of TIC interventions for children's general wellbeing, following experiences of abuse (Zhang et al., 2021; Bunting et al., 2019).

Adopting TIC in DA settings can lead to considerable patient healing for both adults and children as well as greater professional satisfaction (Romano et al., 2019; Purkey et al., 2018; Howarth et al., 2018). TIC methods may help reduce symptoms of PTSD and other mental health disorders, and the risk of re-traumatisation (Wilson et al., 2015). Due to the risk of later mental health disorder onset after experiencing DA in childhood, intervening-early is essential (Silverman et al., 1996).

1.2. Emotional awareness

Emotional awareness refers to the ability to conceptualise our own and others' emotions (Lane & Smith, 2021). Experiencing DA in childhood has been associated with significant negative effects on emotional and behavioural functioning (Evans et al, 2008; Kitzmann et al., 2003). Katz et al. (2007) found that exposure to intimate partner violence at a young age actively reduced later development of emotional awareness. With the evidence suggesting the impact DA can have on a child developing emotionally it seems relevant to target emotional awareness development within interventions.

1.3. Delivery-Methods and Age-Groups: Impact on intervention outcomes

Limited research has explored intervention modality (group or one-to-one format) in relation to intervention effectiveness for children. For instance, 1-to-1 programmes may help improve autistic children's general symptoms and language expression more so than groups and could also improve child pro-social behaviours (Malero et al., 2021; Tachibana et al., 2018). However, group-interventions can offer opportunities for learning adaptive behaviours through participation in group activities and may be more cost-effective (Cotugno, 2009). Regarding children affected by DA, there is little research favouring one modality over another. A major consideration is the intervention itself. CBT, talking therapies, trauma-informed and relational interventions focus on distinct aspects of the 'issue', addressing them based on their accepted ontology. It is therefore imperative to understand delivery-method differences for each intervention being assessed so that the most accurate conclusions can be drawn.

It is accepted that children of different ages demonstrate diverse functioning and behavioural responses to DA with varying signs, symptoms, developmental, psychological, and behavioural impacts (Fantuzzo & Mohr, 1999; Osofsky, 1995). Despite this understanding, little research focuses on how these could impact intervention effectiveness. However, suggestions that younger children have better symptom reduction through intervention than older children have been made, which highlights the importance of early intervention (Lock & Barrett, 2003). It is therefore important for any intervention to assess its effectiveness for the age demographics it intends to support.

As very little research has focused on any age and delivery method differences relating to intervention outcome for children affected by DA, understanding how all factors may interact is clouded. Individual differences in age and delivery are important factors to understand when designing interventions and programmes, to ensure the best outcomes.

1.4. The healing together programme

The Healing Together programme was developed in 2020 and has been utilised across the U.K. with over 1000 facilitators who already work therapeutically with children affected by DA. Facilitators receive 17 h of training, access to ongoing coaching, and on demand CPD sessions to support them with the implementation of the programme. The programme covers 6-sessions, delivered on a weekly basis, with each session lasting approximately 45 min. Facilitators conduct a pre-assessment prior to delivering the programme to identify whether the child requires a 1–1 or group-based modality. The programme is designed to encourage collaborative discussion, which, within the group modality can be done between children, and in the 1–1 modality can be completed between child and facilitator. The Healing Together programme is designed to be offered flexibly based on the needs of the child, as well as the resources available to the organisation offering the programme. Facilitators are also given coaching sessions to ensure they maintain course principles and structure when utilising different modalities.

The Healing Together programme avoids using cognitive behaviour therapy approaches as it is noted that some complex trauma patients can be resistant to this, and neuroscientific researchers suggest trauma cannot be cognitively processed (Niles et al., 2018; Van der Kolk, 2015; D'Andrea & Pole, 2012). Instead, the Healing Together programme uses neuroscientific, attachment, and relational theories as its foundations. The evidence-base includes the Polyvagel Theory (Porges, 2001), Hand Brain Model (Siegel, 2012), Neuro-Sequential Model (Perry & Dobson, 2013), and Safe Relational Experiences (Perry, 2013). Furthermore, many TIC principles are incorporated, such as ensuring physical/emotional-safety, establishing trust, understanding peer-support, and creating collaborative environments. Importantly, the programme does not ask children to talk about their traumatic experiences to minimise the risk of re-traumatisation (Innovating Minds, 2022). The programme is designed to be implemented over six-sessions by one-or-more members of the school/organisation's staff, for children affected by DA. These are done via groups or 1-to-1 (Delivery Method), for both primary (ages 5–10 years) and secondary (ages 11–16 years) children (Age of Child). The programme has not been studied extensively previously.

