Linnaeus University Dissertations
No 315/2018

Karin Pernebo

Children in group interventions after exposure to violence toward a caregiver

– Experiences, needs, and outcomes

LINNAEUS UNIVERSITY PRESS

Children in group interventions after exposure to violence toward a caregiver

– Experiences, needs, and outcomes

Linnaeus University Dissertations

No 315/2018

CHILDREN IN GROUP INTERVENTIONS AFTER EXPOSURE TO VIOLENCE TOWARD A CAREGIVER

– *Experiences, needs, and outcomes*

KARIN PERNEBO

LINNAEUS UNIVERSITY PRESS

Children in group interventions after exposure to violence toward a caregiver – Experiences, needs, and outcomes
Doctoral Dissertation, Department of Psychology, Linnaeus University, Växjö, 2018

ISBN: 978-91-88761-45-3 (print), 978-91-88761-46-0 (pdf)
Published by: Linnaeus University Press, 351 95 Växjö
Printed by: DanagårdLiTHO, 2018

Abstract

Pernebo, Karin (2018). *Children in group interventions after exposure to violence toward a caregiver – Experiences, needs, and outcomes,* Linnaeus University Dissertations No 315/2018, ISBN: 978-91-88761-45-3 (print), 978-91-88761-46-0 (pdf). Written in English with a summary in Swedish.

This thesis consists of three empirical studies, all part of the same research project, with a general aim to explore interventions for children exposed to intimate partner violence (IPV). Because witnessing violence toward a caregiver is associated with negative impact on children's health and development, effective interventions for children exposed to IPV are necessary.

The aim of Study I was to elucidate young children's experiences of participating in group interventions for children exposed to IPV. Nine children, aged 4 to 6 years, were interviewed after participating in group programs designed for children exposed to IPV. The interviews were analyzed using interpretative phenomenological analysis. Five master themes embracing the children's experiences were identified: joy; security; relatedness; talking; and competence.

The aim of Study II was to investigate young children's accounts of their abused parent. Interviews were conducted with 17 children between 4 and 13 years old who had witnessed IPV. Thematic analysis identified three main themes: coherent accounts of the parent; deficient accounts of the parent; and parent as a trauma trigger.

Study III was an effectiveness study investigating the outcomes of two group interventions for children exposed to IPV and their non-offending parent: one psycho-educative community-based intervention (CBI) and one psychotherapeutic treatment intervention. The study included 50 children between 4 and 13 years old and their mothers. Child and maternal mental health problems and trauma symptoms were assessed before and after treatment. The results indicate that although children benefited from both interventions, symptom reduction was larger in the psychotherapeutic intervention. Despite these improvements, most of the children's mothers still reported child trauma symptoms at clinical levels post treatment. Both interventions, however, significantly reduced maternal post-traumatic stress.

The results showed that children generally appreciated and benefited from both interventions studied, but most still showed symptoms at clinical levels post treatment and a possible need for additional and/or different support and interventions. These results indicate not only the need for continuous and post-treatment assessment of children's symptoms in routine clinical practice, but also the value of including children as informants in research.

Keywords: Children, Intimate partner violence, Children's experiences, Post-traumatic stress, Treatment, Qualitative research, Outcome research

Sammanfattning

Att som barn bevittna våld mot en förälder är förknippat med negativ påverkan på barns hälsa och utveckling, vilket medför att det finns ett behov av verksamma interventioner för barn som exponerats för våld mot en förälder. Denna avhandling innehåller tre empiriska studier som alla är del av ett sammanhållet forskningsprojekt. Det övergripande syftet är att undersöka interventioner för barn som exponerats för våld mot en förälder.

Studie I syftade till att belysa små barns upplevelser och erfarenheter av att delta i gruppinterventioner riktade till barn som bevittnat våld mot en förälder. Nio barn, 4 till 6 år gamla, intervjuades efter att de deltagit i gruppverksamhet för barn som bevittnat våld i sina familjer. Intervjuerna analyserades med interpretativ fenomenologisk analys, och fem huvudteman identifierades: glädje, trygghet, att vara i relation, att prata och kompetens.

Syftet med studie II var att undersöka hur barn berättar om en våldsutsatt förälder. Intervjuer genomfördes med 17 barn mellan 4 och 13 år som bevittnat våld mot en förälder. Tematisk analys identifierade tre huvudteman: sammanhängande berättande om föräldern, bristfälligt berättande om föräldern och föräldern som trigger för traumareaktioner.

Studie III var en utfallsstudie som undersökte utfallet av två olika gruppinterventioner för barn som bevittnat våld mot en förälder, en psykoedukativ och en psykoterapeutisk. Studien inkluderade 50 barn mellan 4 och 13 år och deras mammor. Symtom på psykisk ohälsa och posttraumatisk stress skattades före och efter interventionerna. Resultaten tyder på att barnen drog nytta av båda interventionerna, men förbättring av symtom var störst för de barn som deltagit i den psykoterapeutiska gruppinterventionen. Trots symtomförbättringarna rapporterade en majoritet av barnens mammor kvarstående symtom på klinisk nivå efter interventionerna. Mammorna visade signifikant lägre nivåer av egna symtom på posttraumatisk stress efter båda interventionerna.

Resultaten tyder på att barnen uppskattade och drog nytta av båda de studerade interventionerna, men en majoritet uppvisade symtom på klinisk nivå även efter behandling och ett möjligt behov av kompletterande och/eller alternativt stöd och behandling. Dessa resultat tydliggör såväl behovet av rutiner för att bedöma barns symtom under och efter behandling som värdet av att inkludera barn som informanter i forskning.

"What is good about the group is that you can play, feel happy; nobody is frightening, you are not afraid, nobody is fighting and stuff."

(Boy, 5 years)

"I liked the concept. It was good for my girl, good for both of us. I got advice and support. Coming to the group makes you feel like a human being again. It is good to know that you are not alone, and that the others aren't weird people. We were just normal people all of us. Such a relief!"

(Mother of girl, 7 years)

Contents

ACKNOWLEDGMENTS

Completion of this thesis was made possible by the contributions and support of several people and organizations. I want to express my sincere appreciation and gratitude to all who helped in so many different ways. I especially want to thank:

Kjerstin Almqvist, my main supervisor: You have shared so much knowledge, grounded me in a sound scientific stance, and supported me all through my doctoral studies. I am truly grateful for having had the advantage of sharing this experience with you, which goes beyond the work on the research project and the thesis. These years have had an invaluable influence on my professional life. Thank you.

Mats Fridell, my supervisor: for your genuine and unfailing support of my work and for always being so generous in sharing your knowledge, thoughts, and time.

Idor Svensson, supervisor: for your constant encouragement and for keeping me connected to Linnaeus University.

All three of you have supported me in my daily striving to combine clinical work and doctoral studies. We all share the objective of improving practice with empirical knowledge, and research with clinical expertise. You have been role models and guides in doing the hard work of combining clinical competence and research.

Doris Nilsson and Carolina Øverlien: for your thorough and invaluable feedback during my midway and final seminars.

All the children and families who contributed to the studies: you have shared your experiences, thoughts, and knowledge with me. No studies and no results would have been possible without your generous and friendly participation.

The personnel and directors at the Bojen Foundation, Gothenburg, and the Child and Adolescent Psychiatry Trauma Unit, Stockholm: Susanne Eriksson at Bojen and Anna Norlén at the trauma unit, thank you for your initial decision to enter the project and for your wholehearted engagement with the families and in gaining new knowledge. I thank all the group leaders for your seriousness, endurance, and flexibility in assisting with the data collection.

Birgitta Grahn and Katarina Hedin, present and former directors of the Department of Research and Development, Region Kronoberg: for offering me a stable yet flexible context for my doctoral studies and for this research.

All of my colleagues at the Department of Research and Development, Region Kronoberg: for your generosity with practical support, interdisciplinary collegial exchanges, and stimulating social companionship. A special thanks to Dorthe Geisler, research secretary, for your invaluable support throughout the years and in making the manuscript presentable.

Anna Lindgren for clear and educative statistical guidance.
Nils Pernebo for patient and reliable work on the database.
Daphne Sams for sharp and yet sensitive linguistic support that indeed improved my manuscript.
Hanna Mäki-Jussila for the beautiful work of art for the cover.

Personnel and colleagues at the Department of Psychology, Linnaeus University. Especially the present and former PhD students at the Department of Psychology and elsewhere: Along the way I have appreciated all our discussions and your support! A special thanks to Johanna Thulin for our inspiring conversations and to Gustaf Waxegård for balancing community and privacy in our shared office.

Ulla Kerren, research secretary at the Department of Psychology, Linnaeus University: I am grateful for your stable and reliable support on all kinds of practical and matters.

My colleagues and superiors over time at the Child and Adolescent Psychiatric Clinic, Region Kronoberg: over many years I have had the opportunity to develop and expand my clinical experience and knowledge in the field of child and adolescent psychiatry together with numerous invaluable colleagues. You have shared your commitment, expertise, and curiosity with me. Thank you for your encouragement and support during my doctoral studies.

Pamela Massoudi, my friend, colleague, and mentor: You have been walking ahead of me, and you convinced me that this was a possible path. You have

mentored me on everything from spelling, grammar, and conference presentations to methodological and theoretical issues. The opportunity to share with you our dual commitment to research and to clinical work with children and families, and our shared wish to spread knowledge and improve practice has been, and is, invaluable.

Anders, Arvid, Nils, Jonathan, Sandra, family, and friends: For being there, having patience, reminding me of the essentials in life, and making me feel safe.

This thesis would not have been possible without financial support. I am grateful for the financial and practical support of the Kronoberg County Council and Södra Regionvårdsnämnden.

LIST OF PUBLICATIONS

This thesis consists of a summary and three research papers, referred to in the text by their Roman numerals:

I. Pernebo, K., & Almqvist, K. (2016). Young children's experiences of participating in group treatment for children exposed to intimate partner violence: A qualitative study. *Clinical Child Psychology and Psychiatry, 21*(1), 119-132. doi:10.1177/1359104514558432

II. Pernebo, K., & Almqvist, K. (2017). Young children exposed to intimate partner violence describe their abused parent: A qualitative study. *Journal of Family Violence, 32*(2), 169-178. doi:10.1007/s10896-016-9856-5

III. Pernebo, K., Fridell, M., & Almqvist, K. (2018). Outcomes of psychotherapeutic and psychoeducative group interventions for children exposed to intimate partner violence. *Child Abuse & Neglect, 79*(C), 213-223. doi: 10.1016/j.chiabu.2018.02.014.

The original articles have been reprinted with permission from the publishers.

ABBREVIATIONS AND DEFINITIONS

CAMHS	Child and adolescent mental health services
CAMHSI	Child and adolescent mental health service intervention
CBI	Community-based intervention
CBT	Cognitive Behavioral Therapy
CTS-R	Conflict Tactics Scale – revised
EBP	Evidence-based practice
EST	Empirically supported treatment
EQ-P	Emotion Questionnaire for parents
IES-R	Impact of Event Scale – revised
IPA	Interpretative phenomenological analysis
IPV	Intimate partner violence
PBE	Practice-based evidence
PTS	Post-traumatic stress
PTSD	Post-traumatic stress disorder
RCT	Randomized controlled trial
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
SDQ-P	Strengths and Difficulties Questionnaire – parental version
TSCYC	Trauma Symptom Checklist for Young Children
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
WHO	World Health Organization

Violence

Violence is any act directed against another person, where this act either harms, hurts or offends in a way that makes the person do something against his/her will or stop doing something that he/she would like to do (Isdal, 2017).

Intimate Partner Violence (IPV)	Behavior by an intimate partner or ex-partner that causes physical, sexual, psychological, or economic harm, or inflicts fear or loss of trust, including physical aggression, sexual coercion, psychological abuse and controlling behaviors (Adams, Sullivan, Bybee, & Greeson, 2008; Isdal, 2017; World Health Organization, 2011, introduction).
Experiences of or exposure to IPV	Children's exposure to IPV may consist of an array of disturbing events, from direct exposure to verbal aggression or physical fights to seeing caregivers threatening each other with weapons, or indirect exposure, by learning about the consequences of parental violence through the physical and emotional impact on caregivers (Holden, 2003).

PREFACE

Working for more than two decades as a clinical psychologist and psychotherapist in the field of child and adolescent psychiatry has given me the privilege to meet numerous children and families who have shared with me their experiences of difficult life events and hardships, as well as much hope and crucial experiences of positive change. The dual experience of sharing the joy of when things change for the better and the frustration when change has been difficult to achieve, has been a constant incitement to me to learn more. My clinical experiences have kept me curious: Which interventions work, when and why? What can we do better? And what do children and families think? Turning to research has given me an invaluable opportunity to expand my own knowledge and to contribute to the development of the field. Another incentive has been a strong wish to make the experiences, knowledge, and needs of children and families visible outside the closed rooms of homes and psychotherapy.

My ambition throughout the work of the thesis has been to keep a focus on the children, rather than the mothers, fathers, clinicians, or decision-makers. I have also strived to bring knowledge from research into the clinical frame, and to enrich academic thinking with knowledge from clinical praxis and lived experience. It is my experience and belief that it is necessary to develop both fields in conjunction.

INTRODUCTION

Exposure to violence toward a caregiver is a common adverse childhood experience throughout the world (United Nations Children's Fund, 2017). The impact of exposure to adverse childhood events is a major risk factor for childhood and lifelong problems with health and development (Felitti et al., 1998). Young children are especially vulnerable to the effects of exposure to abuse, violence, and neglect due to their developmental immaturity and dependence on caregivers (Siegel, 2012; Teicher et al., 2003), but they are also more malleable than older children to benefit from positive interventions from caregivers and professionals to improve their developmental trajectory and overall health (Osofsky, 2017).

The United Nations Convention on the Rights of the Child (UNCRC; United Nations, 2014) states children's rights to protection, provision, and participation. In this context, children have rights to be protected from exposure to violence and to be provided with support when needed. Children are also afforded the right to influence the development of supports and interventions directed toward them. This obliges us to see children as protagonists, both as recipients of interventions and as experts on their own experiences and knowledge.

Throughout the text, gender neutral language is often used in discussing caregivers, although the violence that children are exposed to is mainly men's against women. The focus of the thesis, however, is on children's exposure to violence against a caregiver, and there are several issues, such as imbalance and inequality between women and men, that fall out of the scope of the thesis. It is also worth noting that research on IPV has evolved mainly in a western framework in countries with legislation against violence toward women. This context is reflected in the consequences and interventions mentioned and used in these and other studies. This limits our knowledge of the consequences and needs faced by children in other contexts.

The first part of the thesis includes an overview of the prevalence and consequences of childhood exposure to violence toward a caregiver, a summary of research on interventions for exposed children, and reflections on design and challenges in research on outcomes of psychological treatment for children. The second part presents the included studies, and the third and last part consists of a general discussion of the results, strengths, limitations, and clinical implications of the studies.

BACKGROUND

Child exposure to violence toward a caregiver

Definitions and prevalence

Violence is a global public health problem, and violence toward women in intimate relations is identified by the World Health Organization (WHO) as one of the major threats to the health of women and children (WHO, 2002). In 2017 it was estimated that one in four children worldwide were living with a mother who was a victim of intimate partner violence (IPV; United Nations Children's Fund, 2017). The field of research on IPV or domestic violence is broad and includes areas such as mechanisms of abuse toward children, women, and men; prevalence and consequences of domestic violence; and the development and evaluation of interventions for prevention, protection, support, and treatment (e.g., Bell & Naugle, 2008; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Ellsberg et al., 2015; Holt, Buckley, & Whelan, 2008; Jewkes, 2002; Vu, Jouriles, McDonald, & Rosenfield, 2016; Yakubovich et al., 2017). This thesis is specifically focused on the experiences and outcomes of treatment interventions in children exposed to violence toward a caregiver. The words exposure and exposed are used in a broad sense including visual, auditory, olfactory, and physical exposure to actual acts of violence, but also exposure to the relational context in which the violence occurs and the consequences of the violence. Children's exposure to IPV may consist of an array of disturbing events, from direct exposure to verbal aggression or physical fights in which parents threaten or injure each other with weapons, to indirect exposure in which the consequences of parental violence is witnessed through the child's recognition of the physical and emotional impact on parents (Holden, 2003).

Violence can be defined as acts inflicting harm: "Violence is any act directed against another person, where this act either harms, hurts, scares, or offends in a way that makes the person do something against his/her will or stop doing something that he/she would like to do" (Isdal, 2017, s 34). IPV is defined by WHO as "behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors" (World Health Organization, 2011, introduction). The definition is gender neutral, and includes physical, psychological, and sexual violence, but not economic violence or latent violence. The economic violence not included in the WHO definition includes acts aimed to control a person's ability to acquire, use, and maintain economic resources (Adams et al., 2008). Latent violence refers to acts evoking fear and loss of trust based on experiences of previous violence and built-up fear (Isdal, 2017).

Swedish studies report a lifetime prevalence of childhood exposure to violence toward a caregiver at approximately 10% for a single exposure and 5% for repeated exposure (Annerbäck, Wingren, Svedin, & Gustafsson, 2010; Janson, Jernbro, & Långberg, 2011; Jernbro & Janson, 2017; Nilsson, Gustafsson, & Svedin, 2012; SOU, 2001:72). The prevalence of IPV in the general population is reported to be somewhat lower in Sweden and the Nordic countries than in other high-income countries in Europe and North America (Dong et al., 2004; Gilbert et al., 2009). The overlap between exposure to IPV and subjection to physical child abuse is reported as 30% to 70% in Swedish and international studies (Annerbäck et al., 2010; Appel & Holden, 1998; Broberg et al., 2011; Edleson, 1999; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Jernbro & Janson, 2017; Osofsky, 2003; Zolotor, Theodore, Coyne-Beasley, & Runyan, 2007). In the broader context of childhood victimization, it has been shown that one kind of victimization by a potentially traumatizing event, e.g. exposure to IPV, elevates the risk of exposure to other kinds of potentially traumatizing events (Dong et al., 2004; Dube, Anda, Felitti, Edwards, & Williamson, 2002). Finkelhor, et al. (2017) reported that in a national cohort in USA victimized children displayed a mean of 2.8 different kinds of victimization.

Consequences of IPV on child development and psychopathology

There is broad agreement that violence against a caregiver constitutes a serious risk to children's psychological health and development. Both short-term and long-term consequences have been reported. Adams (2006) summarizes the consequences of witnessing IPV in five major clusters:

1) Emotional functioning (internalizing disorders such as depression, post-traumatic stress disorder [PTSD], and low self-esteem)
2) Behavioral functioning (externalizing behavior problems)

3) Social adjustment (insecure attachment and difficulties in peer relationships)
4) Cognitive functioning (e.g., poorer verbal skills and decrements in IQ)
5) Physical and biological functioning (somatic health, effects on neurobiological states and development)

In the first two clusters (the areas of emotional and behavioral functioning) several studies on IPV have shown increased risk for a variety of symptoms of psychological distress (mainly anxiety, depression, and post-traumatic stress [PTS] reactions), and a risk for inducing behavior disorders and disturbances in self-regulation (Cater, Miller, Howell, & Graham-Bermann, 2015; Chan & Yeung, 2009; Evans, Davies, & DiLillo, 2008; Holt, Buckley, & Whelan, 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003; Margolin & Vickerman, 2007; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Symptoms of PTS have been shown to be a common reaction in preschoolers exposed to IPV. Theese reactions include symptoms of hyper-arousal, avoidance and negative cognitions/mood as well as re-experiencing/flashbacks and dissociative symptoms (Hagan, Hulette, & Lieberman, 2015; Levendosky, Huth-Bocks, Semel, & Shapiro, 2002; Miller-Graff, Galano, & Graham-Bermann, 2016).

The third cluster of symptoms includes increased difficulties in social adjustment and interaction throughout childhood and adolescence. Difficulties observed in the parent–child relationship include disorganized attachment in infancy, toddlerhood, and later, as well as controlling attachment patterns in early childhood (Levendosky, Bogat, & Huth-Bocks, 2011; Zeanah et al., 1999). Other studies have shown increased risk for difficulties in peer relationships during school years and adolescence (Levendosky, Huth-Bocks, & Semel, 2002; McCloskey & Stuewig, 2001).

In the fourth cluster – cognitive functioning – children exposed to IPV have been shown to suffer negative effects such as difficulties in schoolwork, lower verbal ability, and lower IQ than non-exposed children (Jouriles et al., 2008; Kitzmann et al., 2003; Koenen, Moffitt, Caspi, Taylor, & Purcell, 2003; Ybarra, Wilkens, & Lieberman, 2007).

The final cluster – physical and biological functioning – comprises both temporary and lasting consequences. Swedish and international studies indicate that children exposed to IPV have increased risk of lower health status, have been shown to more regularly be prescribed medication, and seek both somatic and psychiatric healthcare more often than non-exposed children (Olofsson, Lindqvist, Gådin, Bråbäck, & Danielsson, 2011; Onyskiw, 2002; Rivara et al., 2007). It has furthermore been recognized that babies and toddlers in particular are at increased risk of exposure to violence between caregivers: a majority of children exposed to IPV are under the age of 6 (Fantuzzo & Fusco, 2007). This is the period in life when the developing brain is most vulnerable to the negative effects of trauma and chronic stress, and the effects on infants and toddlers' development after being exposed to IPV may be severe and persistent (Fantuzzo, Boruch, Beriama, & Atkins, 1997; Fusco & Fantuzzo, 2009; Gjelsvik, Verhoek-Oftedahl, & Pearlman, 2003; Howell, 2011; Levendosky et al., 2002; National Scientific Council on the Developing Child, 2005/2014; Teicher et al., 2003). This can be understood in light of the young child's need for protection, dependence on both physical and emotional closeness with the caregiver (Levendosky, Bogat, & Martinez-Torteya, 2013), the neurological sensitivity and vulnerability of its growing brain, and the interactive nature of neurological development (Caspi et al., 2002; Schore, 2013; Siegel, 2012; Teicher et al., 2003). The effects of early deprivation and abuse have severe influence on brain development and may be an undervalued confounder in later psychiatric adversities (Teicher & Samson, 2016). Infants and young children are in especial need to be protected from over-stimulation and persistent stress such as parental violence.

Research on the consequences of child exposure to potentially traumatic events and extreme stress other than IPV reports symptoms in similar areas: PTS-reactions, general psychological health (mainly anxiety and/or depression), affect regulation, and attachment/relational difficulties (Cohen, Mannarino, & Deblinger, 2006; Ford & Curtois, 2013). The overall rate for PTSD among trauma-exposed children varies from 16% to 33%, with girls at particular risk and the highest rates found among children exposed to interpersonal trauma (Alisic et al., 2014). Maltreated children have repeatedly shown elevated levels of insecure attachment patterns, with particular risk of disorganized attachment (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Cyr, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010).

Consequences of IPV on parental mental health and parenting

In the aftermath of IPV women have been shown to deal with a variety of consequences that affect their daily lives, relationships, and physical and psychological health (Eliasson, 2014; Ellsberg et al., 2008; Heimer, Björck, & Kunosson, 2014; NCK-rapport 2014:1). Other research has focused on the psychological health and functioning of abusive or formerly abusive men (Eliasson, 2014; Gottzén & Jonsson, 2012; Hearn et al., 2012). These are important issues, but beyond the aim and scope of this thesis. The focus here is on the consequences on parenting, child–parent relationships, and children's health when children experience a caregiver being abused.

Caregiver support and functioning are critical factors in how young children respond to exposure to trauma (Lieberman & Knorr, 2007; Scheeringa & Zeanah, 2001), and parental factors, such as stress may greatly impact children's experience of and response to traumatic events (Schechter & Willheim, 2009). The indirect effects of domestic violence have been described by pointing out the effects of IPV on family functioning, the caregiver's mental health, the quality of the caregiver's interaction with the child, and the associations between these factors and child's development, functioning, and health (English, Marshall, & Stewart, 2003).

The abused parent/mother

Mothers who are involved in violent interpersonal relationships are themselves at increased risk for stress and depression (Huth-Bocks, Levendosky, & Semel, 2001), which may impact their parenting capacity. Some studies have found women's mental health (depressive mood and trauma symptoms) to be linked to their parenting behavior (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003), while others have found parenting to be independent from mental health symptoms (Gewirtz, DeGarmo, & Medhanie, 2011). The most salient connection between mothers' health and parenting in the aftermath of IPV appears to be maternal PTS negatively influencing parenting. Mothers who deal with post-traumatic reactions to victimization may not be as emotionally available to their children and may tend to be more impulsive in their actions toward their children (Holden & Ritchie, 1991; Johnson & Lieberman, 2007). Mothers influenced by symptoms of PTS also tend to underestimate their children's distress and are less likely to seek mental health services for their children (Chemtob & Carlson, 2004). Maternal attributions and mental representations of their children may be another link between parenting capacity and child functioning if the mother holds maladaptive attributions and representations of the child. Schechter et al. (2008) suggest that maternal mental representations of the infant may be a more powerful predictor of parenting behaviors than maternal PTS symptoms.

In summary the experience of IPV has been shown to influence parenting in abused mothers in various ways. Some mothers demonstrate impairment in their parenting by abdicating from their parental role, acting impulsively and harshly punitively, using more physical punishment with their children, and being less emotionally available, involved, and warm (George & Solomon, 2008; Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 2001; Levendosky et al., 2003; Levendosky, Leahy, Bogat, Davidson, & Von Eye, 2006; Murray, Bair-Merritt, Roche, & Cheng, 2012). However, in other studies some mothers subjected to IPV appear to compensate for the experiences of violence by becoming more engaged and competent parents (Cox, Kotch, & Everson, 2003; Levendosky et al., 2003).

The abusive parent/father

Fathers in domestically violent families have been shown to be more physically punitive and less physically affectionate and to employ more disciplinary and less constructive parenting behaviors than nonviolent fathers (Fox & Benson, 2004; Holden & Ritchie, 1991). At the same time, these fathers have described fathering as a central part of their lives, highlighting their role as provider (Holt, 2015). However, most men who have admitted to being abusive and who admit that their children have experienced IPV show little insight into how their own behaviors affect their children (Holt, 2015; Salisbury, Henning, & Holdford, 2009). Children exposed to their father's violence against their mother describe their fathers parenting as not being engaged and not being responsible providers of care, with the mere absence of violence being judged as "good-enough" (Cater & Forssell, 2014).

Consequences of IPV on child–caregiver relationship

The negative impact of IPV begins early in the child's life in the realm of the relationship between the child and its caregiver, rather than later in the realm of problem behaviors and general well-being of the child (Levendosky et al., 2003). When one parent is abusive and the abused other cannot assume or fulfill the role of provider of protection and care, the child may be left without support in a state of dysregulation and helplessness (Levendosky et al., 2011). The combination of exposure to IPV and the experience of not being able to use the abusive or the abused parent for protection, support, and emotional regulation jeopardizes the predictability of the child–parent relationship, threatening to leave the child without sufficient support when in need of physical and emotional regulation (Kobak & Madsen, 2008; Schore & Schore, 2008; Zeanah, Berlin, & Boris, 2011). From the perspective of the child, family violence may have the unfortunate consequence of undermining parents as protectors and as sources of support (Margolin & Vickerman, 2007). The child may experience not only a loss of a sense of being cared for and nurtured, but also a loss of trust in the caregivers' availability and capacity to provide support and protection (Kobak & Madsen, 2008; Swanston, Bowyer, & Vetere, 2014; Zeanah et al., 2011).

Attachment theory argues that the attachment relation serves the dual function of being a secure base from which the child can explore and learn about self and environment and being a safe haven in times of distress or perceived danger (Bowlby, 1980; Zeanah et al., 2011). Sensitive parenting is a prerequisite for the development of emotional regulation, and the child depends on the caregiver(s) for emotional and neurological development (Schore & Schore, 2008). In the context of IPV the child may experience fear without solution when the parent is the source of fear and danger and simultaneously the child's natural source of safety, placing the child in a disorganizing approach-flight paradox (Hesse & Main, 2006). The experience of IPV has been shown to affect the attachment relationship and the child's inner representations of both the abusive and the abused parent (Sternberg, Lamb, Greenbaum, & Dawud, 1994; Sternberg, Lamb, Guterman, Abbott, & Dawud-Noursi, 2005). A high prevalence of disorganized attachment and later controlling attachment patterns in children exposed to IPV have been demonstrated (Levendosky et al., 2011; Levendosky et al., 2003; Zeanah et al., 2011; Zeanah et al., 1999). Disorganized attachment is a strong risk factor for future disturbance including behavior problems, PTS symptoms and dissociation (Sroufe, 2005; Van Ijzendoorn, Schuengel, Bakermans, & Kranenburg, 1999; Zeanah et al., 2011).

The negative impact of experiences of IPV on the child–caregiver relationship can thus result in negative effects on the child's capacity for emotional regulation and development of internal working models for establishing current and future relations to significant others, peers, and partners (Kogan & Carter, 1996; Schore, 2013; Sroufe, 2005).

Child relationship with the abused parent/mother

Few studies have specifically explored the relationship between children and their abused parent. A victimized parent who is frightened, depressive, dissociative, or neglectful risks putting the child in a state of non-resolution, both frightened and deprived of a secure haven to meet its needs (Hesse & Main, 2006; Kobak & Madsen, 2008). When the parent appears as helpless, fearful, abdicated, and incapable of protecting herself and the child, this may instill fear in the child. It may also place the child in an adult position in relation to the abused parent. In preschool age such a relationship risks being characterized by role reversal, with the child controlling the parent instead of the reverse (Levendosky et al., 2011). Disorganized attachment has repeatedly been shown to predict role-reversed relationships between toddler and preschoolers and their mothers (Macfie, Fitzpatrick, Rivas, & Cox, 2008; Van Ijzendoorn et al., 1999).

Child relationship with the abusive parent/father

Children experiencing IPV are caught in a paradoxical situation in relation to an abusive caregiver (often the father), who is expected to provide protection and comfort, but who is simultaneously a source of danger (Kobak & Madsen, 2008). In this situation the child is torn by the urge to approach the caregiver for protection and the impulse to flee the source of danger, a situation with no ready solution (Hesse & Main, 2006). A few studies have explored how children with experiences of IPV relate and describe their fathers.

Children have described both positive and negative feelings toward their abusive fathers (Cater, 2007; Staf & Almqvist, 2015). Cater & Forsell (2014) showed that children with experience of IPV did not expect their fathers to be engaged, responsible, and reliable. Children further described an absence of reciprocity in the relationship to their father after parental separation following IPV and a lack of paternal nurturance, interest, and willingness to spend time with them (Holt, 2015).

Staf & Almqvist (2015) showed how children understood and handled their relationship with a father who had subjected the mother to IPV by relating to disparate images of the father: one of an abusive, violent father, and others more idealized. The images were not constant, but the strategy of maintaining coexisting images without integrating them was seen as a way of coping for children in a difficult situation. Alternatively, children may strive to keep general pictures of fathers as good and violence as bad, but either allow violence as only a small part of their own fathers' multifaceted person or distance the father's violence from his perceived relative goodness (Cater, 2007).

Maltreated children

While research on the consequences on the child–caregiver relationship in families with experiences of IPV is limited, it is relevant to consider knowledge gained from adjacent fields of research. Studies on how physically maltreated children describe their parents show complex results. Maltreated children tend to be more likely than others to develop negative representations of both their parents, and their representations of mothers have been shown to be less integrated, less benevolent, and more punitive no matter which parent was the actual perpetrator (Manashko, Besser, & Priel, 2009; Sternberg et al., 2005). Similarly, students who have been physically abused as children perceive their parents as more controlling and less affectionate than non-abused children do (Nilsson, Nordås, Pribe, & Svedin, 2017). Some maltreated children, however, show an adaptive cognitive style and a tendency to idealize their caregivers by overstating their benevolence (Manashko et al., 2009).

Predictors, moderators, and mediators of consequences of IPV

In order to more fully explore the relationship between exposure to violence and child outcomes, predictive, moderating, and mediating factors have been investigated. Predictive factors are conditions such as gender, age, and ethnicity, which could predict a certain outcome or the severity of an outcome, in this case, of exposure to IPV. In this context a moderator is a variable or a group of variables moderating the outcome of exposure once it has occurred, e.g. severity of violence, poly-victimization, ongoing visitations with the abusive parent, caregiver mental health, and availability of support. A mediator is a variable that is necessary for exposure to lead to outcome, such as parental stress or parental symptoms of PTS.

Gender and age

The gender of the child does not seem to influence the effects of IPV, but older age in some studies is linked to an increase in externalizing symptoms (Evans et al., 2008; Kitzmann et al., 2003; Sternberg, Lamb, Guterman, & Abbott, 2006; Wolfe et al., 2003). Other studies note an association of young age at the onset of IPV with more PTS symptoms in children (Telman et al., 2016). It may be that younger children are more vulnerable and at higher risk of developing post-traumatic reactions as a consequence of IPV and older children might be more prone to demonstrate specific consequences such as externalizing symptoms.

Frequency and severity of violence

Frequency and severity of incidents of violence have repeatedly been shown to be positively related to more severe adjustment problems and more trauma symptoms in children (Hunter & Graham-Bermann, 2013; Kitzmann et al., 2003; Miller, Howell, & Graham-Bermann, 2012).

Multiple victimization

Exposure to one type of victimization increases the risk of exposure to additional types of victimization, specifically the risk for children exposed to IPV to be subjected to physical abuse is elevated (Dong et al., 2004; Felitti et al., 1998; Graham-Bermann, Castor, Miller, & Howell, 2012; Jernbro, Tindberg, Lucas, & Janson, 2015; Zolotor et al., 2007). Meta-analyses of the effects of children's exposure to domestic violence report that children exposed to both IPV and child maltreatment show a higher rate of adjustment problems and trauma symptoms than children exposed to a single type of victimization (Sternberg, Baradaran, Abbott, Lamb, & Guterman, 2006; Wolfe et al., 2003). Others report no difference in outcomes for children exposed to both IPV and physical abuse compared with children exposed to solely IPV (Kitzmann et al., 2003). Hagan, Sulik, and Lieberman (2016) investigated a high-risk, ethnically diverse sample of children aged 3 to 6 at an outpatient trauma clinic (N = 211) and found that severe exposure to a combination of verbal and physical victimization, witnessing violence, and serious physical illness predicted greater internalizing and PTS symptomatology in relation to other combinations of traumatic experiences. International and Swedish studies have found the number of traumatic events experienced to be a strong predictor of distress symptoms in children and adolescents (Finkelhor, Turner, Shattuck, & Hamby, 2013; Gustafsson, Nilsson, & Svedin, 2009). Poly-victimization, defined as exposure to four or more different kinds of victimization in a single year, is more highly related to trauma symptoms than repeated victimization of one type of trauma (Finkelhor, Ormrod, & Turner, 2007; Turner, Finkelhor, & Ormrod, 2010). A few Swedish studies have reported on prevalence and consequences of childhood poly-victimization and conclude that it is more common to be victimized repeatedly than a single time and that exposure to four or more kinds of victimization is associated with significantly poorer psychological health in children (Aho, Proczkowska-Björklund, & Svedin, 2016; Cater, Andershed, & Andershed, 2014; Jernbro & Janson, 2017).

Contact with the abusive adult

It is common for children exposed to IPV to continue to have contact with an abusive father after the mother has separated from the father (Broberg et al., 2011; Hunter & Graham-Bermann, 2013). Fathers without contact with their children after separation tend to have been more violent and to have used more lethal threats. However, father contact has been shown to moderate externalizing symptoms, suggesting that child contact with a less violent or nonviolent father or father figure might have a buffering effect on behavior problems in children exposed to IPV (Hunter & Graham-Bermann, 2013).

Maternal mental health and parenting

Maternal psychological functioning and parenting behavior have been shown to influence the consequences of IPV on children (Hungerford, Wait, Fritz, & Clements, 2012). Parental stress is significantly associated with higher levels of maternal post-traumatic symptoms and a moderator of mental health in children exposed to IPV, child abuse and other potentially traumatic events (Roberts, Campbell, Ferguson, & Crusto, 2013; Telman et al., 2016).

Current research offers mixed results concerning the specific influence of IPV on maternal mental health and parenting and the subsequent moderating or mediating impact of maternal mental health and parenting on child adjustment. Bogat, DeJonghe, Levendosky, Davidson, and von Eye (2006) found a significant relationship between infant and maternal trauma symptoms. In contrast Chemtob and Carlson (2004) found no correlation between PTSD in mothers and PTSD in children. Schechter et al. (2011) reported maternal PTS to mediate the consequences of IPV on child PTS externalizing and internalizing symptoms, and to be even more predictive of preschool children’s externalizing behavior problems than the children’s exposure to violence. Thakar, Coffino, and Lieberman (2013) reported maternal depressive symptomatology and parent–child dysfunction to influence the variability in children’s behavioral and emotional functioning after trauma exposure. In this study maternal PTSD symptoms were not significantly associated with child functioning. Koverola et al. (2005) found maternal depressive symptoms to mediate the effect of IPV on child internalizing and externalizing symptoms and on socialization. In a recent longitudinal study, children and mothers were followed for 4 years and levels of maternal PTS, depression, and anxiety symptoms were found to determine children's recovery from or persistence of behavioral dysfunctions (McFarlane et al., 2017).

Caregiver functioning can be a mediator between IPV and child outcome (English et al., 2003). Parenting stress has been shown to be a significant moderator for post-traumatic symptoms and child adjustment in families experiencing IPV, child abuse, and other potentially traumatic events (Crusto et al., 2010; Huth-Bocks & Hughes, 2008; Roberts et al., 2013; Telman et al., 2016). Huang, Wang, and Warrener, (2010) found that maternal mental health partially mediated the consequences of IPV on children's behavior problems, but pointed out that the association could be indirect via factors other than parenting behavior. Maternal sensitivity, for example, is a mother's ability to interpret her child's emotional cues accurately and to respond to them appropriately, promptly, and consistently (Ainsworth, 1969). Johnson and Lieberman (2007) found difficulties in maternal sensitivity and attunement to the child's experiences of emotion to contribute to the prediction of behavior problems in preschoolers exposed to domestic violence.

Existing research offers no distinct patterns of interaction between maternal mental health (e.g., depression, anxiety, and/or PTS), parenting behavior, or child–parent relational dysfunction and child outcome in the aftermath of IPV. Such patterns may be difficult to establish due to the extent of overlapping and multidirectional associations between these areas.

Paternal mental health and parenting

Studies on father's mental health and parenting in relation to child consequences of IPV are very few (Hungerford et al., 2012). A violent parent's capacity to function as a secure base and a safe haven may be absent or constricted and thereby contribute to the development of insecure or disorganized attachment patterns in children (Carlson et al., 1989; Cyr et al., 2010; Hesse & Main, 2006).

Child functioning and predispositions

It has been argued that once present, child trauma symptoms may act as potential triggers or mediators for the development of further child symptoms. Child PTS reactions may mediate the relationship between exposure to violence and internalizing and externalizing adjustment problems (Miller et al., 2012). Research further indicates the importance of genetic factors, stressing an interactive relationship between a predisposing genotype and maltreatment during childhood, leaving some children more vulnerable and increasing the risk of later behavioral and psychological problems (Caspi et al., 2002; Jaffee et al., 2005).

Conclusion

The experience of violence toward a caregiver during childhood is not uncommon and its negative consequences on child health and development have been identified in several areas. The next section addresses children's needs for intervention and the effectiveness of available interventions.

Interventions for children who have experienced violence toward a caregiver

Need for intervention

As discussed in the previous section children experience exposure to IPV in many different ways. There is also much variation in the degree to which children experience the consequences of such exposure. Some struggle with multifaceted and profound difficulties, while others experience limited challenges or adjust well. Martinez-Torteya, Bogat, von Eye & Levendosky (2009) followed preschool children exposed to IPV in a longitudinal study and reported that a little more than half showed a positive developmental trajectory and could be viewed as resilient (Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009). This is in accord with the estimation that some 40% to 60% of children exposed to IPV are less resilient, have problems within the clinical range, and need treatment (Grych, Jouriles, Swank, McDonald, & Norwood, 2000). The demand for effective interventions is further strengthened by the increased prevalence of PTSD in children exposed to traumatic events and the notion that without effective treatment childhood PTSD and associated deleterious outcomes may persist (Alisic et al., 2014; Hiller et al., 2016; Scheeringa, Zeanah, Myers, & Putnam, 2005).

Focus and setting

To prevent and limit the adverse consequences of exposure to IPV, accessible interventions are required for children with clinical and sub-clinical problems (Graham-Bermann, Miller-Graff, Howell, & Grogan-Kaylor, 2015; Weisz, Sandler, Durlak, & Anton, 2005). Ideally children should be referred for treatment within the healthcare sector (e.g., in child and adolescent mental health service units) when their symptoms reach a threshold of severity or complexity that indicates a need for clinical treatment. In addition, those with problems not reaching the clinical range could be offered an intervention, typically being community-based with a psycho-educative approach.

The primary objectives in services for IPV-exposed children is to provide protection, to end their exposure to violence, and to prevent further exposure. Additional psychological support interventions include stabilization, psycho-educational, and normalizing interventions to enable children to express their experiences, thoughts and feelings; parental support; and psychotherapeutic or psychiatric treatment. Interventions with a preventive or psycho-educative focus are typically community-based, include children based on experience and not on symptomatology, and aim at promoting resilience and facilitating for children to have their voices heard. Psychotherapeutic treatment, in contrast, is more often applied in clinical settings at child and adolescent mental health units, and it typically focuses on complex symptomatology and aims to reduce symptoms.