The Healing Together programme utilises the body-based approach, which revolves around how our emotions physically feel and

recognising them (van der Kolk, 2014). Another aspect of the programme involves children recognising what happens to their brain when their body is feeling unsafe and learning discreet body-based strategies (i.e. breathing exercises) to help their body and brain to feel and be safe and calm. Both characteristics aim to help the child improve their own emotional awareness and regulation. Innovating Minds, who developed Healing Together and train facilitators, offer manuals, worksheets, and trauma informed video animations to aid the delivery of Healing Together. All above information is available on the Innovating Minds impact report and information pertaining to the copyrighted programme are available via the Innovating Minds webpage (https://www.innovatingmindscic.com/).

1.5. Rationale, aims, and hypotheses

TIC arose from the need to see behaviour in the context of trauma and to understand why individuals may act in the ways they do due to past traumatic experiences (Taft et al., 2017; Smithgall et al., 2013). Cognitive and established therapies that treat trauma-related disorders are often ineffective for some individuals due to their complex nature of symptoms (Niles et al., 2018; D'Andrea & Pole, 2012; Bradley et al., 2005). From this, Innovating Minds developed the Healing Together programme as a potentially viable solution for children affected by DA.

There is limited knowledge around how factors such as delivery-method, and age-of-child interact with intervention effectiveness. This is important to understand as they can be modified by recommending specific formats for specific age-groups, depending on what the findings may suggest. It was predicted that there would be significant improvements in children's emotional awareness from pre to post-test. In addition, possible interactions with age-group and delivery-method were assessed.

This study was designed as part fulfilment of an MRes qualification. The primary author of this paper had no part in the development or design of the programme. The secondary author of this paper is the CEO of Innovating Minds and founder of the Healing Together programme, and the third author acted as a research advisor.

2. Methodology

All data used within the research is secondary data collected by Innovating Minds whose data collection is ongoing. Innovating Minds have an online platform where facilitators access resources, including the questionnaires used to assess children's emotional awareness. The children complete these pre-and-post-programme which facilitators then submit to the platform, where they are anonymously analysed (facilitators assign children a unique participant code). Data were anonymous and secondary in nature, however consent from facilitators was taken for the final included sample. Children and guardians gave initial consent through their facilitators and Innovating Minds for the child(ren) to take part in the Healing Together programme, and have their data recorded and published by Innovating Minds. Facilitators gave secondary consent for data to be published in academic journals.

2.1. Participants

Children receiving the Healing Together programme were identified using a convenience-sampling method by the school/organisation as requiring support. The only inclusion criteria were to be 5–16 years old (school age) and have been referred for DA. Children were referred by the existing services referral pathways, for example early help teams would have received referrals from children in need plans, and schools would have referred children if DA was identified via safeguarding processes or data shared via the police (such as Operation Encompass). During this process the consent forms and pre-assessment would have been completed before the Healing Together programme commenced.

A preliminary power-analysis using G*Power version 3.1, with alpha set at 0.05 and power at 0.80. revealed a sample of N = 113 as acceptable to reach adequate power. The final sample was $N = 437$. From this, a total of $N = 110$ were removed for incomplete data. Only $N = 54$ of these datasets were missing pre-or-post-emotional awareness data (as opposed to grouping data – Age or Delivery-Method), meaning the drop-out rate was 12.4 %. See Table 1 for sample breakdown. The final sample was $N = 327$. Children were offered the programme on a group or 1-to-1 basis based on the child's need at pre-assessment (conducted by the facilitator) and the resources available to the organisation. Children received the Healing Together programme from various sources, illustrated in Table 2.