The objectives of psycho-educative and psychotherapeutic treatment interventions overlap to some extent and differ in other respects. Preventive psycho-educative interventions aim to strengthen children's capacity to cope with their experiences and thereby reduce their risk of negative effects of stress and trauma in the future. In contrast, psychotherapeutic treatment interventions primarily aim to decrease current symptoms and suffering. Both kinds of interventions share the goals of reducing shame, preventing alienation, and strengthening the capacity to understand and express feelings, thoughts, and experiences.

Target population

Interventions are often adapted to a specific age range or severity of symptoms. In the population of children exposed to IPV, subgroups based on age, reactions and symptoms, additional victimization, focus of interventions, etc. can be identified and interventions tailored accordingly. From the high prevalence of additional victimization, there is, however, likely a need to rethink and develop preventive and treatment interventions generic enough for children with a variety of combined traumas, rather than tailored to distinct types of trauma (Cater et al., 2014; Finkelhor, 2017).

Intervention modalities

Interventions for children who have been exposed to IPV are provided in a variety of modalities: directly to children and/or indirectly aimed to impact children through parenting programs and other interventions directed at caregivers. Interventions such as psycho-educative support and psychotherapeutic treatments directed to children are offered in individual, dyadic/family, and group settings, depending on method applied and practical considerations. A common type of support offered to children as well as caregivers at a secondary preventive level are support groups and for severely traumatized children with high levels of clinical symptoms individually tailored treatments are often suggested. For young children child–parent treatment is often recommended, while for school-aged children and adolescents individual or group format is more common.

Group interventions

Group formats based on cognitive behavioral, psychodynamic, and integrative approaches are widely used in interventions for children exposed to IPV. Different forms and objectives of these interventions include activity, support, problem-solving and psycho-educational, and psychotherapeutic groups, with the last two both aimed to promote change (Montgomery, 2002).

Deblinger, Pollio, and Dorsey (2016) summarize the benefits and challenges entailed by the group format in treatment for children exposed to trauma. Practical advantages can be reduced wait lists, time and cost-effectiveness, and allowing new or inexperienced staff to serve as co-therapists and get on-the-job training and support from more experienced colleagues. For children, sharing their experiences may counteract stigmatization and bring relief from feelings of shame. The group format also allows therapeutic work to be combined with fun activities and joy and provides children the opportunity to practice new skills with peers and support each other in their use. Furthermore, a group format is excellent for psychoeducation and skill building in caregivers and allows them to share coping efforts and inspire each other to practice effective parenting and coping skills at home. Learning of others' trauma(s) and difficult experiences also contributes to reducing parental shame and stigma. Challenges inherent in the group format include how to address or work with individual trauma, disclosure, and other issues that parents and/or children do not feel comfortable sharing in a group setting. Deblinger and colleagues (2016) advocate the inclusion of individual sessions for both children and parents combined with assessment by standardized measures before and after group participation to identify participants in need of individual services.

Interventions designed for children exposed to IPV

Effective and promising interventions for children exposed to IPV have been developed and evaluated for use in different contexts (in social services and psychiatric care), for different age groups (from infants to teenagers), and in different settings (individual and dyadic, as well as group; Cohen, Mannarino, & Iyengar, 2011; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Jouriles et al., 2009; Lieberman, Van Horn, & Ippen, 2005). In general, the interventions aim to reduce symptoms of psychological distress and behavioral difficulties among the children. The treatment interventions focus to varying degrees on self-regulation, social interaction, difficulties in the parent–child relationship, psychoeducation on violence and trauma, and the non-offending parent's psychological health. Interventions targeting infants and toddlers are more seldom offered and have not been as well-evaluated as interventions targeting school-aged children and adolescents (Bidonde & Meneses, 2017; Rizo, Macy, Ermentrout, & Johns, 2011).

In Sweden, psycho-educational and psychodynamic groups adapted for children and families exposed to IPV are presently offered in addition to dyadic, family, and individually tailored interventions.

Interventions and outcomes

So far few interventions designed for children exposed to IPV have been thoroughly subjected to scientific evaluation (Rizo, Macy, Ermentrout, & Johns, 2011). Among published evaluation studies, few have yet demonstrated an effectiveness supporting further dissemination. A recent overview of reviews of interventions for children exposed to violence in close relationships concludes that there is still considerable lack of knowledge about effective interventions for children who have experienced violence, and the evidence gap is particularly evident for the youngest group (Bidonde & Meneses, 2017). A Swedish national review and evaluation indicated that the outcomes of such interventions are positive but weak (Broberg et al., 2011; Grip, Almqvist, & Broberg, 2012). Different methods address children of different ages with a variety of symptoms and problems, and the development of new methods and the improvement of available methods continues. There is a particularly urgent need for effective and feasible interventions appropriate for young children who have experienced IPV, as this group is the largest and most severely affected.

Research on interventions for children exposed to IPV

The 2011 review by Rizo et al. of literature concerning interventions that either directly or indirectly targeted IPV-exposed children identified 31 articles published between 1990 and 2010. The interventions were found mainly to be offered directly to children and/or to caregiving mothers. Interventions with multiple components were considered to probably be the most efficacious. Furthermore, involving parents in interventions for children exposed to IPV, either in joint or parallel interventions, has been associated with positive outcomes (Graham-Bermann et al., 2007; Stover, Meadows, & Kaufman, 2009). Overbeek, de Schipper, Lamers-Winkelman, and Schuengel (2012) conclude that these results support a focus on trauma as well as on the parent–child relationship in treatments of IPV-exposed children aimed to reduce child adaptive problems. Kearney & Cushing (2012) interpret present research findings as supporting the idea that a useful intervention could be a relationship-based treatment for children and abused mothers. An intervention consisting of a trauma-focused CBT intervention for the children and an attachment-based, psychodynamically influenced group intervention with psycho-educative components and the promotion of reflective functioning for the mothers.

Among specific treatment interventions for children exposed to IPV with clinical-level problems, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Child–Parent Psychotherapy (CPP) have repeatedly been found efficient in efficacy RCTs (Cohen et al., 2011; Lieberman, Ghosh Ippen, & Van Horn, 2006; Lieberman et al., 2005). To varying degrees, these interventions show reductions in children's symptoms of general psychological distress and PTS (small to medium effect sizes) and in parental symptoms of depression and PTS. Group interventions in both community settings and clinical practice are less thoroughly evaluated.

Trauma-Focused Cognitive Behavioral Therapy

TF-CBT has been developed for school-aged children and youth. The intervention is most commonly provided as a combined individual and joint parent–child intervention over 12 to 16 sessions. The treatment includes psychoeducation and parenting support combined with relaxation training, identification of emotions, desensitization, cognitive processing of trauma, and the creation of a narrative of the traumatic experiences (Cohen et al., 2006). An abbreviated form of TF-CBT (8 sessions) provided in a community setting to children 7 to 14 years old with experiences of IPV was found to significantly reduce children's symptoms of PTS (specifically hyperarousal and avoidance) and anxiety compared with usual care (Cohen et al., 2011). TF-CBT has also been adopted for preschoolers exposed to heterogeneous types of trauma; it significantly reduced PTS symptoms with a large effect size ($d = 1.01$) in the treatment group in one study using the wait list as control (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). Additionally, TF-CBT has been adapted for use in a group format (Deblinger et al., 2016). However, most studies on TF-CBT focus on sexually abused school-aged children and adolescents, and in these groups it has been found effective in improving PTSD, depression, and behavior problems (medium to large effect sizes) in several RCTs; Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Knudsen, 2005; Deblinger, Lippmann, & Steer, 1996). Its sustained effect has also been shown on PTS symptoms (Cary & McMillen, 2012).

Child–Parent Psychotherapy

CPP is a relationship-based treatment intervention conducted with weekly joint caregiver–child sessions. The model was developed for children up to 6 years of age and treatment length is usually 6 to 12 months. Vital components are the parent–child relationship, safety, affect regulation, reciprocity in relationships, traumatic experiences, continuity of daily living, and coordination of care (Lieberman, Ghosh Ippen & Van Horne, 2015). Lieberman, Van Horn, & Ghosh Ippen (2005) conducted an RCT of CPP for children referred for having witnessed domestic violence. Post treatment, children attending CPP showed significantly larger reductions in total behavior problems and traumatic stress symptoms than a control group receiving case management plus community referral for individual treatment. Mothers attending CPP with their toddlers showed significantly greater reductions in avoidance than the control group (Lieberman et al., 2005).

Results from a 6-month follow-up suggest that improvements in children's behavioral problems and in maternal symptoms continued after treatment termination (Lieberman et al., 2006). The studies showed small to medium sized effects sizes for children (*d* = 0.24–0.64) and mothers (*d* = 0.38–0.50). Additional studies have supported these results, and CPP has additionally been found to significantly improve children's representations of themselves and their mothers, positively altering children's attachment patterns and increasing maternal empathy (Cicchetti, Rogosch, & Toth, 2006; Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011; Lieberman, Weston, & Pawl, 1991; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002).

Psycho-educational group interventions

Among interventions targeting IPV-exposed children at risk of developing symptoms or with sub-clinical levels of problems, the most common support offered is the psycho-educational group in community setting. Community-based interventions (CBIs) for children after exposure to IPV include group interventions for children, combined interventions for children and their parents, individual interventions for children, and psycho-educative interventions for parents. Typically, CBIs have not targeted PTS in children and thus often do not assess trauma symptoms in evaluations. However, other areas of outcomes have been assessed and promising results have been reported in changing attitudes toward violence and reducing child behavior problems and symptoms of distress (small to medium effect sizes; Graham-Bermann et al., 2007; Graham-Bermann et al., 2015). The level of improvement might be affected by the group format per se. Interventions in community settings often involve children from heterogeneous populations and expend fewer resources in carrying out interventions than do programs carried out in the context of efficacy trials, which may affect the outcomes (Marchand, Stice, Rohde, & Becker, 2011). A range of different interventions target children exposed to IPV, among which The Kids Club group intervention program is probably the most evaluated (Graham-Bermann et al., 2007; Graham-Bermann et al., 2015). The Kids Club consists of a 10-session intervention completed in 5 weeks, with parallel groups for children and mothers, and is provided for school-aged children as well as for preschoolers. The intervention has been found effective in a community setting for children exposed to IPV (Graham-Bermann et al., 2007; Graham-Bermann et al., 2015).

In Sweden psycho-educational groups designed for children exposed to IPV are commonly inspired by the Children Are People Too (CAP) model, a program for children and adolescents with parents addicted to drugs or alcohol (Hawthorne, 1990). Some groups provide parallel support groups for mothers. The community-based group program for children exposed to IPV and their caregivers applied in the present studies (described in the Method section) is based on CAP. An adapted manual for children's and parents' groups has been developed, evaluated, and refined for work with children exposed to IPV (Grip, Almqvist, & Broberg, 2011; Grip et al., 2012). Four to eight children in the same age range are seen every week for 15 weeks. Mothers are seen in groups parallel to the children's groups. The theme for each session is structured according to the manual. In an evaluation of the Swedish adaption of CAP for children with experiences of IPV mothers reported small to medium reductions in their children's symptoms of general psychological distress, yet many children still had high levels of behavioral problems post treatment (Grip et al., 2012).

Research on other child interventions targeting trauma

The shortage of controlled studies on the outcomes of interventions designed for children with experience of violence toward a caregiver, and the high rate of poly-victimization and overlap of more than one possibly traumatizing event among exposed children, makes it relevant to consider research on outcomes of interventions for children with experiences of other traumas.

The evidence base for psychosocial treatments for child and adolescent trauma exposure was reviewed by Silverman et al. (2008) and updated in a meta-analysis by Dorsey et al. (2017). Silverman et al. (2008) reviewed 21 studies following the strict criteria for RCTs and concluded that only TF-CBT could be rated as well-established with truly evidence based effects. A meta-analysis comparing outcomes in four clusters (PTS, depressive symptoms, anxiety symptoms, and externalizing behavior problems) across different treatments showed medium effect sizes for PTS, small effect sizes for depression and externalizing behavior problems, and minimal effect sizes for anxiety. On average, treatments had positive, though modest, effects. The update by Dorsey et al. (2017) includes 37 additional studies targeting studies assessing trauma exposure and mental health symptoms, but is not limited to RCTs. In the update individual CBT with and without parental involvement and group CBT are considered well-established interventions for children and adolescents exposed to traumatic events.

Shared components in interventions

Several authors have shown that empirically supported and feasible treatments for trauma-related psychological problems share many objectives and components.

Rizo et al. (2011) summarized the commonalities in goals for children across interventions for IPV-exposed children as (1) learning about and dealing with IPV; (2) developing and enhancing coping skills; (3) developing and enhancing communication skills; (4) developing and enhancing conflict resolution and problem-solving skills; (5) exploring attitudes and beliefs about family violence; (6) increasing personal safety; (7) improving trauma symptoms and overall psychological well-being; (8) increasing self-esteem and self-efficacy; (9) increasing social skills and social support; (10) decreasing self-blame; (11) understanding and expressing feelings; (12) improving emotion regulation; and (13) changing maladaptive behaviors. Common intervention goals for caregivers were summarized as: (1) developing and enhancing caregivers' knowledge on the impact of IPV on children; (2) developing and enhancing parenting and disciplining skills; (3) decreasing parenting stress; (4) increasing self-esteem and parenting self-efficacy, (5) increasing emotion and psychological well-being; (6) helping caregivers/parents develop safety plans; (7) developing and enhancing social support; (8) developing and enhancing self-advocacy skills; (9) developing and enhancing communication and problem-solving skills; (10) developing caregivers'/parents' knowledge of and connection to community resources; (11) improving caregiver–child interactions and activities; and (12) improving the caregiver–child relationship.

Cook et al. (2005) developed a general model for the treatment of children, from infants to adolescents, with complex trauma and suggest that interventions for these children focus on six main components (1) safety; (2) self-regulation; (3) self-reflective information processing (including creating trauma narratives); (4) integration of traumatic experiences; (5) reparation, reconstruction, or construction of inner working models for attachment; and (6) support of positive self-evaluation. The authors suggest that the components be carried out consecutively using multiple methods, building on strengths, and coordinating interventions across systems by co-working with other providers (Cook et al., 2005). The view that trauma treatment should generally be carried out in phases, with components focused on safety and stabilization preceding trauma-focused components, and consolidation is shared by many (Ford & Courtois, 2013).

Dorsey et al. (2017) summarize core components in treatments for children and adolescents exposed to a broader range of traumatic events and conclude that all treatments rated as well-established include some combination of: (1) psychoeducation of trauma; (2) training in emotion regulation; (3) imaginal exposure; (4) in vivo exposure; (5) cognitive processing; and/or (6) problem solving.

In summary the components described by Cook et al. (2005) and Dorsey et al. (2017) comprise the more refined objectives in interventions for IPV-exposed children described by Rizo et al. (2011).

Involving parents in interventions

Including parents either in joint sessions with their child exposed to IPV or other trauma or in collateral sessions or parental groups has been associated with more positive outcomes than interventions directed exclusively at the child (Graham-Bermann et al., 2007; Rizo et al., 2011; Silverman et al., 2008; Stover et al., 2009). However, Dorsey et al. (2017) conclude that while inclusion of parents is empirically supported, it is not indispensable; some treatments reach the same outcome without including parents. Moderator analyses indicate that including parents is essential in treatments for young children (3–6 years), children with behavioral problems, families in which parents were perpetrators themselves, and families in which parents have mental health problems or unhelpful trauma beliefs (Dorsey et al, 2017). These characteristics are typical for children exposed to IPV, implying the importance of caregiver involvement in interventions for these children.

Trauma exposure in interventions

There has been some debate on whether explicit exposure (imaginal or in vivo) is required in treatment aimed to reduce PTS symptoms. Several studies highlight exposure as an active and often necessary component of treatments for PTS (Foa, 2009; Ford & Courtois, 2013). The few studies that have randomized children to trauma-focused treatment with or without exposure conclude that explicit exposure may not be decisive for sustainable improvements (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012; Nixon, Sterk, & Pearce, 2012; Salloum & Overstreet, 2012).

Predictors, moderators, and mediators on outcomes of interventions for children exposed to IPV

As with understanding the consequences of child exposure to IPV, it is also essential not to overlook the influence of external or confounding variables on the outcomes of interventions.

Due to a shortage of research studies, the impact of predictive, moderating, and mediating factors on the outcomes of treatment for children exposed to IPV is not definitive. A few studies have reported associations between child outcomes, such as reduction of emotional, behavioral, and trauma symptoms, and possible confounding variables outside or within treatment. Often initially high levels of symptoms in children and caregivers have been found to be strongly related to a larger decrease in child symptoms than in children with lower initial symptom levels (Broberg et al., 2011; Graham-Bermann, Howell, Lilly, & DeVoe, 2011; Grip et al., 2012; Hagan et al., 2017). Child factors such as high exposure to IPV, young age, and high attendance at sessions have also been associated with a greater post-treatment reduction in children's psychological symptoms (Broberg et al., 2011; Graham-Bermann et al., 2011; Grip et al., 2012). Maternal factors such as decreased exposure to violence and decreased symptoms of PTS have also been associated with a greater post-treatment reduction in children's psychological symptoms (Broberg et al., 2011; Graham-Bermann et al., 2011; Grip et al., 2012).

The results of studies investigating predictors, moderators, and mediators of treatment outcomes for children exposed to a broad range of traumatic events suggest that type of treatment and type of trauma may moderate effect sizes. In the meta-analysis by Silverman et al. (2008) CBT interventions appears to be more efficacious than non-CBT interventions in reducing symptoms of PTS, depression, and externalizing behavior and treatments for sexual abuse seems to be more efficacious in reducing symptoms of PTS and depression than treatments for other types of trauma. Silverman et al. (2008) further suggest future research to examine the possible influence of parental involvement in the child's treatment, dosage (number of treatment sessions) and participants' age on treatment effects.

Conclusion

Many children with experience of violence toward a caregiver need effective interventions to reduce symptoms, improve mental health, promote normal development, and prevent future suffering. Research has shown promising results for some existing interventions, but there is a need for more knowledge on their effectiveness and on ways to improve existing interventions. The next section will address some issues concerning the focus and design of research on the outcomes of child interventions.

Focus and design in research on outcomes of child interventions

The field of research on the outcomes of psychological treatments for children and youth is limited but growing. Existing research mainly concerns adolescents, and to a lesser extent, younger children; preschool aged children are least represented in published studies. In a multilevel meta-analysis, Weisz et al. (2017) report a mean overall effect size of psychological therapy in children and youth (4–18 years old, M 9.84 years) of $d = 0.46$. The impact of psychotherapy does not seem to differ with type of treatment, but it does differ with type of targeted problem, with the strongest effect for anxiety ($d = 0.61$) and the weakest for depression ($d = 0.29$). For treatment targeting multiple problems, the effect was non-significant ($d = 0.15$). The effect sizes are lower when the control condition is usual care than when no intervention or wait list conditions are used. The authors emphasize the ecological validity of usual care control conditions, and conclude that this points to the importance of testing whether treatments can improve on existing clinical care (Weisz et al., 2017). These findings underscore both the benefits of psychological treatment and the need for improved therapies. Drawing on this need, the authors call for more representative, informative, and rigorous studies. There is a need for research on the outcomes of specific methods of intervention as well as on the feasibility of methods across diverse contexts. Such contexts might be different community and clinical settings, complex and fluctuating symptomatology, various populations, a broad range of service providers, and multifaceted cultural conditions.

Experimental vs. naturalistic research designs

Research on treatment interventions has been largely influenced by the paradigm of evidence-based medicine and the continuing endeavor to design and perform RCTs leading to the establishment of empirically supported treatment (EST). Evidence-based medicine is defined as the integration of clinical expertise with the best available external evidence from systematic research; it requires a bottom-up approach that integrates the best available evidence with individual clinical expertise and patient choice (Sackett, 1997a). Sackett stresses that experimental evidence can inform, but never replace, knowledge from clinical practice.

In clinical practice, evidence-based medicine emphasizes the use of research findings, together with clinical expertise and patient preferences, to make clinical decisions about individual patients (Sackett et al., 2000). Margison et al. (2000) point out that evidence-based practice (EBP) focuses almost exclusively on RCTs measuring efficacy, while practice-based evidence (PBE) gathers good-quality data from routine practice to capture effectiveness. For psychotherapy to have robust evidence both paradigms are needed. Margison et al. emphasize measurement as the foundation of EBP and suggest that in routine practice measurement can support EBP and PBE to improve effectiveness in clinical care and provide a model of professional self-management. Good clinical practice is described as bridging of the efficacy-effectiveness gap.