2.2. Materials and procedure

Innovating Minds selected the Emotion Awareness Questionnaire (EAQ) (updated version) by Rieffe et al. (2008) to measure the impact of the programme in increasing levels of Emotional Awareness. Only three constructs from the original six are actively utilised by Innovating Minds: Differentiating Emotions, Verbal Sharing of Emotions and Not Hiding Emotions. The EAQ and these constructs were chosen as they coincide and relate to the TIC outcomes of interest, which are understanding and differentiating between emotions, and being able to share emotions with trusted others. The EAQ and chosen constructs were also reviewed and approved by an expert in childhood trauma and DA at Manchester Metropolitan University, for their reliability, validity, and suitability for the programme's intended outcomes. This scale can also be used with the wide age range covered by the programme (5–16-years-of-age). The EAQ constructs used show adequate Cronbach-alpha scores ranging from $\alpha = 0.68$ to $\alpha = 0.77$ (Rieffe et al., 2008). The questionnaire was designed for young children to be able to engage and answer questions themselves with the support of facilitators where necessary. For instance, some of the youngest children may have needed a facilitator to help them read aspects of the question. The data utilised in this study was collected between June 2021 and June 2023.

As almost all participants were below 16-years-of-age, Innovating Minds gathered initial consent from parents/guardians with secondary assent from children, as per BPS (2018a) guidelines. Both the child and parent/guardian could withdraw this consent at any time. Before the first session, children were asked to complete the EAQ and then again immediately after the last session at week six (pre-post design). Facilitators created participant numbers and submitted the data to Innovating Minds, alongside information about the child's age, and delivery method.

2.3. Data analysis

The hypotheses were tested using a mixed within/between, Multivariate Analysis of Variance (MANOVA). The MANOVA followed a 2x2x2 design: Delivery Method (Group x 1-to-1) x Age of Child (5–10 x 11–16) x Time (pre x post Healing Together) and was completed using IBM SPSS version 26.

2.4. Ethics

The study was granted ethical approval by the University of

Table 1
Final sample breakdown.

Group	Category	*N*		
Delivery-Method	1:1	136		
	Group	191		
			Mean	Standard Deviation
Age-of-Child	5–10	214	8.19	1.40
	11–16	113	12.50	1.40
	All Ages	327	9.60	2.40

Note: All decimals shown to the nearest one-decimal-point; *N*=Sample Size.

Table 2
Delivery organisation breakdown.

Organisation Type	*N*	Percent of Whole Sample
Primary School	17	5.20 %
Secondary School	6	1.84 %
Council or Local Authority	153	46.89 %
Charity	87	26.61 %
Private Company	38	11.62 %
Not-For-Profit Community Interest Group	22	6.73 %
Freelance/Independent	3	0.92 %
Unknown	2	0.61 %
	Total = 327	

Note: Percents shown to the nearest two-decimal points; *N*= Sample Size.

Birmingham's Ethical Review Committee and was conducted in compliance with BPS 'Code of Ethics' (2018b).

3. Results

3.1. Reliability tests

The EAQ underwent Cronbach's alpha testing to ensure internal consistency met the standards required (Churchill, 1979). Cronbach's alpha scores ranged from 0.61 to 0.77 and all age and construct breakdowns are shown in Table 2. All scores similarly reflected the reliability statistics in the original primary/secondary samples used by Rieffe et al. (2008) and no deletions would result in substantial changes to alpha scores. It is important to note that the scores for 5–10 year-olds were below the 0.70 level considered satisfactory (See Table 3).

3.2. Descriptive statistics

Demographic information was obtained, however, due to no pre-set list of ethnicities, many responses could not be adequately coded resulting in 46 missing responses. From data that could be categorised, the sample was majority white ($N = 224$, 68.5 %). The gender and age breakdowns can be seen in Table 4.

3.3. MANOVA

A mixed 2 x 2 x 2 MANOVA was used (time x delivery method x age) with the three dependent variables of not hiding emotions, verbal sharing of emotions and differentiating emotions. Prior to running the MANOVAs, the assumptions were checked, including homogeneity of covariance matrices, normality (i.e. multivariate outliers), multicollinearity, and linearity. All the assumptions were met. See Table 5 for all means and standard deviations.

The results are presented with the results for the MANOVA first, followed by the univariate tests for the three dependant variables. We then present follow-up analyses to unpack the significant 2-way interactions.

Firstly, there were main effects for time [Wilks' Lambda = 0.86, $F(3,321) = 17.76$, $p < 0.001$, ŋ2p = 0.142] and age [Wilks' Lambda = 0.94, $F(3.321) = 6.41$, $p < 0.001$, ŋ2p = 0.057]. There were also significant 2-way interactions for age x time [Wilks' Lambda = 0.97,F (3.328) = 2.66, p = 0.048, ŋ2p = 0.024] and delivery method x time [Wilks' Lambda = 0.96, $F(3,321) = 4.68$, $p = 0.003$, $\eta^2p = 0.042$].

The univariate tests showed that there was a significant effect of time for not hiding emotions [$F(1,323) = 37.61$, $p < 0.001$, $\eta^2p = 0.104$], verbal sharing of emotions [$F(1,323) = 21.44$, $p < 0.001$, $\eta^2p = 0.062$], and differentiating emotions [$F(1,323) = 29.95$, $p < 0.001$, ŋ2p = 0.085]. The results show an increase in children's emotional awareness across all three dependant measures from pre- to post-test.

There was also a main effect of age for not hiding emotions [$F(1,323) = 18.44$, $p < 0.001$, $\eta^2p = 0.054$] and verbal sharing of emotions [$F(1,323) = 7.62$, $p = 0.006$, $\eta^2p = 0.023$], The age effect for differentiating emotions was not significant [$F(1,323) = 1.80$, $p > 0.05$, $\eta^2p = 0.006$]. These effects were qualified by significant 2-way interactions for age x time for not hiding emotions and verbal sharing of emotions [$F(1,323) = 5.80$, $p = 0.017$, $\eta^2p = 0.018$ and $F(1,323) = 4.87$, $p < 0.028$, $\eta^2p = 0.015$ respectively]. The 2-way interaction for differentiating emotions was not significant [$F(1,323) = 2.44$, $p > 0.05$, $\eta^2p = 0.007$].

Follow-up analyses for time x age for not hiding emotions and verbal sharing of emotions showed there was an effect of time for not hiding emotions for both age-groups ($p < 0.001$ for 5–10 years and $p = 0.022$ for 11—16 years), but the mean difference was larger for 5–10 year olds compared to 11–16 year olds. For verbal sharing of emotions, the effect of time was significant only for the 5–10 year olds ($p < 0.001$) and not for 11–16 year olds ($p > 0.05$). This suggests that the intervention had a greater effect for the younger age-group.

There were significant 2-way interactions for delivery method x time for not hiding emotions and verbal sharing of emotions [$F(1,323) = 6.98$, $p = 0.009$, $\eta^2p = 0.021$ and $F(1,323) = 11.63$, $p < 0.001$, $\eta^2p = 0.035$ respectively]. The 2-way interaction for differentiating emotions was not significant [$F(1,323) = 1.12$, $p > 0.05$, $\eta^2p = 0.03$]. For not hiding emotions, there was a significant effect of time for 1–1 ($p < 0.001$) and group-based, ($p = 0.007$) but 1–1 had a larger mean difference. For verbal sharing of emotions, only 1–1 was significant [$p < 0.001$] and not group-based ($p > 0.05$). Thus, the results suggest that the intervention had a greater effect when delivered on a 1–1 basis.

Table 3
Cronbach's alpha breakdown.

Construct	Age Group	α
Differentiating Emotions	5–10	0.62
	11–16	0.77
Verbal Sharing of Emotions	5–10	0.61
	11–16	0.70
Not Hiding Emotions	5–10	0.66
	11–16	0.73

Note: All decimal places shown to two decimal points; α=Cronbach's alpha.

Table 4
Gender and age breakdown by referral-reason & delivery-method.

Between-Factor IV's	Female	Male	5–10-Year-Olds	11–16-Year-Olds
Overall sample (*N* = 327)	*N* = 154 (47 %)	*N* = 173 (65 %)	*N* = 214 (65 %)	*N* = 113 (35 %)
Group Delivery-Method (*N* = 191)	*N* = 93 (49 %)	*N* = 98 (51 %)	*N* = 112 (66 %)	*N* = 65 (34 %)
1-to-1 Delivery-Method (*N* = 136)	*N* = 61 (45 %)	*N* = 75(55 %)	*N* = 88(65 %)	*N* = 48 (35 %)
5–10-Year-Olds (*N* = 214)	*N* = 99 (46 %)	*N* = 115 (54 %)		
11–16-Year-Olds (*N* = 113)	*N* = *55* (49 %)	*N* = 58 (51 %)		

Note: Percentages shown to the nearest whole-percent; *N* = sample size; IV = Independent Variable.

4. Discussion

This study set out to assess the Healing Together programme's overall effectiveness for helping children affected by DA. The findings suggest the Healing Together programme is effective in increasing children's emotional awareness (for Differentiating Emotions, Not Hiding Emotions and, Verbal Sharing of Emotions), immediately after programme delivery. Increased emotional awareness for children generally has positive impacts, such as better interpersonal functioning (Mancini et al., 2013). However, children who have experienced trauma usually have reduced emotional awareness due to emotional dysregulation and attachment difficulties, and focusing on this area within this

Table 5
Means (and standard deviations) for time by delivery method and age.