Effects from RCTs always reflect group, rather than individual, results. Researchers on EST have learned a great deal about producing average treatment benefits, but at the expense of personalized interventions to optimally benefit each individual (Ng & Weisz, 2016). The impact of ESTs is further constrained by the extent to which they can be disseminated to families and service providers and how well they can be implemented in everyday practice (Ng & Weisz, 2016). Furthermore, EBP may raise rather than lower costs of care (Sackett, 1997b).

Personalized interventions, on the other hand, provide evidence-based methods for tailoring research findings into individual treatment plans (Ng & Weisz, 2016). Personalized interventions require reliable assessment of clinically relevant individual characteristics and propose treatments tailored for individuals who share those characteristics to optimize their treatment gains. Personalization can refer to facilitating treatment by paying attention to predictors such as comorbidity, motivation, treatment history; selecting treatment methods by choosing the appropriate type(s), combination, focus, and/or sequence; and continually assessing treatment response and side effects. Interventions can be tailored at the outset to patient characteristics, but also adjusted according to the patients' treatment response over time (Lei, Nahum-Shani, Lynch, Oslin, & Murphy, 2012).

Research on interventions for children with experience of violence toward a caregiver is characterized by a great variety of locally developed and applied interventions, which are often insufficiently described and evaluated. Rizo et al. (2011) conclude that most studies on interventions for children exposed to IPV suffered from the lack of a control group, recruited very few participants, did not include follow-up assessments, and had significant attrition. Several authors point to the considerable challenges of adhering to rigorous scientific demands in performing studies in community and clinical settings and to the difficulties of implementing evidence-based methods in clinical practice (Rizo et al., 2011; Toth & Manly, 2011; Warren, Brown, Layne, & Nelson, 2011).

Measuring outcomes

Outcomes of interventions are predominantly evaluated through quantitative measures of change. Most efficacy and effectiveness studies of interventions targeting psychological health and well-being focus on measuring symptoms and experiences of well-being. In interventions for children exposed to IPV, typically changes in child externalizing and internalizing symptoms and symptoms of PTS are measured. This is sometimes complemented by measures of changes in parental psychological well-being, PTS, attachment quality, and other aspects of the child–caregiver relation or parenting. Other measurable outcomes could be novel adverse events, physical safety, everyday functioning, quality of relationships in a broader context, physical health, cognitive functioning and school performance, changes in attitudes and perceived quality of life, and prevention of future difficulties and symptoms.

Another issue of concern is the dearth of studies with a longitudinal design and assessment of long-term outcomes (Bidonde & Meneses, 2017). Bidonde and Meneses argue that this is particularly important in evaluating interventions for children exposed to violence as the complexity and severity of damage implies that a short-term focus is most likely not enough to assess sustainable change.

Change may be assessed and presented as statistical significance, effect size, clinical significance, and/or patient experience. Statistical significance shows whether the magnitude of mean differences is beyond what could have been resulted by chance alone, effect sizes add information about the amount of change, and clinical significance describes the clinical relevance of change (Lambert & Ogles, 2009). Combining these different aspects to evaluate interventions contributes to the breadth and depth of the knowledge gained and augments the applicability of results.

Children’s experiences of interventions

Although research shows some encouraging results in measuring treatment effects such as symptom relief and enhanced function, little is known about the views of the children themselves. Several authors emphasize the scarcity of existing research on children’s experiences of mental health services directed toward them and the importance of adding this perspective to the field of research on psychological treatment (Biering, 2010; Carlberg, Thorén, Billström, & Odhammar, 2009; Dew & Bickman, 2005; Godley, Fiedler, & Funk, 1998). In a review of research on child and adolescent experience and satisfaction with psychiatric care, Biering (2010) concludes that there is a lack of knowledge of how children and adolescents experience satisfaction with interventions directed toward them. Published studies mainly concern school-aged children and teenagers, and studies on how children younger than 13 years experiences mental health care are almost non-existent.

Research on children's experiences of interventions

Two Swedish evaluations of interventions for children exposed to violence against a caregiver explicitly asked for the children's views and reported that the children had generally appreciated the interventions (Broberg et al., 2011; Georgsson, Almqvist, & Broberg, 2007). Cater (2014) investigated the participation of children (aged 4–19) in CBIs for children exposed to IPV and concluded that most children did not participate in the decision to contact the units. At a later point in time many children appreciated being able to participate in the decision about whether to take part in the intervention (Cater, 2014). Once enrolled in the intervention, some children described actively deciding whether to disclose and talk about the violence they had experienced. This decision was based on the clinician's facilitating actions, the children's experience of the therapeutic relationship, and their sense of trust.

In the broader range of psychotherapeutic treatment and mental health care interventions for children, only a few studies have investigated children's experiences. One study on children's experiences of psychodynamic psychotherapy reported that most children expressed positive experiences, although some expressed negative feelings toward the psychotherapy and did not want to take part (Carlberg et al., 2009). Midgely, Target, and Smith (2006) interviewed adults who had attended intensive psychodynamic psychotherapy as children and found that two thirds expressed their experience of psychotherapy as helpful, while one third expressed their experience that therapy had made certain aspects of their life worse, including making them feel different from their peers.

Studies exploring children's experiences of family therapy conclude that children are active participants and able to reflect on their experiences, that they see therapy as a place to solve a problem, to make things better, and find solutions, but that they are also sensitive to judgment and reprimands and are sometimes insecure about the rules of family therapy (Lobatto, 2002; Moore & Seu, 2011; Stith, Rosen, McCollum, Coleman, & Herman, 1996; Strickland-Clark, Campbell, & Dallos, 2000). Stith et al. (1996) and Strickland-Clarke (2000) showed that children valued being listened to and included in therapy, but some also expressed that therapy could be painful, with overwhelming feelings and feelings of not being understood.

Metel and Barnes (2011) found that most children in a peer group for bereaved children said the main benefit of the group was being able to meet other children with similar experiences, which allowed them to speak openly and to feel less isolated and different from their peers. The authors conclude that a group setting with peers may be especially beneficial for children who experience social isolation.

Studies focused on children’s experiences of mental health care in general show that children appreciate treatment interventions and a supporting professional relationship; however, they may not understand the purpose of the treatment or how the treatment is linked to their difficulties, and some may not want to take part (Buston, 2002; Paul, Foreman, & Kent, 2000).

Studies from both family therapy and general mental health care conclude that during treatment sessions children in particular appreciate stimulation, activities, and opportunities to play (Day, Carey, & Surgenor, 2006; Lobatto, 2002; Moore & Seu, 2011; Stith et al., 1996).

Objectives for including children’s experiences in research

To respect the rights of children and improve treatment it is necessary to integrate evidence-based knowledge about the effects of interventions with both clinical experience and improved knowledge of children’s own experiences of treatment. We have insufficient knowledge of children’s experiences of taking part in interventions directed toward them; our knowledge of younger children’s experiences of participating in interventions is particularly inconclusive.

Including the perspectives of children in the field of research on interventions for children exposed to IPV is essential for several reasons. Children’s right to be heard and to express themselves is one of the cornerstones in the UNCRC (United Nations, 2014). The fact that research on school-aged children and adolescents has shown a low correlation between children’s and their parents’ experiences of mental health services casts doubt on the practice of letting parents answer for their children on questions of experience and satisfaction with mental health care (Biering, 2010; Garland, Haine, & Boxmeyer, 2007; Lambert, Salzer, & Bickman, 1998). Children’s satisfaction may be related to their compliance to treatment, receptiveness to treatment for future problems, and readiness to recommend treatment to others (Godley et al., 1998). The perspectives of children will profoundly contribute to knowledge useful in developing, evaluating, and implementing services in clinical settings (Carlberg et al., 2009; Day et al., 2006; Dew & Bickman, 2005).

Sources of information

Research on children relies on several sources of information. Caregivers are often the primary source, especially in research on young children. Observations, teachers’ ratings, and clinical assessments are common complements, while turning directly to the children themselves is more uncommon. Researchers tend to show more skepticism toward the children’s own statements than to those of external assessors, even though using external assessors entails a filter between the child’s experience and the data collected.

It is difficult to argue who is most reliable, gathering multi-informant data and using multiple views to monitor outcomes in clinical practice are sometimes recommended (Terrelonge & Fugard, 2017). Koverola et al. (2005) advocate the use of multiple informants; they stress that there are many possible perspectives on any given issue and that the accepting of each perspective as the individual's reality enriches the research.

Caregivers as source of information

Koverola et al. (2005) found that when reporting child levels of distress after IPV, children and teachers agreed, while parents tended to rate their children's levels of externalizing and internalizing problems higher. In assessing outcomes of interventions through symptom ratings, Terreleonge and Fugard (2017) suggest that clinicians tend to overestimate change, while caregivers' and youths' own ratings are closer to actual change. Differences in ratings may have several explanations, including caregivers' unique closeness to and insight into the complexity of the child's functioning and situation and the differing objectives of children, parents, teachers, and clinicians.

Children as participants

Neglect of children's views may stem partly from underestimation of children's capacity to communicate their views, despite empirical findings supporting that from the age of 3 years children form and retain accurate, organized, and verbally accessible memories of past experiences (Day et al., 2006; Fivush & Schwarzmueller, 1998). Furthermore, it has been shown that if interviews with young children are properly adapted to their development, children as young as 3 and 4 years old can provide meaningful information about their experiences (Hershkowitz, Lamb, Orbach, Katz, & Horowitz, 2012; Lamb et al., 2003). In their study on children's experiences of psychotherapy, Carlberg, et al. (2009) interviewed children aged 6 to 10 and concluded that even young children and children with major difficulties were able to express their experiences of psychotherapeutic treatment.

An ethical concern is whether taking part in research may be inconvenient or harmful to vulnerable children with potentially traumatic experiences and/or psychological distress. The conclusion, however, is that children have been shown not to mind or feel hurt by being asked, in research or in clinical setting, about their potentially traumatic experiences and other sensitive issues (Dos Santos, Jensen, & Ormhaug, 2016; Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014; Zajac, Ruggiero, Smith, Saunders, & Kilpatrick, 2011). A minority of children, about 5%, report that being asked about sensitive issues is emotionally stressful. This minority of children are also the same children who report the highest degree of exposure and trauma symptoms (Appollis, Lund, Vries, & Mathews, 2015; Dos Santos et al., 2016).

Most children seem to appreciate being taken seriously and having the opportunity to express their experiences, therefore their risk of harm from taking part in research about traumatic experiences can be regarded as low (Appollis et al., 2015; Dos Santos et al., 2016; Jensen, 2012). On the contrary, the benefits of taking part in a good and supportive interview may outweigh potential distress; children may appreciate the experience of being listened to by someone genuinely interested and the opportunity to discuss and make sense of their experiences (Solberg, 2014). Through taking part in research, children can also feel they are helping to improve the situation for others, which can be an empowering experience (Cater & Øverlien, 2014).

In summary, so long as appropriate developmentally and ethically informed considerations are taken, there are no convincing arguments to exclude children's voices from research.

Research interviews with children

From research on forensic interviewing, Lamb and Brown (2006) conclude that adult interviewers can help children to become competent in describing their experiences and that these results are applicable to interviewing children in research studies. Techniques that enhance children's competence in research interviews include establishing rapport with them and offering them a chance to practice providing detailed information of experienced neutral events before turning to substantive issues. It is also important to be clear with children about their role as experts on their own and the acceptability of their disagreeing with or correcting the interviewer (Lamb & Brown, 2006). To tap recall memory, rather than recognition memory, open-ended questions and prompts are recommended in addition to recalling information already mentioned by the children as cued invitations to provide more detail. Open-ended invitations have proved to elicit more detailed and more correct information than forced-choice and suggestive questions (Lamb et al., 2003). Solberg (2014) argues that children can take part in conventional research interviews, even on sensitive issues, if precautions are taken to attend to their needs and interests. Solberg stresses three main prerequisites for successful outcomes in research interviews with children: (1) providing clarity about the purpose of the research, stressing the interviewer's lack of knowledge on the specific experiences of the child and need to learn from their experiences, and using the children's own cues during the interview, (2) providing guidance in the co-production of the account, taking a rather active stance, asking for clarifications, and taking responsibility for the direction and focus of the interview while making room for negotiations about how to proceed, and (3) careful listening, implying sensitivity to children's signs of readiness, appreciation, or reluctance to talk (Solberg, 2014).

Ethical considerations in research concerning children in vulnerable situations

Questions about power, consent, and confidentiality require special attention when conducting research with children in vulnerable situations (Cater & Øverlien, 2014; Flewitt, 2005).

Researchers need to consider the discrepancies in power between children and adults, such as caregivers, researchers, and other professionals, of whom the children depend upon and who make decisions affecting the child (Flewitt, 2005). This power imbalance may cause children to feel uncomfortable or to try to please adults or meet their perceived expectations.

Dockett & Perry (2007) stress the importance of regarding young children as competent, capable, and trustworthy reporters of their own experience, and they recommend giving children the opportunity to provide a developmentally adapted form of informed consent. In this process the researcher needs to recognize the existing inequality in power between researcher and child, and the consent should be seen as relational and temporary (Dockett & Perry, 2007). Such a provisional consent is ongoing and depends on reciprocal trust, collaboration, and minute-by-minute negotiation (Flewitt, 2005). The temporary nature of children's consent makes it essential to pay close attention to children's verbal and non-verbal signals of how much they want to participate, regardless of their initial approval to take part (Dockett & Perry, 2011). Solberg (2014) formulates this as a continuous negotiation about the limits of the child's participation and advocates an approach in which researchers are relatively active, clearly showing their wish to learn from the children as subjects and experts on their own experiences. The qualitative research interview can be seen as child friendly, creating a space for children to express themselves, with a focus on the child helping the adult to see the world from the child's perspective (Cater & Øverlien, 2014). As Solberg (2014) points out, children usually appreciate being interviewed by someone genuinely interested, and they are eager to make the interviewer understand their views.

Confidentiality includes respect of participants' right to anonymity and not intruding in participants' personal affairs. Research on children in vulnerable situations and with experiences of abuse risks the child's disclosure of previously unknown risks or abuse, in many countries obliging the researcher to report to parents or authorities, thereby breaking the confidentiality (Cater & Øverlien, 2014). This restraint on confidentiality should be made clear to participants at the onset and as necessary during the research, motivated by a commitment to protect the child from harm. In addition to this, confidentiality also includes keeping to the aim of the research and not leaking information from children and parents that are beyond the scope of the research (Flewitt, 2005).

Mudaly & Goddard (2009) point out the need to balance children's right to be protected from harm and trauma and their right to be heard in issues that concern them. They advocate a research design that pays close attention to children's social and psychological vulnerabilities, offers support and treatment if needed, recognizes the importance of the non-offending parents' attitude toward the child's participation, and does not encourage children to verbalize details of abuse (Mudaly & Goddard, 2009). Cater & Øverlien (2014) also discuss the necessity of balancing children's competence and vulnerability – viewing children simultaneously as autonomous and in need of care – with their right to be heard and their right to protection in accordance with the UNCRC. Research on children in vulnerable situations requires a high degree of reflectivity and professional responsibility. Reflective responsibility includes not applying rules in a routine way, but being sensitive and modifying rules to suit children's needs and variables such as age, developmental stage, gender, social class, and ethnicity (Cater & Øverlien, 2014).

Conclusion

Knowledge of the prevalence and consequences of childhood exposure to violence toward a caregiver, the need for more knowledge on effective interventions for exposed children, and reflections on design and research challenges informed the design, performance, analysis, and discussion of the three studies included in this thesis. Specifically, the aims of the studies were influenced by the gap in knowledge on young children's experiences and needs in the aftermath of IPV. Improved knowledge about the outcomes of existing interventions, children's experiences of taking part in interventions, and children's experiences with their abused caregiver will contribute to the further development of support and treatment for children exposed to IPV.

THE CURRENT STUDIES

Aims

The general aim of the thesis was to augment knowledge on interventions for children exposed to IPV. The research questions dealt with the effectiveness of group interventions in reducing symptoms of general psychological ill-health and traumatic stress in children and parents; how children describe their abused parent and children's experiences of participating in interventions.

Specific aim of Study I

The aim of Study I was to elucidate young children's experiences of participating in group interventions designed to improve their psychological health in the aftermath of IPV.

Specific aim of Study II

The aim of Study II was to expand knowledge of how children exposed to IPV describe their abused parent.

Specific aim of Study III

The aim of Study III was to investigate the outcomes of two established group interventions for children exposed to IPV: one community-based psycho-educative intervention and one psychotherapeutic treatment intervention.

Method

Overall study design

The three studies presented are all part of a continuous research project (Figure 1) using a mixed methods design (one longitudinal effectiveness study and two interview studies) in a naturalistic setting.

The studies concern interventions to support children and parents in the aftermath of IPV. The naturalistic study design explored two interventions currently performed in a Swedish treatment setting. In this way, we aimed to gain new theoretical and clinical knowledge to enable generalizations to children and parents taking part in the type of interventions offered in real, rather than in a laboratory setting.

The different research methods used in the separate studies were chosen in accord with the specific aims and research questions.

To explore the experiences and views of young children and give voice to the children themselves, we considered in-depth interviews conducted by an experienced child psychologist and qualitative analysis of the data appropriate. The interviews aimed to gain deeper insight into the perspectives of the children using broad invitations to talk about the main focuses with an inductive approach. The use of self-report inventories was not considered applicable for children under the age of 8.

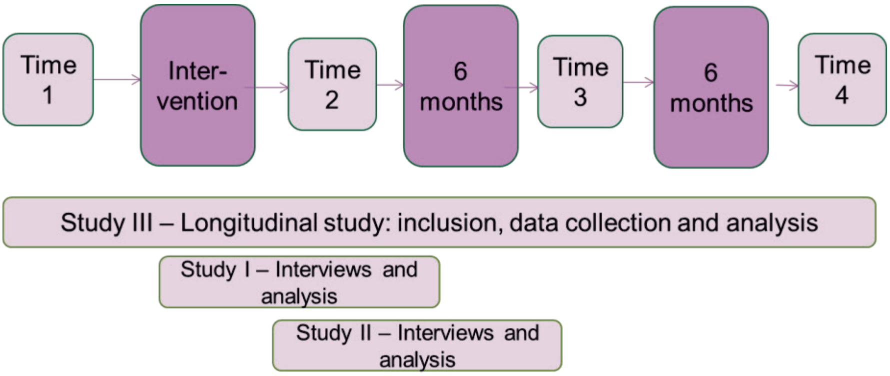

Figure 1. Flow chart of the overall study design.

To investigate the outcomes of two group interventions, we designed and implemented a longitudinal effectiveness study at two agencies offering interventions for children with experiences of IPV. We used a naturalistic design, with assessments before and after the intervention and possible follow-ups at 6 and 12 months after termination. At each assessment point socio-demographic data were collected and outcomes for both children and participating parents were assessed.

Participants, general description

Children were recruited from two treatment agencies specializing in interventions for children suffering from the consequences of domestic violence. The first agency provided a CBI and the second, a child and adolescent mental health service intervention (CAMHSI). All children included had been exposed to violence toward a caregiver. Violence against the parent included psychological violence (e.g., threats, insults, and controlling behavior) and physical violence (e.g., slapping, hitting, pushing, kicking, choking, and sexual coercion). Children who were included took part in group interventions for children with experiences of domestic violence. All children lived in one of the two major urban areas in Sweden and were Swedish speaking. For an overview of the participants, see Table 1. All 9 children in Study I were included in Study II, and 13 of the children in Study II were included in Study III.

Table 1. Participants in in Studies I, II, and III

	n	Boys/girls	Age range, yrs	Age M, yrs
Study I	9	4/5	4–6	5.5
Study II	17	7/10	4–13	7.1
Study III	50	26/24	4–13	7.4

Participants in Study I

In Study I we interviewed 9 children (5 girls and 4 boys) aged 4 to 6 years (M = 5.5 years; *Mdn* = 5.5 years); 5 attended the CBI and 4 attended the CAMHSI. Eight mothers and one foster parent took part in treatment. In seven cases, the perpetrator was the biological father; in one case, both the biological father and a new partner of the mother; and in one case, a new partner of the mother. The mothers reported that the physical violence had ceased, although 6 mothers reported that they were still exposed to verbal offenses and threats from the perpetrator. According to their mothers, 7 of the children had been physically abused (e.g., slapped, hit, pushed, and/or choked), all by the same perpetrator as their mother. No ongoing violence against the children was reported at the time of the interview. Of the 9 children, 6 had at least one parent who was not native Swedish; 7 lived with the abused parent, 1 in foster care, and 1 alternately with each parent; 7 had no contact with the abuser.