	5–10 years		11–16 years		Total	
	Pre	Post	Pre	Post	Pre	Post
DE						
1–1	13.49	15.10	12.90	14.25	13.28	14.80
	(2.91)	(3.06)	(3.17)	(3.30)	(3.00)	(3.16)
Group	13.17	14.31	13.40	13.91	13.25	14.17
	(3.00)	(2.94)	(3.36)	(3.58)	(3.07)	(3.17)
Total	13.30	14.64	13.19	14.05	13.26	14.43
	(2.96)	(3.00)	(3.28)	(3.45)	$(3.07)_a$	$(3.17)_a$
NHE						
1–1	9.14	10.82	8.17	9.35	8.79	10.30
	(2.48)	(2.28)	(2.57)	(2.60)	(2.55)d	$(2.44)_d$
Group	9.15	10.26	8.78	8.82	9.03	9.77
	(2.62)	(2.73)	(2.27)	(2.35)	$(2.52)_e$	$(2.69)_e$
Total	9.14	10.49	8.52	9.04	8.93	9.99
	$(2.57)_b$	$(2.55)_b$	$(2.41)_c$	$(2.46)_c$	$(2.53)_f$	$(2.16)_f$
VSE						
1–1	5.19	6.33	4.71	5.38	5.02	5.99
	(1.77)	(1.60)	(1.50)	(1.60)	$(1.69)_h$	$(1.68)_h$
Group	5.49	5.89	5.57	5.45	5.52	5.74
	(1.71)	(1.68)	(1.84)	(1.72)	(1.75)	(1.60)
Total	5.37	6.07	5.20	5.42	5.31	5.84
	$(1.74)_g$	$(1.62)_g$	(1.75)	(1.69)	$(1.74)_i$	$(1.67)_i$

Means in a row or column sharing a subscript are significantly different.

demographic is essential (Cook et al., 2005). Additionally, when emotional awareness increases, better development of emotional intelligence can occur, with the latter linked to better interpersonal-relationships and improved-overall-health (Castilho et al., 2016; Ogilvie & Carsky, 2002). Moreover, those with higher emotional intelligence are better able to manage/mitigate stress (Drigas & Papoutsi, 2020), which is a known risk-factor for the development of many mental health related symptoms, from which individuals impacted by trauma have an increased risk of developing (Chandan et al., 2019; Springer et al., 2003). Therefore, these data suggests that the Healing Together programme can act as an early-intervention strategy, to help the healing from trauma and reduce the later-risk of these children developing mental health issues through increased emotional awareness delivered through a TIC approach (Rackoff & Newman, 2020; Bartlett & Smith, 2019).

From examining the interactions, it was found that 1:1-delivery was generally more effective than group delivery when increasing NHE and VSE, immediately after programme delivery. In addition, the programme appears to be more effective for 5–10-year-olds when assessing NHE and VSE. This could be due to younger children generally having a lower baseline than older children regarding emotional awareness, which could account for the greater increases in emotional awareness suggested here (Lane & Smith, 2021). Neither delivery method nor age group impacts the increase in DE immediately after programme delivery. This suggests there are more effective routes to use when working with specific ages/delivery methods, but overall, the programme is effective in increasing emotional awareness immediately after programme delivery.

4.1. Effect of age

Interaction effects suggest that younger children's emotional awareness increased to a more significant degree, particularly for NHE and VSE. It has been noted that younger children (aged between six-twelve) affected by DA develop a more sophisticated emotional awareness of the self and others, whereas older children tend to use disengagement and other adaptive coping mechanisms to manage their situations (Holt et al., 2008). This could explain the greater increases in emotional awareness for younger children. This may be because younger brains are more malleable to development or the process of neuroplasticity (Asby, 2018). The process and trauma-informed elements of the Healing Together programme could create the 'sweet spot' of neuroplasticity, enforcing the values of collaboration and safe relationships (Stewart et al., 2016). Here parts of the pre-frontal cortex responsible for emotional awareness may have been positively impacted throughout the sessions (Teicher & Samson, 2016), allowing for neuroplasticity in younger brains.