Participants in Study II

Study II included interviews with 17 children (10 girls and 7 boys), aged 4 to 13 years (M = 7.1 years, *Mdn* = 5.9 years). The caregivers who took part in treatment were 16 mothers and 1 foster parent. In 13 cases the perpetrator was the biological father, in two cases it was a new partner of the mother, in one case the biological mother, and in one case both the biological father and a new partner of the mother. All but one of the parents reported that the physical violence against them had ceased, but 6 reported ongoing verbal offenses and threats from the perpetrator. According to the parents, 12 of the children had been physically abused by the same perpetrator as the parent and 5 had not. At the time of the interview 7 parents of the physically abused children reported no ongoing violence against the children and the other 5 were unsure whether the violence had ceased or continued during visitations with the other parent. All but 2 of the children were born in Sweden, but 9 had at least one parent who was not native to Sweden; 13 children lived with the abused parent, 3 lived alternately with each parent, and 1 lived in foster care; 9 of the children had no visitations with their father.

Participants in Study III

Study III involved 50 children (24 girls and 26 boys) aged 4 to 13 years (M = 7.4 years, *Mdn* = 6.8 years, SD = 2.5 years) and their mothers. About 60% (31) of the children attended the CBI and about 40% (19) the CAMHSI. The children were recruited from 11 different groups (six CBI and five CAMHSI). In 45 cases the perpetrator was the biological father, in four cases it was a new partner of the mother, and in one case both the biological father and a new partner of the mother. According to the mothers' reports, 62% of the children had additional experiences of physical child abuse. Ongoing physical abuse of the child by the perpetrator was reported by one mother, and 8 reported ongoing verbal abuse of the child. All but 3 (94%) of the children were born in Sweden, and 28 (56%) had at least one parent who was not native to Sweden; 42 children lived with the abused parent, 7 lived alternately with each parent, and one lived in foster care. At the pre-intervention assessment 28 children had no visitations with their father. The children who received the CBI were significantly older (t (48) = 5.45, $p \leq .001$) and had more ongoing contact with their father (χ^2 (1) = 13.94, $p \leq .001$) than the children who received the CAMHSI. There were no other significant differences in background characteristics between the two intervention groups.

Both interventions offered treatment for children accompanied by mothers and by fathers; however, only mothers attended the interventions during the time of the study. The mothers were aged 23 to 51 (M = 36.9, SD = 6.3), and the perpetrators 24 to 54 (M = 40.1, SD = 7.3). All mothers reported exposure to physical and psychological aggression from a former partner; 87% also reported experiencing sexual coercion, and 85% reported partner-inflicted physical injuries.

Procedure, general description

Two units specialized in assessing and treating children with experiences of IPV were contacted and invited to participate in the research project. One unit was a community-based agency offering psycho-educative interventions, and the other was a specialized child and adolescent mental health outpatient unit offering psychotherapeutic treatment interventions. The background, aims, and research protocol were described and implemented at multiple organizational levels. At onset of the research project, information was given, and discussion was stimulated at meetings with directors, staff meetings, specific meetings with group leaders, and in individual dialogs with key persons. The directors of the agencies signed a research contract. One or two groups were completed each semester at each agency, which implied a 3-year period of inclusion in the study to obtain an acceptable number of participants. Group leaders were given a thorough review of the study objectives, methods, and instruments used. Group leaders then assisted in giving parents written and verbal information about the study, asking for written consent to participate, collecting sociodemographic data, and administrating the questionnaires. All interviews were performed by the author, an experienced child psychologist and psychotherapist. The author/researcher visited the agencies regularly and monitored the data collection throughout the entire research project. The personnel involved in the study received concrete and accessible support from the author/researcher on these occasions or by phone or email as needed. During the course of the research project, feed-back and preliminary results were presented at both agencies.

During 2013, 2014, and 2015, all children invited to take part in group interventions for children exposed to IPV at the two agencies were eligible for inclusion in the study. To be included, the child had to be older than 4 years but under the age of 16, and the caregiver needed to possess sufficient Swedish language skills to understand and answer the questionnaires. When invited to take part in the interventions, the caregivers received written and verbal information about the study from the staff members. At their next appointment, the caregivers were asked for written consent to participate. No payment or other compensation for participation was provided.

Procedure in Studies I and II

All participants in group interventions for children exposed to IPV during the spring of 2013 were eligible for Studies I and II. In most cases the mother was the single custodian. In one case in Study I and five cases in Study II the parents had shared custody after separation following IPV.

In cases where one parent was the single custodian, that parent was the one who received verbal and written information about the study, and the one who approved of the child's participation by signing a consent form. Children with parental consent were given verbal and written information if they were over 8 years old, or verbal information only if they were under 8, and asked for their own consent to participate.

In cases with shared custody, information about the study and a consent form was sent to the custodian parent not in contact with the agency if (1) the parent in contact with the agency and the child (if 8 years or older) had consented to participate, and (2) the parent in contact with the agency accepted contact between the researchers and the other custodian parent. The parent not in contact with the agency provided passive consent by not returning the form or withheld consent by returning the form refusing permission for the child's participation.

All parents approached agreed to their child's participation and provided background information about themselves and their child. At the end of the intervention, the parents were asked to schedule a research interview for their child. The parents were encouraged to inform their child about the study before the interview. At the time of the interview, the children received written and/or verbal information from the interviewer, and were asked for their consent to participate. All the children agreed to participate and interviews were conducted with 17 children. In Study I interviews with the 9 youngest children were analyzed; in Study II all interviews were included.

The children's consent was an integral part of an ongoing process; during the interview, they were able to influence both length of the interview and the depth and content of their responses (Dockett & Perry, 2007, 2011). The children could end the interview, pause it, or pass on a question at any time. All interviews took place at the agencies in March, May, and June of 2013. All children but one were interviewed without their parents present, and one child chose to have the mother in the room. Each interview lasted from 19 to 53 minutes.

In research with children, the guidelines for conducting interviews need to be adapted to permit extended time for the children to become comfortable and to encourage a more active and guiding approach from the researcher than otherwise (Smith, 2004). In the present study, the children were first asked to talk about going to preschool or school or to describe something they liked to do to establish rapport and allow the children to practice being interviewed (Lamb & Brown, 2006). The interviewer emphasized the child as the expert and the researcher as one in need of knowledge from the child.

The interviews with the children were guided by two main focuses. Children were asked to tell about their experiences of participating in the group treatment and to talk about their abused parent and their relationship with that parent. The interviewer used broad invitations to talk and open questions such as “Tell me about coming to the group,” “Can you tell me about Mom?” and “Can you tell me about you and your Mom?” Follow-up questions probed responses already given by the child as cues for further questioning, including such prompts as “Can you tell me more about that?” and “Can you explain what you mean?” In addition to answering the questions verbally, the children were given the opportunity to illustrate their answers by drawing or using toys. The illustrations and toys informed the interviews and were used as cues for further questioning, but did not form part of the data that was analyzed. All interviews were recorded and transcribed verbatim

Procedure in Study III

During 2013, 2014, and 2015, all children invited to take part in group interventions for children exposed to IPV at the two agencies were eligible for inclusion in Study III. To be included the child had to be older than 4 years but under the age of 16, and the mothers had to have sufficient Swedish language skills to understand and answer the questionnaires used. During the period of inclusion, 54 children were invited to participate in the interventions. Two families were excluded because of poor language skills and two families did not want to participate.

When invited to take part in the group intervention, the caregiver in contact with the agency was given verbal and written information about the study. At their next appointment the caregivers were asked for written consent to participate. Once before the group intervention (T1) and once after completing the intervention (T2), mothers who agreed to participate provided background information on themselves and their child in a structured interview and responded to self-report inventories about themselves and their child. Identical instruments for assessment were used at T1 and T2. The pre- and post-treatment assessments were conducted at each of the two treatment units by the regular staff.

The intervention programs

The intervention programs at the two agencies were both well-established and part of the routines at the units. The community unit offered an intervention with a psycho-educative concept while the child and adolescent mental health unit offered an intervention with a psychotherapeutic approach. Both programs were manualized and consisted of 12 to 15 weekly 90-minute sessions, with parallel group sessions for children and for abused parents. Taking part in the intervention programs implied that the child and the abused parent had both acknowledged the IPV. It was also necessary that the intimate relationship between the mother and the abusive partner had terminated before the start of the intervention. In all cases, the parents and staff considered IPV the main reason for their taking part in the intervention; however, in neither of the two agencies there was a formal routine for performing trauma screening. Participation was voluntary and free of charge.

The psycho-educative intervention

The psycho-educative intervention was provided at a unit offering community services for children exposed to IPV and their non-offending parent. The intervention was directed at children exposed to IPV regardless whether they presented any symptoms or difficulties. The group program was based on the CAP program (Hawthorne, 1990), originally developed for children with parents who abuse alcohol or drugs, and revised, adjusted, and evaluated for use with children exposed to IPV (Georgsson et al., 2007; Grip et al., 2011; Grip et al., 2012). The groups were led by two experienced social workers and were composed of four to eight children aged 4 to 13 years, with an age range of 18 months within each group. Each session was structured on a unique theme and combined a short presentation with additional exercises, discussions, play, and a snack. Themes included education about violence, safety planning, reactions to IPV, feelings, family relationships, and communication. The goals were to strengthen the children's capacity to cope with their experiences and to reduce the risk of them being negatively affected by those experiences in the future. Other goals were to help children express and understand their feelings, thoughts, and experiences and to decrease their feelings of alienation and shame. The parents' program used themes parallel to those in the children's group, with the aim of increasing parental knowledge and skills and reducing parental feelings of shame and alienation.

The psychotherapeutic intervention

The psychotherapeutic treatment intervention was provided at an outpatient child and adolescent mental health unit specialized in assessments and interventions for traumatized children. The intervention was trauma-focused time-limited psychotherapy in a group setting for children exposed to IPV who showed psychiatric symptoms and complex reactions. The treatment was based on trauma theory, attachment theory, and psychodynamic theory (Brager & Lichtenstein, 2015). The groups were composed of four to six children aged 4 to 6. Each group was led by two experienced group leaders who were psychologists or social workers. The sessions followed a fixed structure and targeted themes such as violence within the family, separation, visitations, fears, grief, and conflicts in daily life. The different themes were approached through dialogues, exercises, trauma-focused play, and free play. The treatment goals were to decrease the children's psychiatric symptoms; to help the children express and understand their feelings, thoughts, and experiences; and to reduce feelings of alienation and shame. The parent group paralleled the themes targeted in the children's group, and were aimed at increasing parental knowledge and skills, reducing feelings of shame and alienation in the parent, and strengthening the parent–child relationship.

Ethical considerations

Research with children and parents struggling with difficult life situations in the aftermath of IPV involves several delicate challenges. Children and parents must be made to feel safe and respected. Interviews with young, vulnerable, and traumatized children have further specific challenges including (1) gaining and retaining the child's informed consent through constant checking, (2) considering the child's vulnerability, risks of uncomfortable or overwhelming experiences during the interview, and possible conflicts of loyalty, and (3) remaining alert to the power imbalance between the researcher and the child (Cater & Øverlien, 2014; Flewitt, 2005; Solberg, 2014). In all three studies these considerations were acknowledged, and efforts were made to make parents and children feel safe and valuable as informants. Steps were taken to recognize each child's limits for participation, to gain approval for the child's participation from the abused parent, to keep the focus of the interview on the research questions, and to avoid encouraging the child to speak about the trauma itself. Language was kept simple and close to the child's own mode of expression. When children spontaneously discussed traumatic experiences, the interviewer actively responded to validate their statements, but did not encourage further exploration of that topic. The interviews were carried out in a setting well-known to the child, and after the interview the child was reunited with the caregiver. Additional professional support was available for both parents and children if needed.

The research project was approved by the Regional Ethics Committee in Uppsala (Dnr 2012/246).

Analysis in Study I

The transcribed interviews were analyzed using interpretative phenomenological analysis (IPA). The approach is inductive, which allow unexpected themes to emerge, and the interpretation is descriptive, empathetic, and critical (Smith, 2004; Smith, Flowers, & Larkin, 2009). IPA is considered applicable when the aim is to explore, describe, and interpret how participants make sense of their experiences, preferably in a small and reasonably homogeneous sample (Smith et al., 2009). The analysis was carried out in the five steps recommended by Smith (2009). The first three steps were (1) listening to the interviews and repeatedly reading the transcribed interviews while making initial descriptive comments; (2) drawing emerging themes out of the initial comments; and (3) forming clusters of superordinate themes, which were listed together with illustrating quotations. These three steps were repeated for each interview before the two final steps were then taken: (4) carrying out the analysis across cases to find common structures and master themes that embrace commonalities and discrepancies in the phenomena; and (5) transforming each theme to a narrative account, with illustrative quotations to explain the content. Five master themes were identified. During the analysis, themes and interpretations were checked against the transcripts. Each step of the analysis was initially carried out independently by the author, and then revised in collaboration with the second author of the published research article before moving to the next step.

Analysis in Study II

The interviews in Study II were analyzed using thematic analysis as described by Braun and Clarke (2006) to identify, analyze, and report patterns in the data. The analysis was conducted inductively using a contextual approach, which is considered appropriate when the aim is to describe, in context, how participants understand their experiences (Braun & Clarke, 2006). The process was guided by the research question, with the aim of identifying, analyzing, and reporting the statements children made about their abused parent. The process of analysis is described below; for a more detailed description of the phases of thematic analysis, see Braun and Clarke, 2006.

Each transcript was read several times by the researcher. Notes were made of significant topics and initial codes close to the content of the transcripts. Themes were then grouped within and across interviews. Coded extracts within each theme were read and compared in order to identify similarities and differences. Finally, grouping the themes and creating sub-themes resulted in three main themes and seven sub-themes. Main and sub-themes were checked against the original transcripts and adjustments were made if necessary. Each step of the analysis was first carried out independently by the author and then revised in collaboration with the second author of the published research article before the next step was taken.

Validity and quality of the qualitative analyses

As suggested by Smith et al. (2009), the validity and quality of the qualitative analyses in Studies I and II were assessed by applying the four broad principles presented by Yardley (2000, 2008): sensitivity to the context; commitment and rigor; transparency and coherence; and impact and importance. Throughout the research project, great sensitivity to context (e.g., conditions at the agencies, life circumstances of the participants, the interview process and its effect on the interviewees, and the emotional nature of the raw material) was essential. This sensitivity naturally included commitment to each child's needs during the interviews and close care of the data from each case. The studies were performed with great rigor in selecting the sample, preparing and conducting the interviews, and analyzing the data. Striving toward transparency, we carefully documented each step in the analysis and made them possible to track by an independent virtual audit. The studies' impact and importance lie in their efforts to bridge gaps in knowledge on how children experience interventions and their relationships, and to uphold their right to be heard on issues that concern them (United Nations, 2014).

Analysis in Study III

To calculate the differences between the pre- and post-treatment assessments in the groups, a two-tailed paired *t*-test was applied. For comparisons of the differences between the CBI and the CAMHSI, an independent *t*-test and Pearson's chi-squared test were used. The interaction between the type of intervention and the change in symptoms from pre- to post-intervention assessment was explored by conducting a general linear model with repeated measures procedure for each dependent variable, with *group* (CBI versus CAMHSI) as the between-subject variable and *time* (pre- vs. post-intervention assessment) as the within-subject variable. To calculate effect sizes, Cohen's *d* was applied, with ≥ 0.80 indicating a large effect, ≥ 0.50 indicating a moderate effect, and ≥ 0.20 indicating a small or no effect (Cohen, 1988). For dropouts, dependent *t*-tests using the last observation carried forward method were conducted. Univariate regression analyses were used to analyze the possible co-variation of outcomes – i.e. change in symptoms between the pre- and post-intervention assessments – with child age, gender, or frequency of IPV as predictors. Controlling for possible associations between a child's change in symptoms from the pre- to the post-intervention assessments and possible influential variables – i.e., a child's experience of physical abuse, a child's ongoing contact with the father, maternal ongoing symptoms of traumatic stress, and child trauma symptoms at the onset of the intervention – multiple regression analysis was applied. To investigate whether the reported changes in symptoms were clinically significant, clinical cutoff scores for the Strengths and Difficulties Questionnaire and the Trauma Symptom Checklist for Young

Children were used. The statistical software SPSS, version 23.0, was applied for all calculations. A significance level of $p < 0.05$ was applied.

Measures in Study III

Several questionnaires were used to assess maternal and child exposure to violence; child mental health, PTS symptoms, emotionality, and emotional regulation; and maternal mental health and PTS symptoms. All questionnaires were completed during an individual visit by the caregiver who attended the intervention. The caregiver could choose to read and answer the questionnaires by themselves, or to have them read aloud by the attending clinician. There was always a staff member in the room to attend to any questions or thoughts shared by the caregiver.

Exposure to violence. The revised Conflict Tactics Scale (CTS2) was used to assess the degree and type of IPV experienced (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The revised version includes parental reports of the child's exposure to the violence experienced by the parent (Broberg et al., 2011). The instrument assesses the prevalence and frequency of psychological aggression, physical assault, sexual coercion, injury, and negotiation. Internal consistency in this study ranged from α = 0.59–0.90, with poor consistency on the injury subscale and acceptable or good consistency on the remaining subscales.

Child mental health. The mothers completed the Swedish parental version of the Strengths and Difficulties Questionnaire (SDQ-P; Goodman, Ford, Simmons, Gatward, & Meltzer, 2000). The questionnaire is designed to assess prosocial behavior and psychopathology in 3- to 16-year-olds and consists of five subscales, plus a supplemental inquiry about the impact of problems. The subscales are emotional symptoms, conduct problems, hyperactivity/ inattention, peer relationship problems, and prosocial behavior; a total difficulties score is generated by summing up all except the prosocial behavior subscale (Goodman, 2001). The suggested Swedish cutoff score for problems in the clinical range is ≥14 points for the total difficulties scale and ≥1 for the impact scale (Smedje, Broman, Hetta, & von Knorring, 1999). In this study, internal consistency was generally satisfactory (mean α = 0.74), and particularly good for the total difficulties scale and the hyperactivity/ inattention subscale (α = 0.83 and 0.84, respectively), while internal consistency of the peer relationship problems subscale was lower (α = 0.58).

Child post-traumatic stress symptoms. To assess the children's PTS symptoms, the mothers filled out the Trauma Symptom Checklist for Young Children (TSCYC; Briere et al., 2001; Nilsson et al., 2012). The TSCYC is a broad-spectrum caretaker report instrument designed for the assessment of trauma symptoms in children aged 3 to 12 years. The purpose is to identify symptoms a young child can show in the aftermath of potential trauma. The instrument contains nine clinical scales. One scale for total PTS and three subscales of intrusion, avoidance, and arousal; the other scales are anxiety, depression, anger/aggression, dissociation, and sexual concerns. The questionnaire has been shown to be reliable and valid for children exposed to potentially traumatizing events (Briere et al., 2001; Nilsson et al., 2012). The suggested clinical cutoff score is a T-score of 70, with T-scores of 65 to 69 indicating potential problems. In this study, raw participant scores were used as primary outcomes, and a T-score of 70 was used as the clinical cutoff score. Internal consistency in this study was satisfactory for all nine scales (mean $\alpha = 0.84$, ranging from 0.74–0.91).

Child emotionality and emotional regulation. Emotional reactivity and capacity for emotional regulation were assessed on the Emotion Questionnaire for Parents (EQ-P), a parental report on a child's reactivity to emotional stimuli and capacity to regulate emotions independently or with the help of an adult (Rydell, Berlin, & Bohlin, 2003). In the present study, internal consistency was good for the emotionality subscale and the emotion regulation subscale ($\alpha = 0.85$ for both scales).

Maternal mental health. The Brief Symptom Inventory (BSI) was used to measure current parental psychological distress and symptoms. It is a screening instrument based on the Symptom Checklist-90 (SCL-90) rating scale (Derogatis & Melisaratos, 1983; Fridell, Cesarec, Johansson, & Malling Thorsen, 2002). The Global Severity Index was used, with higher scores indicating more problems. In the present study, the internal consistency was satisfactory ($\alpha = 0.93$).

Maternal post-traumatic stress symptoms. To measure maternal symptoms of PTS, a self-report trauma symptoms inventory with the three subscales of intrusion, avoidance, and hyperarousal the Impact of Event Scale-Revised (IES-R) was applied (Weiss, 2004). Although the IES-R is not intended as a diagnostic instrument, a mean of ≥ 1.89 on a subscale indicates problems and a mean of ≥ 1.8 on the total score indicates PTSD. Internal consistency in the current study was good: $\alpha = 0.83$ for the intrusion subscale, 0.79 for the avoidance subscale, 0.82 for the hyperarousal subscale, and 0.90 for the total score.

Results and conclusions

Results from Study I

Five master themes concerning how children experienced taking part in the interventions emerged in the analysis of the interviews with the children: (1) joy = positive emotional experience of participation, (2) security = feeling safe, (3) relatedness = relationships within the group, (4) talking = externalizing the experience of violence, and (5) competence = new knowledge and skills. The first three themes embody how the children experienced their participation in the interventions, and the latter two describe their experiences of the content of the interventions.

Conclusions

The children described the intervention as a safe place to have fun and meet others, offering an opportunity to discuss distressing matters and gain new abilities. These are general needs of young children that may be insufficiently met among children exposed to IPV, often leading to symptoms. Consequently, these children appreciate and benefit from a context that meets their needs in areas where they have difficulties. The study further highlighted the benefit of listening to children; the importance of not being overly focused on specific components of treatment, but primarily on issues of genuine and positive relationships, security, and joy; and the need to consider these important non-specific areas of psychological treatment when choosing or evaluating treatment methods.

Results from Study II

The analysis of the interviews with the children resulted in three themes with seven sub-themes reflecting how the children described their abused parent: (1) coherent accounts of the parent, with the sub-themes of general benevolence; provision of support, protection, and nurture; and parental distress; (2) deficient accounts of the parent, with the sub-themes of vague accounts and disorganized narrations; and (3) the parent as a trauma trigger, with the sub-themes of avoidance and breakthroughs of intrusive memories and thoughts.

Conclusions

The children were shown to have capacities as well as difficulties in reflecting upon the abused parent, indicating that they may have both integrated and deficient or blocked internal representations of their parent in the aftermath of IPV. The understanding of this variety and the risk that the parent may serve as a trauma trigger has implications on theory about the consequences of IPV and on clinical practice in designing and performing interventions for children exposed to IPV. The study further shows that children in early and middle childhood who have witnessed IPV are able to reflect upon and talk about their abused parent and their relationship with that parent.

Results from Study III

Children's symptoms.

Mothers of children in both interventions reported significant reduction of some symptoms in children after participating in the interventions. Mothers in the CAMHSI reported large significant positive changes in their child's depressive symptoms and capacity to regulate emotions (*d* = .85 to *d* = .99). They also reported significant positive changes in their child's overall mental health, the impact of difficulties on everyday life, emotional symptoms, hyperactive symptoms, emotionality, anger, arousal, and dissociation (*d* = .46 to *d* = .76). Mothers in the CBI reported significant reduction with medium effect size in the impact of difficulties in everyday life (*d* = .62), and with small effect size in their child's emotional, PTS, and intrusive symptoms (*d* = .34 to *d* = .40).

Maternal symptoms.

Mothers in both interventions reported significant and large decrease in symptoms of PTS (*d* = .93 to *d* = 1.03). In addition mothers in the CBI reported significant moderate improvement in general mental health (*d* = .60).

Comparing outcomes of the two interventions.

The mothers in the CAMHSI reported significantly larger improvement in their children on depression, anger, emotional regulation, dissociation, and prosocial behavior than mothers in the CBI (*d* = .66 to *d* = .80). No significant differences between the two interventions were found in the treatment effects on maternal outcomes.

Children's outcomes and possible predictors, moderators, and mediators.

Higher levels of pre-treatment PTS were associated with larger improvements on several measures post treatment. Higher levels of continuing maternal PTS post treatment were associated with lower improvement in child PTS.

Clinical significance.

Despite the reported decrease in several symptoms following the interventions, many mothers still reported their children's symptoms to be above the cutoff score for clinical problems.

Conclusions

The results of the study indicate that children benefited from both the psycho-educative and the psychotherapeutic group interventions but in somewhat different aspects. Symptom reduction was substantially larger in the psychotherapy intervention, and children with initially high levels of trauma symptoms benefited the most. Both interventions were successful in reducing mothers' PTS, but children whose mothers remained severely affected by trauma symptoms benefited less from the interventions. The fact that most mothers still reported their children as having trauma symptoms at clinical levels post treatment implies a need for routine follow-up of children's symptoms and the possible need of additional services after interventions.

Summary of the of findings from the three studies

Study I showed that the interviewed children described treatment as a safe place to have fun and meet others, offering an opportunity to talk about distressing matters and to gain new abilities.

Study II indicated that children in interventions after exposure to IPV may have both integrated and deficient or blocked internal representations of the abused parent.

Study III indicated that children and mothers benefited from both the psycho-educative and the psychotherapeutic group interventions, yet many children still showed clinically significant symptoms post treatment.

The studies further elucidate the benefit of including young children's voices in research (Studies I and II) and the need for thorough assessment (Studies II and III) and reflection in designing, implementing, and evaluating interventions for children exposed to IPV.

GENERAL DISCUSSION

The general aim of the thesis was to augment knowledge on interventions for children exposed to violence against a caregiver. The three studies included are all part of the same research project, aimed at elucidating the experiences, needs, and outcomes of children taking part in group interventions after exposure to IPV. The overall approach is to combine studies with different methodologies, designs, and complementary focuses on related research questions to allow a complex and rich understanding to evolve.

In the three studies, the children demonstrated a range of capacities, resources, and opportunities for recovery in the aftermath of IPV. Capacities such as the ability to reflect and resources such as access to supportive and nurturing internally integrated representations of the maternal caregiver were highlighted (Study I and II). Children described feelings of joy and safety associated with the interventions and mothers reported a significant decrease in child symptoms after interventions (Study I and III).

On the other hand, many of the children demonstrated ongoing symptoms at clinical levels post treatment; some showed difficulties in reflective thought and deficient or blocked internal representations of the mother, and some were easily triggered, ambivalent about their mother, or reluctant to talk about their experienced trauma in treatment (Study I, II and III). These children appeared to be particularly vulnerable and in need of additional or different support and services.

The effectiveness of the group interventions

In evaluating the effectiveness of the two group interventions, several issues are relevant to discuss and reflect upon. This section will discuss the effectiveness of the two interventions in comparison with other evaluated interventions for children exposed to IPV, similarities and differences between the two interventions, possible relations between the content of the interventions and outcome, and some areas of outcome of special interest.

The two interventions compared with other empirically evaluated interventions for children exposed to IPV

The results from the studies included in this thesis show both similarities and differences to previous research on interventions for children exposed to IPV. The children's satisfaction with the interventions agrees with previous studies on group interventions (Broberg et al., 2011; Georgsson et al., 2007; Metel & Barnes, 2011), and the reduction in children's symptoms of general psychological distress had effect sizes (small to medium) similar to those reported elsewhere of CBI (Graham-Bermann et al., 2007; Graham-Bermann et al., 2015; Grip et al., 2012). The effect sizes of decreased trauma symptoms in children in both interventions studied were lower than those reported in previous studies of trauma-focused individual and dyadic psychotherapy for children exposed to IPV (Cohen et al., 2011; Lieberman et al., 2006; Lieberman et al., 2005).

The reported reduction in depressive symptoms in children in the CAMHSI in this study was significant and with larger effect sizes than the reduction of symptoms of general psychological distress and depression reported in earlier studies on psychotherapeutic treatments for children and youth (Silverman et al., 2008; Weisz et al., 2017). The results from the CAMHSI indicated that the intervention was more effective in reducing depressive symptoms (large effect size) than symptoms of PTS (small to medium effect sizes). This finding is contrary to the meta-analysis of trauma treatments for children by Silverman et al. (2008), reporting medium sized effect sizes for PTS and small effects on depression.

In conclusion, both interventions seem at least as effective as other comparable evaluated interventions in reducing externalizing and internalizing symptoms. Individual and dyadic trauma-focused interventions seem to be more effective in reducing trauma symptoms than the two interventions studied (Cohen et al., 2011; Lieberman et al., 2005; Silverman et al., 2008). This could indicate that the group format, offering extensive possibilities for normalization and joyful experiences, may be well-suited to target depression and general psychological health. Symptoms of traumatic stress, on the other hand, may be better treated in individual and dyadic trauma-focused interventions.

In previous research, clinical significance is often not discussed and analyses mostly rely on statistical tests of mean differences (Dorsey et al., 2017). This makes it difficult to compare this aspect of the results of the present studies with previous research. Nevertheless, the result that many children still exhibited high and clinical levels of symptoms post treatment accords with previous Swedish reports of clinical significance and evaluations of interventions for children exposed to violence against a caregiver (Broberg et al., 2011; Grip et al., 2012).

Comparison of the two interventions

Research on outcomes of interventions for children exposed to IPV include few RCTs or naturalistic studies, and the interventions have been evaluated mainly through studying specific interventions with no comparison with a control group or alternative interventions (Rizo et al., 2011). The present research design, including two different interventions in a naturalistic setting, represents an attempt to extend perspectives on the effectiveness of the interventions and the experiences of children by enabling comparisons of both similarities and differences across conditions.

Mothers of children in both the studied interventions reported high levels of pre-treatment symptoms in the children, often above clinical cutoff levels. However, when evaluating their outcomes, it is important to bear in mind the different objectives of the two interventions. The CBI aimed to help children cope with their situation and to prevent increased distress and malfunction in the future, while the clinical intervention had the added explicit objective of reducing symptoms. Consequently, children in the CAMHSI could be expected to show a greater reduction in symptoms after treatment. Children demonstrated decreased symptoms after both interventions, and as expected, the decrease was found in more areas and with larger effect sizes in the CAMHSI.

It is worth reflecting on whether the selection of assessment methods influenced the outcomes. In Study III, we used measures focused on psychological symptoms, a frequent choice given the availability of measures, the clinical focus of studies, and the expectation of symptom reduction (Silverman et al., 2008). It is possible, though, that these measures of outcome are better suited to assessing interventions in child and adolescent mental health services than in community settings. Due to the different objectives of the interventions studied, this choice may have favored the CAMHSI, and measures of attitudes, knowledge about violence, and interactions with others could have been more suitable for evaluating the CBI. Silverman et al. (2008) argue in the same direction when they recommend that evaluations of treatments for child trauma combine assessments of PTSD, depression, and externalizing behavior problems with additional functional outcomes such as social competence, school achievement, and legal involvement. Measures of attitudes and knowledge about violence may be more adequate to evaluate interventions in community setting.

The results from the CAMHSI are ambiguous. These children showed a greater decrease in their symptoms of depression, anger, and dissociation, along with significantly greater improvements in their capacity for emotional regulation than did the children in the CBI, which is as expected. However, CAMHSI children showed limited change in symptoms of PTS, which is a less satisfactory result considering that this intervention is focused on treating trauma. The children in the CBI also showed some decrease in symptoms, specifically some emotional and PTS symptoms and the impact of their difficulties in everyday life. These results combined with the children's experiences of joy, safety, new relationships, and skills can be seen as satisfactory.

Content of the interventions

In comparing these two group interventions with other existing interventions for children with experiences of IPV it is relevant to consider to what extent they included elements typical of ESTs for children exposed to traumatic events: psychoeducation of trauma; training in emotion regulation; imaginal exposure; in vivo exposure; cognitive processing; and/or problem solving (Dorsey et al., 2017). Both interventions contained elements focused on psychoeducation, emotion regulation, and problem solving. The CBI had a greater emphasis on psychoeducation while the CAMHSI had a somewhat greater emphasis on emotion regulation. This may be reflected in the results, in that the CAMHSI was more effective in reducing emotionality and increasing capacity for emotion regulation. Imaginal exposure, in vivo exposure, and cognitive processing of the individual trauma was limited in both interventions, which may be reflected in the relatively small changes in symptoms of PTS. This supports the notion that severe symptoms of PTS, specifically avoidance and intrusion, may not be efficiently treated without inclusion of some components of exposure and cognitive processing of the individual trauma (Foa, et al., 2009). These components can be difficult and inappropriate to include in group interventions, especially with young children. Some sessions containing exposure and processing of individual trauma were included in individual and dyadic sessions during intake and post intervention, but they were limited. Children exhibiting a high level of trauma symptoms might benefit from the procedure suggested by Deblinger et al.

(2016) including individual sessions focused on exposure and the individual trauma narrative within or in addition to the group sessions.

Specific dimensions of outcome

Satisfaction with treatment

Satisfaction with interventions is necessary to encourage attendance and may counteract drop-out, and attendance enables children and parents to benefit from interventions. Satisfaction with interventions also fosters hope and trust in community services and healthcare, and promotes future willingness to seek help if needed (Godley et al., 1998). The safety and joy described by the children in Study I are obvious and strong contributors to both child and parental satisfaction with the intervention; as suggested by Deblinger et al. (2016), the group format may offer unique opportunities to promote joy in sessions, which in turn may encourage attendance and improve outcomes.

Capacity for affect regulation

Several aspects of the results of the three studies form a picture of developing, and often improved, affect regulation in the children: the children's ability to reflect upon the intervention and their abused parent; their feelings of safety in the interventions; the mothers' reports of reduced child symptoms (especially arousal and anxiety); the decreased impact of symptoms on daily living; and their improved capacity for emotional regulation. In Study I most children expressed feeling secure and safe in treatment, and in Study II several children were able to reflect on their abused parent in an integrated manner. At the same time, some children in Studies I and II demonstrated the difficulties they faced by being triggered by trauma reminders (e.g., the mother, trauma focus in treatment), leading to traumatic stress reactions, and possibly indicating complex reactions in the relationship with the mother and/or ambivalence or reluctance about a focus on trauma in treatment. Two possible paths for the children in treatment are discernible. On one path, their growing experience of safety and improved affect regulation contributes to children's ability to situate themselves in a "window of tolerance," the optimal arousal zone between of hypo- and hyperarousal (Siegel, 2012). Staying within the window of tolerance may be a prerequisite for effective treatment by enabling children to learn and change through the integration of information on cognitive, emotional, and sensorimotor levels (Ogden, Minton, & Pain, 2006). On the other pathway, however, children tend to be easily triggered, exhibiting re-experiences, arousal, avoidance, and disorganizing and dissociative symptoms. This may indicate remaining difficulties and the absence or insufficiency of improvement despite of treatment.

There broad is consensus on the importance of stabilization for children exposed to traumatic events. A sequential model is often advocated, with safety and stabilization as primary foci, followed by components targeting processing and symptom reduction (Cook et al., 2005; Ford & Courtois, 2013). The current studies illustrate that in complex traumas, when the primary caregiver has been part of the traumatic experience and reminders of trauma reside in the child–parent relation, this sequential model might not meet the needs of exposed children. When experiences of insecurity are inherent in the child–parent relationship, due to past traumatic events or recurrent trauma reminders within the relationship, balancing between stabilization and exposure may be a continuous negotiation throughout interventions and recovery.

In conclusion, physical and emotional safety and improved capacity to regulate emotions may be some of the keys to treatment effectiveness and symptom reduction. For some children the group intervention may be satisfactory, and for others it may establish a foundation that allows them to benefit from other interventions. Still others may benefit from additional or different services.

The relationship between the child and the abused parent

In the aftermath of IPV mothers as ewll as children typically struggle with the consequences of the exposure to violence and coping with symptoms of PTS. Maternal PTS has been shown to have a negative impact on parenting and/or the child (Hungerford et al., 2012; McFarlane et al., 2017; Schechter et al., 2011), and treating maternal PTS while also focusing on the child–parent relationship may therefore be beneficial in services for young children exposed to IPV.

Both interventions studied were child oriented, and their primary objectives were focused on the children’s well-being. Nevertheless, mothers in both interventions reported substantially improved mental health, with symptoms of PTS reduced from clinical to sub-clinical levels on symptoms of intrusion, avoidance, and hyperarousal (medium to large effect sizes). It is noteworthy that the parental groups in the two interventions did not focus on the abused parents’ traumas, symptoms, or needs. Neither did any of the group interventions studied encompass components equivalent to parental training. Parental training programs are widely recommended and used in both community settings and in child and adolescent psychiatry when families struggle with relational and/or child behavioral challenges, and typically focus on training parenting practices. Both the parental groups in the interventions studied paralleled the themes in the child groups, focusing on psycho-education, empowering the caregiver, and improving attachment to the child. Improvements in adult functioning and mental health seem to have been accomplished through their concern for the child and focus on the parent/child relationship.

In Study III the reported improvement in maternal mental health, particularly the decrease in symptoms of PTS in both intervention groups, was striking. The benefit of this is multifold. The health benefits for the women are obvious, but the results also indicate that children whose mothers have continuing high levels of PTS at post-intervention assessment benefit less from intervention. This indicates the importance of targeting caregiver health in interventions for young children, a notion in accord with previous research associating maternal and child symptoms of PTS (Bogat et al., 2006; McFarlane et al., 2017). The large effects of the interventions on maternal health seem to have contributed to their child's well-being, whether through direct influence on child functioning or through improved parenting. One can further hypothesize that these effects on maternal psychological health may contribute to the sustainability of positive child outcomes of interventions, continuous recovery in children, and/or the prevention of future child malfunctioning and distress. Finally, the results of the present studies illustrate the benefit of focusing on the child–caregiver relationship, as emphasized in theory and research (Graham-Bermann et al., 2007; Rizo et al., 2011; Silverman et al., 2008; Stover et al., 2009). In accord with current research findings and existing theory, Studies II and III indicate a twofold reason to focus on this relationship: the attachment relationship is the main source of safety, nurturance, and recovery for young children and children are at severe risk when this relationship malfunctions. When a parent serves as a trigger for trauma reactions in the child, this needs to be identified and targeted in treatment.

What works?

When reflecting on the effectiveness of interventions, it is relevant to consider what works in the sense of which components contribute to positive change, what may not contribute to desired development, and what may lead to unwanted changes or even deterioration. EBP argues that to be effective interventions must be supported by current research, compatible with clinical experiences, and accepted by clients (Sackett, 1997b).

The first prerequisite of effectiveness is that an intervention is offered to those who actually need it. As Dorsey et al. (2017) emphasizes, the biggest challenge in trauma treatments is how to implement and sustain interventions with evidence of efficacy or effectiveness. Feasible interventions, even if less effective, may have the greatest impact (Dorsey et al., 2017). It is also very important that the intervention offered is accepted by both organizations and the clinicians, and it must be compatible with the objectives of the organization, with the competence level of the personnel, and the actual contextual conditions. To be sustainable over time, the intervention further needs to be continually confirmed in all these aspects. The two interventions studied in this thesis were both well-established and had been applied in the agencies for some years. Both agencies were stable, had a clear definition of their mission and objectives, and had a reasonable mix of new, experienced, and expert staff members. Furthermore, both agencies had a high ambition to continually improve interventions by integrating new knowledge. Clear routines, stringent performance, pre- and post-treatment assessments, and participation in research are all components that were present and are known to contribute to high quality in interventions, which suggests that the requirements to carry out interventions mentioned above were met.

Secondly, an intervention must be accepted by parents and children, sufficiently meet the clients' expectations, and be perceived as meaningful and in most respects also rewarding. The most obvious confirmation of this for the interventions in the studies in this thesis was the fact that parents and children did attend the intervention and followed the intended format. Compliance was strengthened by children's enjoyment of the interventions. The group format in the interventions studied offered rich opportunities to enhance child and caregiver satisfaction. Satisfied children and parents do attend interventions, a potential precondition for positive change and symptoms relief. Study I clearly showed that children associated the two group interventions with joy and security, a fact that considerably augments the probability that children will want to take part and that parents will bring their children. This was further validated by the fact that very few child–caregivers dropped out of the interventions once they had started (Study III). This also accords with earlier studies demonstrating that children and parents appreciate trauma-focused interventions in the aftermath of IPV (Broberg et al., 2011; Grip et al., 2012).

Finally, when reflecting on the effectiveness of interventions, one may consider whether the method applied, or specific components within the intervention, are evaluated to be effective. The results indicate that the two interventions studied both had a high legitimity and did contribute to positive change in the children, although at the post-treatment assessment the CAMHSI seemed to have been somewhat more effective in reducing symptoms of psychological distress (Study III). These two interventions both involved caregivers, and even though no comparison was made with interventions not including caregivers, the results point in the same direction as previous research emphasizing the positive impact of involving parents in interventions (Graham-Bermann et al., 2007; Rizo et al., 2011; Silverman et al., 2008; Stover et al., 2009). Studies II and III further support this notion by indicating the importance of focusing on the child–caregiver relationship, parenting, and parental mental health when offering services to children with experiences of exposure to IPV. Conclusions must be drawn with caution from the finding that both interventions were in many cases insufficiently effective in reducing child symptoms, especially of traumatic stress. This may indicate that while many children who have been exposed to severe forms of IPV struggle with complex and severe symptomatology, more extensive services and treatment are called for. It may also be that effective treatment in these cases would benefit from adding components of exposure and/or direct dyadic/relational interventions.