4.2. Effect of modality

Interaction effects suggest that the 1-to-1 intervention modality increased emotional awareness to a more significant degree than group modalities, particularly for NHE and VSE. Qualitative research by Stanley et al (2012) suggest that children who have been affected by DA experience barriers to disclosure such as stigma, shame and embarrassment. Additionally, DA can have negative side-effects including anxiety and fear, which continues the secrecy surrounding the violence and abuse. It therefore seems understandable that children may prefer to access support in a 1-to-1 setting over a group setting, at least in the initial stages. However, 1-to-1 settings limit the possibility of peer-support, a corner stone of the trauma-informed approach (SAMSHA, 2014) and so providing a positive help-seeking experience on a 1-to-1 basis may support these children to access group-based support in the future.

4.3. Impacts on TIC

Many accepted/mainstream TIC interventions follow the cognitive paradigm (such as TF-CBT/EMDR), which adopts some TIC values and principles (Hodas, 2006). Nonetheless, these interventions suffer due to the constrained ontological and epistemological approach. For instance, they ignore inferences that trauma is not cognitively processed, and much data pertaining to their 'success' focus on statistically significant changes instead of meaningful symptom reduction (van der Kolk, 2015). Non-cognitive alternative-interventions free themselves from these pitfalls, however, they tend to be longitudinal, requiring continued patient motivation (such as ARC), or are only appropriate with small age ranges (such as PC-CARE) (NCTSN, 2018, 2012). The Healing Together programme is distinct from the cognitive mainstream and does not share the same weaknesses as other non-cognitive alternatives. For instance, the programme is only six sessions and is designed for children aged between 5–16, covering a large portion of childhood/adolescents.

4.4. Limitations

There are important limitations to discuss. Although falling in line with previous EAQ-scores, and within Churchill's (1979) standards, the Cronbach's alpha scores did not meet various other guidelines stating 0.70 to be the lowest adequate-level (DeVellis, 2003; Nunnally & Bernstein, 1994). Nonetheless, Cronbach's alpha has been critiqued for its susceptibility to skewedness and multidimensionality among other issues, and appropriate alternatives, such as omega have been presented (Hayes & Coutts, 2020; Trizano-Hermosilla & Alvarado, 2016). However, when conducting omega, the results were only slightly higher, still below some guidelines and factor analysis tests did not show outliers within-constructs. These 'low' scores could be due to many factors such as, low number of questions, poor interrelatedness between items, or heterogeneous constructs, and can severely weaken the reliability of data produced (Tavakol and Dennick, 2011). This can have implications for the above findings and is worthy of further investigation.

There was also a lack of control group to provide a critical comparison and help increase power and limit bias (Malay & Chung, 2012). Therefore, the absence of the control group means we cannot assess what would occur in the absence of the intervention, or whether children's emotional awareness increased by chance (Moley, 2020). However, due to the sampling constraints and ethical considerations, having a control group was not possible for the current study, but future research may wish to assess this further and within ethical guidelines, such as comparing to a waitlist control. Additionally, a convenience sampling technique was used, whereby facilitators who felt the programme could be beneficial for the children utilising the service, referred those children based on their availability to participate in the research. The largest drawback of such as approach is the introduction of sampling bias into the research (Golzar & Tajik, 2022).

A further weakness is that no delayed follow-up tests were completed. This was due to risks associated with maintaining contact with families who may continue to be victims of domestic abuse, and many organisations who offered the programme, such as some of the charitable organisations, do not maintain contact with families once they have completed the programme. This means claims can only be made on the increase of emotional awareness immediately following programme delivery.

An additional weakness is the sole focus on only emotional awareness, which excludes other psychological and behavioural factors, which limits the conclusions of the findings in terms of the impacts on other potential outcomes. Pilot studies of the programme contained more measures such as the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997; Goodman et al., 1998), however, both facilitators and children reported that there were too many outcome measures, and they were not being completed appropriately by children. Therefore, only emotional awareness was measured.

4.5. Conclusion

Without minimising the critiques discussed above, the data suggests the Healing Together programme increased the emotional awareness of children who had been affected by DA, immediately after the programme was delivered. The programme may be more effective for younger children, denoting the importance of early intervention, and may also be more impactful when conducted on a 1:1 basis. Future research could also benefit from triangulating methods such as observational and/or qualitative data, as well as monitoring other facets of psychological and behavioural symptoms presented in children affected by DA.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

Data will be made available on request.

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