Reflection on the effectiveness of interventions also raises the question of identifying ineffective interventions or components. Across studies, 5% to 10% of patients are shown to develop increased or new symptoms over the course of psychotherapy (Lambert, & Ogles, 2004; Lilienfeld, 2007). Research has repeatedly shown that some children report feeling bad or stigmatized, and a few may suffer from increased symptoms when taking part in interventions (Carlberg et al., 2009; Lobatto, 2002; Midgley et al., 2006; Stith et al., 1996; Strickland-Clark et al., 2000). None of the studies in this thesis indicated any increase in symptoms or distress in the children, which indicates that these two group interventions may be regarded as safe for both children and caregivers. The combination of the group format that offers a natural normalizing context and the stabilizing components that strengthen affect regulation seems to counteract stigmatization and harmful overwhelming feelings. Whether some components are unnecessary remains unknown. However, the large prevalence of multiple victimization and the subsequent need to offer generic interventions which can be applied to a variety of experiences, symptoms, and needs suggest that interventions need to comprise more components than needed or applied in any individual case (Cater et al., 2014; Finkelhor, 2017).

Children’s voices in research

The UNCRC is based on the three pillars of participation, protection, and provision (United Nations, 2014). The field of research on interventions for children with experiences of IPV has been dominated by a dual focus on protection and provision: the urge to protect children from exposure and the endeavor to provide feasible and effective services and interventions. The children’s own perspective of participation has often been neglected. Inclusion of the voices of children in the field of evaluation of interventions offers a way to include more of the rights of children and simultaneously to further develop and improve interventions. Interviews with children and qualitative research methods offer opportunities to pose new and different questions in the field of evaluation of interventions, a field traditionally dominated by quantitative research methods. This will both amplify and deepen the field. Previous research has argued that including young children in research is in the interest of the children themselves, necessary for the field to develop, and can be ethically appropriate (Cater & Øverlien, 2014; Solberg, 2014). The research presented in this thesis demonstrates how an ethically sound and well thought-out way of including the experiences of children enriched knowledge and understanding. Given this possibility and the knowledge gained through these studies, one may conclude that not including children in research that affects them would not only reduce potential knowledge gains, but also be unethical.

Strengths and limitations

The strengths of the research project primarily reside in the naturalistic setting and the use of multiple methods. A naturalistic study does not enable causal conclusions, but warrants high generalizability to comparable populations and contexts.

An important asset in the present study design is the naturalistic recruitment. Two different samples, both consecutively recruited in two different cities in Sweden were included. In all, 50 children and their mothers were enrolled in the study. This posed challenges on the organizations in terms of continuity and on the researcher when collecting data, but due to high willingness to collaborate on behalf of staff members in both sites, problems could be solved. An alternative recruitment like randomized controlled study or quasi-experimental design was never considered realistic, primarily due to the limited recruitment base and the difficulty to create a control-group design in an ethically sound way.

Despite high severity of the problems among mothers and children, the attrition and dropout rate was very low and almost all children offered the interventions in the two settings during the recruitment period were enrolled in the study and assessed and followed up. A clinical study in a naturalistic setting promotes high compliance from clinicians as well as caregivers and children. This is accomplished mainly by the fact that the participants experience the aim of the research as meaningful and their participation as essential and personally rewarding. Clinicians and clients are probably primarily motivated to participate in the evaluation, development, and progress of issues that are close to their lived experience. An additional strength is the fact that the researchers involved in the research project share a dual origin in both clinical work and research. This contributed to the process of bridging science and practice and shielded the project on both sides. Long professional experience in clinical work with children became an important asset in supporting the legitimacy of both the project and the researcher to colleagues, agencies, and parents. Efforts were made to communicate our genuine interest, curiosity, and commitment, and the clinical experience that guided the focus, aims, design, and procedures of the project. Scientific stringency and seriousness, however, were the foundation and frame, and never had to be compromised. This double competency contributed to the trust the researchers gained from both clinicians and participants.

During the entire project, the researchers had in-depth knowledge and insight into all steps and aspects of the research process. Practically, our thorough work of implementing the study, close monitoring throughout the process of data-collection, and effort to be generous with feedback to the participating organizations and clinicians contributed to promote the sustainability and positive attitude that characterized the process of data collection.

Another strength of the research project is its combination of designs and methods of analysis. The combination of interviews with children and assessment through standardized questionnaires creates a triangulation of data sources and strengthens internal validity. Statistically significant change benefits from further analysis in terms of magnitude of average change (effect size) and translation into clinical significance (Lambert & Ogles, 2009). This means describing whether an individual showing a decrease in symptoms still reports symptoms within the clinical range or actually demonstrates a change from clinical to sub-clinical levels of symptoms. The research project represents an ambition to combine these statistical and clinical aspects with the patient’s own experiences to contribute to as full an understanding as possible of the effectiveness of the interventions.

The research project and the separate studies have some limitations. The relatively small number of participants and the naturalistic setting limit the external validity and generalizability to the types of specific settings used in this study. While the high compliance and completeness of data strengthens the internal validity of the study, collecting information only from children themselves and their mothers may be regarded as a limitation to the internal validity. On the other hand, the need for secure treatment settings did not allow for any compromises in secrecy of the participants, which limited the possibility of using external data sources.

Trauma screening in children and caregivers and including measures of parenting and relational quality between children and caregivers could have improved the quality of the data analysis and possibly generated refined results. Furthermore, the studies did not include any formal measure of the treatment integrity or adherence to protocol of the clinicians which would have strengthened the results. The present studies discuss outcomes in terms of children’s and mothers’ symptoms with the children’s own experiences of interventions giving an in-depth understanding of the interventions. However, there are likely other relevant outcomes not measured, such as attitudes and knowledge about violence, cognitive development, somatic health, and peer relations. To make the results more reliable and clinically meaningful, follow-up studies of further change and sustainability are needed.

Clinical implications

The research project illustrates that children and mothers contacting service providers in the aftermath of IPV display high levels of symptoms and benefit from the group interventions offered. This emphasizes the need to make interventions accessible to children and parents. Furthermore, the studies elucidate the importance of acknowledging both the opportunities for positive outcomes in group interventions for young children in the aftermath of IPV and the need for the further development of such services.

The results show that given the complexity of experiences and reactions in children exposed to IPV, there is a great need for thorough trauma screening and assessment of mental health and symptoms of PTS in children before and after treatment, as stressed by Cater et al. (2014) and Finkelhor (2017). In clinical praxis, initial assessment is often routine; screening for traumatic experiences and continuous and post-intervention assessments are rarer. Assessment and evaluation can be integrated into treatment procedures to elucidate areas not covered and to identify children in need of additional services. In addition, the necessity and utility of including young children's experiences of interventions is as applicable to clinical settings as well as to research. In clinical practice, this would imply the development and implementation of methods and routines to ensure children are heard and regarded as active participants in the services and interventions they receive.

Awareness of the significance of maternal mental health and knowledge of the resources, possible constraints, and challenges in the child–caregiver relationship have implications on practice in mental health interventions for young children. Interventions for young children benefit from including assessment of and focus on improvement and growth in the parent–child relationship. There is a need to focus on the child's relationship with the caregiver as a source of safety and positive development as well as a possible hindrance to recovery after interpersonal trauma. This calls for routines to include assessments of parental mental health and child–caregiver relationships, as well as a subsequent focus on improving parental mental health and the child–caregiver relationship when needed.

Summary and conclusions

The children appreciated the interventions studied, which fostered their compliance and contributed to their decrease in symptoms. Nevertheless, the decrease in symptoms was unsatisfactory. Specifically, some children displayed high levels of trauma symptoms post intervention, indicating a need for additional focus on experienced trauma, trauma reminders, and triggers for trauma reactions within the child–parent relationship.

1. The diversity of experiences among children exposed to IPV entails a variety and complexity of child consequences and reactions; this situation requires diversity in the interventions offered and will result in a variety in outcomes. This calls for a highly reflective stance in research and clinical practice, combined with standardized assessments, multifaceted methods, and a variety of participants and sources of data.

2. Children in vulnerable situations after exposure to IPV experience and demonstrate competence as well as vulnerability. They experience joy, learning, positive development, and safe and nourishing relations, as well as fear, confusion, symptoms of distress, malfunctioning, and insecure relations. This simultaneous competence and vulnerability in children implies a need for professionals to balance the objectives of protection, provision, and participation.

POPULÄRVETENSKAPLIG SAMMANFATTNING PÅ SVENSKA

Syftet med denna avhandling har varit att bidra till ökad kunskap om insatser till barn som exponerats för våld mot en förälder. De tre inkluderade studierna är del av ett sammanhållet forskningsprojekt som syftat till att belysa erfarenheter, behov och utfall hos barn som deltagit i gruppinterventioner riktade till barn som varit utsatta för våld mot sin förälder.

Våld är ett globalt folkhälsoproblem och enligt WHO ett av de största hoten mot kvinnors och barns hälsa. UNICEF uppskattar 2017 att 25 procent av alla barn i världen lever med en våldsutsatt mamma. I västvärlden och i Sverige är förekomsten något lägre: 5-10 procent av alla barn exponeras för våld mot en förälder under sin uppväxt.

Att vara med om svåra livshändelser, som t.ex. att bevittna våld mot sin mamma, under uppväxten är en betydande riskfaktor vad gäller psykisk och fysisk hälsa och utveckling under barndomen och i ett livstidsperspektiv. Att bevittna våld mot en förälder medför ökad risk för symtom i form av psykisk ohälsa, beteendestörningar, svårigheter med affektreglering och socialt samspel samt en ökad risk för desorganiserad anknytning. Små barns utvecklingsmässiga omognad och beroende av sina omsorgsgivare gör dem särskilt sårbara, vilket medför att effekterna av utsatthet under den tidiga barndomen kan vara särskilt svåra och omfattande. Samtidigt är möjligheterna för omsorgsgivare och professionella att bidra till positiva förändringar särskilt goda tidigt i barns liv. Av de barn som bevittnar våld mot en förälder har uppskattningsvis omkring hälften svårigheter som innebär att de har behov av riktade insatser.

Det finns idag riktade insatser till barn som levt med våld mot en förälder såväl med fokus på psykoedukation och att förebygga framtida svårigheter som psykoterapeutiska behandlingsinsatser med symtom-reducerande målsättning. Insatserna kan ges till barnet och/eller till föräldrar individuellt, i familj eller i grupp. Utvärdering av befintliga verksamheter i Sverige har visat att de insatser som görs i dagsläget för dessa barn har gett positiva men otillräckliga resultat; insatserna som erbjuds behöver utvecklas och det är angeläget med mer kunskap om vilka metoder som visar sig verksamma. Detta står i samklang med internationella studier – några interventionsmetoder visar på positiva resultat, dock är många insatser som ges bristfälligt utvärderade. Det är framför allt brist på studier gällande insatser till de yngsta barnen.

Få studier har systematiskt samlat in och analyserat barns förväntningar, erfarenheter och åsikter om vad som är hjälpsamma professionella insatser vad gäller deras psykiska hälsa. Barns rätt till delaktighet och till att uttrycka sin åsikt om saker som angår dem är en av hörnstenarna i FN:s konvention om barns rättigheter. Psykoterapiforskning visar dessutom i linje med detta att patienters uppfattning av den behandling de får är av betydelse för utfallet. Sammantaget finns ett behov av studier som belyser barns egna erfarenheter av behandlingsinsatser.

De tre studierna i avhandlingen rör barn som deltagit i två olika gruppinterventioner för barn som bevittnat våld mot en förälder. De två studerade gruppinterventionerna var båda manualiserade och väletablerade i en svensk kontext; en psykopedagogisk och en psykoterapeutisk. Båda gruppinterventionerna inbegrep parallella grupper för barn och för den våldsutsatta föräldern med två erfarna gruppledare i varje grupp. Grupperna träffades en gång i veckan vid 12-15 tillfällen.

Målet med studie I var att belysa små barns erfarenhet av att delta i gruppintervention för barn som levt med våld mot en förälder. Nio barn, 4 till 6 år gamla, intervjuades efter att de deltagit i interventionerna. Analysen visade på fem huvudteman i barnens beskrivning av sin erfarenhet av att vara med i grupperna: (1) Glädje = positiv emotionell erfarenhet av att delta, (2) Trygghet = att känna sig skyddad och säker, (3) Att vara i relation = relationer med jämnåriga och vuxna i gruppen, (4) Att prata = externaliserat fokus på våldet, samt (5) Kompetens = ny kunskap och nya färdigheter.

Studie II syftade till att undersöka hur barn som levt med våld mot en förälder berättar om sin våldsutsatta förälder. Intervjuer med 17 barn mellan 4 och 13 år genomfördes. Tre huvudteman, med sju underteman identifierades: (1) Sammanhängande berättande om föräldern – som välvillig, omsorgsgivande eller psykiskt belastad, (2) Bristfälligt berättande om föräldern – vagt eller desorganiserat, samt (3) Föräldern som trigger för traumareaktioner – undvikande eller genombrott av påträngande minnen.

I studie III utvärderades utfallet av de två interventionerna. Femtio barn mellan 4 och 13 år och deras mammor deltog i studien. Mammorna skattade såväl barnens som sina egna symtom på psykisk ohälsa och posttraumatisk stress före och efter deltagande i interventionerna. Resultaten indikerar att barnen hade nytta av båda interventionerna, medan barnen i den psykoterapeutiska gruppinterventionen fick något större symtomreduktion. Trots förbättringarna hos barnen rapporterade en majoritet av mammorna fortfarande omfattande symtom på posttraumatisk stress hos sina barn efter deltagande i interventionerna. Mammorna som deltog i båda interventionerna förbättrades signifikant vad gäller egna symtom på posttraumatisk stress.

Sammanfattningsvis visar resultaten från studierna att barnen uppskattade och drog nytta av att delta i båda interventionerna. Att en stor del av barnen visade posttraumatisk stress även efter deltagande i interventionerna pekar på ett behov av rutiner för kontinuerlig och uppföljande bedömning av symptom och behandlingsbehov. En del barn kan behöva andra, kompletterande eller ytterligare insatser. Vid allvarliga symptom på posttraumatisk stress kan insatser som inkluderar direkt individanpassat fokus på det upplevda traumat, på påminnelser av traumat, på traumatriggers inom ramen för föräldra–barn relationen och direkt relationellt fokus på föräldra–barn relationen vara värdefulla. Resultaten illustrerar värdet av att inkludera små barn som deltagare i forskning.

REFERENCES

Adams, A. E., Sullivan, C. M., Bybee, D., & Greeson, M. R. (2008). Development of the Scale of Economic Abuse. *Violence Against Women, 14*(5), 563-588. doi:10.1177/1077801208315529

Adams, C. M. (2006). The Consequences of Witnessing Family Violence on Children and Implications for Family Counselors. *The Family Journal, 14*(4), 334-341. doi:10.1177/1066480706290342

Aho, N., Proczkowska-Björklund, M., & Svedin, C. G. (2016). Victimization, polyvictimization , and health in Swedish adolescents. *Adolescent Health*, 89-99.

Ainsworth, M. D. S. (1969). *Maternal care scales*. Unpublished manuscript. Retrievable as Maternal Sensitivity Scales from http://www.psychology.sunysb.edu/attachment/measures/content/ainsworth_scales.html

Alisic, E., Zalta, A. K., van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: meta-analysis. *The British Journal of Psychiatry, 204*(5), 335-340. doi:10.1192/bjp.bp.113.131227

Annerbäck, E. M., Wingren, G., Svedin, C. G., & Gustafsson, P. A. (2010). Prevalence and characteristics of child physical abuse in Sweden - Findings from a population-based youth survey. *Acta Paediatrica, International Journal of Paediatrics, 99*(8), 1229-1236.

Appel, A. E., & Holden, G. W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology, 12*(4), 578-599.

Appollis, T. M., Lund, C., Vries, P. J. d., & Mathews, C. (2015). Adolescents' and Adults' Experiences of Being Surveyed About Violence and Abuse: A Systematic Review of Harms, Benefits, and Regrets. *American Journal of Public Health, 105*(2), e31-e45. doi:10.2105/ajph.2014.302293

Bell, K. M., & Naugle, A. E. (2008). Intimate partner violence theoretical considerations: Moving towards a contextual framework. *Clinical Psychology Review, 28*(7), 1096-1107. doi:https://doi.org/10.1016/j.cpr.2008.03.003

Bidonde, J., & Meneses, J. (2017).The effect of interventions for children who have experienced violence in close relationships: an overview of reviews [Effekten av tiltak for barn som har opplevd vold i nære relasjoner: en oversikt over oversikter] *Rapport – 2017*. Oslo: Norwegian Institute of Public Health.

Biering, P. (2010). Child and adolescent experience of and satisfaction with psychiatric care: a critical review of the research literature. *Journal of Psychiatric & Mental Health Nursing, 17*(1), 65-72. doi:10.1111/j.1365-2850.2009.01505.x

Bogat, G. A., DeJonghe, E., Levendosky, A. A., Davidson, W. S., & von Eye, A. (2006). Trauma symptoms among infants exposed to intimate partner violence. *Child Abuse & Neglect, 30*(2), 109-125. doi:http://dx.doi.org/10.1016/j.chiabu.2005.09.002

Bowlby, J. (1980). *Attachment and loss*. New York, NY, US: Basic Books.

Brager, S., & Lichtenstein, A. (2015). *Traumafokuserad psykoterapigrupp för barn som upplevt våld i familjen*. [Trauma focused group psychotherapy for children with experience of family violence.] Stockholm: BUP Traumaenhet.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., . . . Ernst, V. (2001). The trauma symptom checklist for young children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect, 25*(8), 1001-1014. doi:10.1016/S0145-2134(01)00253-8

Broberg, A., Almqvist, L., Axberg, U., Almqvist, K., Cater, Å., & Eriksson, M. (2011). *Stöd till barn som upplevt våld mot mamma. Resultat från en nationell utvärdering*. [Support to children who have witnessed violence against their mothers. Results from a national evaluation study.] Göteborg: Department of psychology, Göteborgs university.

Buston, K. (2002). Adolescents with mental health problems: what do they say about health services? *Journal of Adolescence, 25*(2), 231-242. doi:http://dx.doi.org/10.1006/jado.2002.0463

Carlberg, G., Thorén, A., Billström, S., & Odhammar, F. (2009). Children's expectations and experiences of psychodynamic child psychotherapy. *Journal of Child Psychotherapy, 35*(2), 175-193. doi:10.1080/00754170902996130

Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989). Disorganized/Disoriented Attachment Relationships in Maltreated Infants. *Developmental psychology, 25*(4), 525-531. doi:10.1037/0012-1649.25.4.525

Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review, 34*(4), 748-757. doi:https://doi.org/10.1016/j.childyouth.2012.01.003

Caspi, A., McClay, J., Moffitt, T. E., Mill, J., Martin, J., Craig, I. W., . . . Poulton, R. (2002). Role of Genotype in the Cycle of Violence in Maltreated Children. *Science, 297*(5582), 851-854.

Cater, A. K., Andershed, A.-K., & Andershed, H. (2014). Youth victimization in Sweden: prevalence, characteristics and relation to mental health and behavioral problems in young adulthood. *Child Abuse & Neglect, 38*(8), 1290-1302. doi:10.1016/j.chiabu.2014.03.002

Cater, Å. (2014). Children's Descriptions of Participation Processes in Interventions for Children Exposed to Intimate Partner Violence. *Child and Adolescent Social Work Journal, 31*(5), 455-473. doi:10.1007/s10560-014-0330-z

Cater, Å., & Forssell, A. M. (2014). Descriptions of fathers' care by children exposed to intimate partner violence (IPV) - relative neglect and children's needs. *Child & Family Social Work, 19*(2), 185-193. doi:10.1111/j.1365-2206.2012.00892.x

Cater, Å., & Øverlien, C. (2014). Children exposed to domestic violence: a discussion about research ethics and researchers' responsibilities. *Nordic Social Work Research, 4*(1), 67-79. doi:10.1080/2156857X.2013.801878

Cater, Å. K. (2007). Children's meaning-conciliation of their fathers' violence related to fathers and violence in general. *Journal of Scandinavian Studies in Criminology and Crime Prevention, 8*(1), 41-55. doi:10.1080/14043850701289538

Cater, Å. K., Miller, L. E., Howell, K. H., & Graham-Bermann, S. A. (2015). Childhood Exposure to Intimate Partner Violence and Adult Mental Health Problems: Relationships with Gender and Age of Exposure. *Journal of Family Violence, 30*(7), 875-886. doi:10.1007/s10896-015-9703-0

Chan, Y. C., & Yeung, J. W. K. (2009). Children living with violence within the family and its sequel: A meta-analysis from 1995-2006. *Aggression and Violent Behavior, 14*(5), 313-322.

Chemtob, C. M., & Carlson, J. G. (2004). Psychological Effects of Domestic Violence on Children and Their Mothers. *International Journal of Stress Management, 11*(3), 209-226. doi:10.1037/1072-5245.11.3.209

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18*(3), 623-649.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Earlbaum Associates.

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A Multi-Site, Randomized Controlled Trial for Children With Abuse-Related PTSD Symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(4), 393-402.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.

Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: A randomized controlled trial. *Archives of Pediatrics and Adolescent Medicine, 165*(1), 16-21.

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse & Neglect, 29*(2), 135-145. doi:10.1016/j.chiabu.2004.12.005

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., . . . Van Der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390-398.

Cox, C., Kotch, J., & Everson, M. (2003). A Longitudinal Study of Modifying Influences in the Relationship Between Domestic Violence and Child Maltreatment. *Journal of Family Violence, 18*(1), 5-17. doi:10.1023/A:1021497213505

Crusto, C. A., Whitson, M. L., Walling, S. M., Feinn, R., Friedman, S. R., Reynolds, J., . . . Kaufman, J. S. (2010). Posttraumatic stress among young urban children exposed to family violence and other potentially traumatic events. *Journal of Traumatic Stress, 23*(6), 716-724. doi:10.1002/jts.20590

Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. J., & Van Ijzendoorn, M. H. (2010). Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. *Development and Psychopathology, 22*(1), 87-108. doi:10.1017/S0954579409990289

Day, C., Carey, M., & Surgenor, T. (2006). Children's Key Concerns: Piloting a Qualitative Approach to Understanding Their Experience of Mental Health Care. *Clinical Child Psychology & Psychiatry, 11*(1), 139-155. doi:10.1177/1359104506056322

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually Abused Children Suffering Posttraumatic Stress Symptoms: Initial Treatment Outcome Findings. *Child Maltreatment, 1*(4), 310-321. doi:10.1177/1077559596001004003

Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety, 28*(1), 67-75.

Deblinger, E., Pollio, E., & Dorsey, S. (2016). Applying Trauma-Focused Cognitive–Behavioral Therapy in Group Format. *Child Maltreatment, 21*(1), 59-73. doi:10.1177/1077559515620668

Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine, 13*(3), 595-605. doi:10.1017/S0033291700048017

Dew, S. E., & Bickman, L. (2005). Client Expectancies About Therapy. *Mental Health Services Research, 7*(1), 21-33. doi:10.1007/s11020-005-1963-5

Dockett, S., & Perry, B. (2007). Trusting children's accounts in research. *Journal of Early Childhood Research, 5*(1), 47-63. doi:10.1177/1476718x07072152

Dockett, S., & Perry, B. (2011). Researching with young children: Seeking assent. *Child Indicators Research, 4*(2), 231-247. doi:10.1007/s12187-010-9084-0

Dong, M., Anda, R. F., Felitti, V. J., Dube, S. R., Williamson, D. F., Thompson, T. J., . . . Giles, W. H. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect, 28*(7), 771-784. doi:http://dx.doi.org/10.1016/j.chiabu.2004.01.008

Dorsey, S., McLaughlin, K. A., Kerns, S. E. U., Harrison, J. P., Lambert, H. K., Briggs, E. C., . . . Amaya-Jackson, L. (2017). Evidence Base Update for Psychosocial Treatments for Children and Adolescents Exposed to Traumatic Events. *Journal of Clinical Child and Adolescent Psychology, 46*(3), 303-330.

Dos Santos, E.N., Jensen, T.K., & Ormhaug, S. M. (2016). Er det så illa att bli spurt om traumer? Barns opplevelser av traumekartlegging i BUP. [Is it so bad to be asked about trauma? Children’s experiences of trauma assessment in child and adolescent psychiatry.] *Tidskrift for norsk psykologförening, 2016*, s.536-545.

Dube, S. R., Anda, R. F., Felitti, V. J., Edwards, V. J., & Williamson, D. F. (2002). Exposure to Abuse, Neglect, and Household Dysfunction Among Adults Who Witnessed Intimate Partner Violence as Children: Implications for Health and Social Services. *Violence and victims, 17*(1), 3-17.

Edleson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women, 5*(2), 134-154. doi:10.1177/107780129952003

Eliasson, M. (2014). *Mäns våld mot kvinnor: en kunskapsöversikt om kvinnomisshandel och våldtäkt, dominans och kontroll*. [Elektronisk resurs]. [Men’s violence against women: a review of knowledge on violence against women and rape, dominance and control.] Stockholm: Natur & Kultur.

Ellsberg, M., Arango, D. J., Morton, M., Gennari, F., Kiplesund, S., Contreras, M., & Watts, C. (2015). Prevention of violence against women and girls: what does the evidence say? *The Lancet, 385*(9977), 1555-1566. doi:https://doi.org/10.1016/S0140-6736(14)61703-7

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet, 371*(9619), 1165-1172. doi:https://doi.org/10.1016/S0140-6736(08)60522-X

English, D. J., Marshall, D. B., & Stewart, A. J. (2003). Effects of Family Violence on Child Behavior and Health During Early Childhood. *Journal of Family Violence, 18*(1), 43-57.

Evans, S. E., Davies, C., & DiLillo, D. (2008). Exposure to domestic violence: A meta-analysis of child and adolescent outcomes. *Aggression and Violent Behavior, 13*(2), 131-140. doi:http://dx.doi.org/10.1016/j.avb.2008.02.005

Fantuzzo, J., Boruch, R., Beriama, A., & Atkins, M. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(1), 116-122. doi:10.1097/00004583-199701000-00025

Fantuzzo, J., & Fusco, R. (2007). Children's Direct Exposure to Types of Domestic Violence Crime: A Population-based Investigation. *Journal of Family Violence, 22*(7), 543-552. doi:10.1007/s10896-007-9105-z

Felitti Md, F. V. J., Anda Md, M. S. R. F., Nordenberg Md, D., Williamson Ms, P. D. F., Spitz Ms, M. P. H. A. M., Edwards Ba, V., . . . Marks Md, M. P. H. J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258. doi:http://dx.doi.org/10.1016/S0749-3797(98)00017-8

Finkelhor, D. (2017). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse & Neglect*. doi:http://dx.doi.org/10.1016/j.chiabu.2017.07.016

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect, 31*(1), 7-26. doi:10.1016/j.chiabu.2006.06.008

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2013). Violence, crime, and abuse exposure in a national sample of children and youth: An update. *JAMA Pediatrics, 167*(7), 614-621. doi:10.1001/jamapediatrics.2013.42

Finkelhor, D., Vanderminden, J., Turner, H., Hamby, S., & Shattuck, A. (2014). Upset among youth in response to questions about exposure to violence, sexual assault and family maltreatment. *Child Abuse & Neglect, 38*(2), 217-223. doi:https://doi.org/10.1016/j.chiabu.2013.07.021

Fivush, R., & Schwarzmueller, A. (1998). Children remember childhood: Implications for childhood amnesia. *Applied Cognitive Psychology, 12*(5), 455-473. doi:10.1002/(sici)1099-0720(199810)12:5<455::aid-acp534>3.0.co;2-h

Flewitt, R. (2005). Conducting Research with Young Children: Some Ethical Considerations. *Early Child Development and Care, 175*(6), 553-565.

Foa, E. B. (2009). *Effective treatments for PTSD : practical guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford.

Ford, J. D., & Courtois, C. A. (2013). *Treating complex traumatic stress disorders in children and adolescents : scientific foundations and therapeutic models*. New York: The Guilford Press.

Fox, G. L., & Benson, M. L. (2004). Violent men, bad dads? Fathering profiles of men involved in intimate partner violence. In R. D. Day & M. E. Lamb (Eds.), *Conceptualizing and measuring father involvement* (pp. 359-384). Lawrence Erlbaum Associates Publishers, Mahwah, NJ.

Fridell, M., Cesarec, Z., Johansson, M., & Malling Thorsen, S. M. (2002). *SCL-90 Svensk normering, standardisering och validering av symtomskalan*. [SCL-90 Swedish norms, standardization and validation of the symptom scale.] Report 4/02. Stockholm, Sweden: The National Board of Institutional Care (SiS).

Fusco, R. A., & Fantuzzo, J. W. (2009). Domestic violence crimes and children: A population-based investigation of direct sensory exposure and the nature of involvement. *Children and Youth Services Review, 31*(2), 249-256. doi:http://dx.doi.org/10.1016/j.childyouth.2008.07.017

Garland, A. F., Haine, R. A., & Boxmeyer, C. L. (2007). Determinates of youth and parent satisfaction in usual care psychotherapy. *Evaluation and Program Planning, 30*(1), 45-54. doi:10.1016/j.evalprogplan.2006.10.003

George, C., & Solomon, J. (2008). The caregiving system: A behavioral systems approach to parenting. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications (2nd ed.)*. (pp. 833-856). New York, NY, US: Guilford Press.

Georgsson, A., Almqvist, K., & Broberg, A. G. (2007). Vad tycker barn som bevittnat våld i hemmet och deras mammor om att delta i en pedagogisk gruppverksamhet? [How do children who have witnessed domestic violence and their mothers experience taking part in a psycho-educational group?] *Aetolia, 9*(2).

Gewirtz, A. H., DeGarmo, D. S., & Medhanie, A. (2011). Effects of mother's parenting practices on child internalizing trajectories following partner violence. *Journal of Family Psychology, 25*(1), 29-38. doi:10.1037/a0022195

Ghosh Ippen, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse & Neglect, 35*(7), 504-513. doi:10.1016/j.chiabu.2011.03.009

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *The Lancet, 373*(9657), 68-81. doi:10.1016/S0140-6736(08)61706-7

Gjelsvik, A., Verhoek-Oftedahl, W., & Pearlman, D. N. (2003). Domestic violence incidents with children witnesses: Findings from Rhode Island surveillance data. *Women's Health Issues, 13*(2), 68-73.

Godley, S. H., Fiedler, E. M., & Funk, R. R. (1998). Consumer satisfaction of parents and their children with child/adolescent mental health services. *Evaluation and Program Planning, 21*(1), 31-45. doi:http://dx.doi.org/10.1016/S0149-7189(97)00043-8

Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(11), 1337-1345. doi:10.1097/00004583-200111000-00015

Goodman, R., Ford, T., Simmons, H., Gatward, R., & Meltzer, H. (2000). Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *The British Journal of Psychiatry, 177*, 534-539. doi:10.1192/bjp.177.6.534

Gottzén, L., & Jonsson, R. (2012). *Andra män. Mmaskulinitet, normskapande och jämställdhet*. [Other men. Masculinity, creation of norms and gender equality.] Malmö: Gleerups.

Graham-Bermann, S. A., Castor, L. E., Miller, L. E., & Howell, K. H. (2012). The impact of intimate partner violence and additional traumatic events on trauma symptoms and PTSD in preschool-aged children. *Journal of Traumatic Stress, 25*(4), 393-400. doi:10.1002/jts.21724

Graham-Bermann, S. A., Howell, K. H., Lilly, M., & DeVoe, E. (2011). Mediators and Moderators of Change in Adjustment Following Intervention for Children Exposed to Intimate Partner Violence. *Journal of Interpersonal Violence, 26*(9), 1815-1833. doi:10.1177/0886260510372931

Graham-Bermann, S. A., Lynch, S., Banyard, V., DeVoe, E. R., & Halabu, H. (2007). Community-Based Intervention for Children Exposed to Intimate Partner Violence: An Efficacy Trial. *Journal of Consulting and Clinical Psychology, 75*(2), 199-209.

Graham-Bermann, S. A., Miller-Graff, L. E., Howell, K. H., & Grogan-Kaylor, A. (2015). An Efficacy Trial of an Intervention Program for Children Exposed to Intimate Partner Violence. *Child Psychiatry & Human Development, 46*(6), 928-939. doi:10.1007/s10578-015-0532-4

Grip, K., Almqvist, K., & Broberg, A. G. (2011). Effects of a group-based intervention on psychological health and perceived parenting capacity among mothers exposed to intimate partner violence (IPV): A preliminary study. *Smith College Studies in Social Work, 81*(1), 81-100. doi:10.1080/00377317.2011.543047

Grip, K., Almqvist, K., & Broberg, A. G. (2012). Maternal report on child outcome after a community-based program following intimate partner violence. *Nordic Journal of Psychiatry, 66*(4), 239-247.

Grych, J. H., Jouriles, E. N., Swank, P. R., McDonald, R., & Norwood, W. D. (2000). Patterns of adjustment among children of battered women. *Journal of Consulting and Clinical Psychology, 68*(1), 84-94. doi:10.1037/0022-006X.68.1.84

Gustafsson, P. E., Nilsson, D., & Svedin, C. G. (2009). Polytraumatization and psychological symptoms in children and adolescents. *European Child & Adolescent Psychiatry, 18*(5), 274-283. doi:10.1007/s00787-008-0728-2

Hagan, M. J., Browne, D. T., Sulik, M., Ippen, C. G., Bush, N., & Lieberman, A. F. (2017). Parent and child trauma symptoms during child–parent psychotherapy: A prospective cohort study of dyadic change. *Journal of Traumatic Stress, 30*(6), 690-697. doi:10.1002/jts.22240

Hagan, M. J., Hulette, A. C., & Lieberman, A. F. (2015). Symptoms of Dissociation in a High-Risk Sample of Young Children Exposed to Interpersonal Trauma: Prevalence, Correlates, and Contributors. *Journal of Traumatic Stress, 28*(3), 258-261. doi:10.1002/jts.22003

Hagan, M. J., Sulik, M. J., & Lieberman, A. F. (2016). Traumatic Life Events and Psychopathology in a High Risk, Ethnically Diverse Sample of Young Children: A Person-Centered Approach. *Journal of Abnormal Child Psychology, 44*(5), 833-844. doi:10.1007/s10802-015-0078-8

Hawthorne, T. (1990). *Children are people, Chemical abuse prevention programs, Support group training manual*. Children are people, Inc.

Hearn, J., Nordberg, M., Andersson, K., Balkmar, D., Gottzén, L., Klinth, R., . . . Sandberg, L. (2012). Hegemonic Masculinity and Beyond. *Men and Masculinities, 15*(1), 31-55. doi:10.1177/1097184X11432113

Heimer, G. M., Björck, A., & Kunosson, C. (Eds.)(2014). *Våldsutsatta kvinnor: samhällets ansvar*. [Women exposed to violence: the responsibility of society.] Lund: Studentlitteratur.

Herrenkohl, T. I., Sousa, C., Tajima, E. A., Herrenkohl, R. C., & Moylan, C. A. (2008). Intersection of Child Abuse and Children's Exposure to Domestic Violence. *Trauma, Violence, & Abuse, 9*(2), 84-99. doi:10.1177/1524838008314797

Hershkowitz, I., Lamb, M. E., Orbach, Y., Katz, C., & Horowitz, D. (2012). The Development of Communicative and Narrative Skills Among Preschoolers: Lessons From Forensic Interviews About Child Abuse. *Child Development, 83*(2), 611-622. doi:10.1111/j.1467-8624.2011.01704.x

Hesse, E., & Main, M. (2006). Frightened, threatening, and dissociative parental behavior in low-risk samples: Description, discussion, and interpretations. *Development and Psychopathology, 18*(2), 309-343. doi:10.1017/S0954579406060172

Hiller, R. M., Meiser-Stedman, R., Fearon, P., Lobo, S., McKinnon, A., Fraser, A., & Halligan, S. L. (2016). Research Review: Changes in the prevalence and symptom severity of child post-traumatic stress disorder in the year following trauma – a meta-analytic study. *Journal of Child Psychology and Psychiatry, 57*(8), 884-898. doi:10.1111/jcpp.12566

Holden, G. W. (2003). Children exposed to domestic violence and child abuse: Terminology and taxonomy. *Clinical Child and Family Psychology Review, 6*(3), 151-160.

Holden, G. W., & Ritchie, K. L. (1991). Linking Extreme Marital Discord, Child Rearing, and Child Behavior Problems: Evidence from Battered Women. *Child Development, 62*(2), 311-327. doi:10.2307/1131005

Holt, S. (2015). Post-separation Fathering and Domestic Abuse: Challenges and Contradictions. *Child Abuse Review, 24*(3), 210-222. doi:10.1002/car.2264

Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse and Neglect, 32*(8), 797-810.

Howell, K. H. (2011). Resilience and psychopathology in children exposed to family violence. *Aggression and Violent Behavior, 16*(6), 562-569. doi:http://dx.doi.org/10.1016/j.avb.2011.09.001

Huang, C.-C., Wang, L.-R., & Warrener, C. (2010). Effects of domestic violence on behavior problems of preschool-aged children: Do maternal mental health and parenting mediate the effects? *Children and Youth Services Review, 32*(10), 1317-1323. doi:http://dx.doi.org/10.1016/j.childyouth.2010.04.024

Hungerford, A., Wait, S. K., Fritz, A. M., & Clements, C. M. (2012). Exposure to intimate partner violence and children´s psychological adjustment, cognitive functioning, and social competence: A review. *Aggression and Violent Behavior, 17*(4), 373-382. doi:10.1016/j.avb.2012.04.002

Hunter, E. C., & Graham-Bermann, S. A. (2013). Intimate partner violence and child adjustment: Moderation by father contact? *Journal of Family Violence, 28*(5), 435-444. doi:10.1007/s10896-013-9517-x

Huth-Bocks, A., & Hughes, H. (2008). Parenting Stress, Parenting Behavior, and Children’s Adjustment in Families Experiencing Intimate Partner Violence. *Journal of Family Violence, 23*(4), 243-251. doi:10.1007/s10896-007-9148-1

Huth-Bocks, A. C., Levendosky, A. A., & Semel, M. A. (2001). The direct and indirect effects of domestic violence on young children's intellectual functioning. *Journal of Family Violence, 16*(3), 269-290.

Isdal, P. (2017). *Meningen med våld*. [The meaning of violence.] Stockholm: Stockholm : Gothia.

Jaffee, S. R., Caspi, A., Moffitt, T. E., Dodge, K. A., Rutter, M., Taylor, A., & Tully, L. A. (2005). Nature nurture: Genetic vulnerabilities interact with physical maltreatment to promote conduct problems. *Development and Psychopathology, 17*(1), 67-84. doi:10.1017/S0954579405050042

Janson, S., Jernbro, C., & Långberg, B. (2011). *Kroppslig bestraffning och annan kränkning av barn i Sverige : en nationell kartläggning 2011*. [Corporal punishment and the violation of children in Sweden: a national survey 2011.] Stockholm: Stiftelsen Allmänna barnhuset.

Jensen, T. K. (2012). Intervjuer med barn og unge i spesielt vanskelige livssituasjoner-kan vi snakke med barn om alt? [Interviews with children and adolescents in particularly vulnerable life situations: Can we talk with children about everything?] In E. Backe-Hansen & I. Frønes (Eds.), *Metoder og perspektiver i barne- og ungdomsforskning* (s. 95–120). Oslo, Norge: Gyldendal Akademiske.

Jernbro, C., & Jansson, S. (2017). *Våld mot barn 2016. En nationell kartläggning*. [Violence against children 2016. A national survey.] Stockholm: Stiftelsen Allmänna barnhuset.

Jernbro, C., Tindberg, Y., Lucas, S., & Janson, S. (2015). Quality of life among Swedish school children who experienced multitype child maltreatment. *Acta Paediatrica, 104*(3), 320-325. doi:10.1111/apa.12873

Jewkes, R. (2002). Intimate partner violence: causes and prevention. *The Lancet, 359*(9315), 1423-1429. doi:https://doi.org/10.1016/S0140-6736(02)08357-5

Johnson, V. K., & Lieberman, A. F. (2007). Variations in Behavior Problems of Preschoolers Exposed to Domestic Violence: The Role of Mothers' Attunement to Children's Emotional Experiences. *Journal of Family Violence, 22*(5), 297-309. doi:http://dx.doi.org/10.1007/s10896-007-9083-1

Jouriles, E. N., Brown, A. S., McDonald, R., Rosenfield, D., Leahy, M. M., & Silver, C. (2008). Intimate Partner Violence and Preschoolers’ Explicit Memory Functioning. *Journal of Family Psychology, 22*(3), 420-428. doi:10.1037/0893-3200.22.3.420

Jouriles, E. N., McDonald, R., Rosenfield, D., Stephens, N., Corbitt-Shindler, D., & Miller, P. C. (2009). Reducing Conduct Problems Among Children Exposed to Intimate Partner Violence: A Randomized Clinical Trial Examining Effects of Project Support. *Journal of Consulting and Clinical Psychology, 77*(4), 705-717.

Kearney, J. A., & Cushing, E. (2012). A multi-modal pilot intervention with violence-exposed mothers in a child psychiatric trauma-focused treatment program. *Issues in Mental Health Nursing, 33(*8), 544-552.

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(2), 339-352. doi:10.1037/0022-006X.71.2.339

Kobak, R., & Madsen, S. (2008). Disruptions in attachment bonds: Implications for theory, research, and clinical intervention. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications (2nd ed.)* (pp. 23-47). New York, NY, US: Guilford Press.

Koenen, K. C., Moffitt, T. E., Caspi, A., Taylor, A., & Purcell, S. (2003). Domestic violence is associated with environmental suppression of IQ in young children. *Development and Psychopathology, 15*(2), 297-311. doi:10.1017/S0954579403000166

Kogan, N., & Carter, A. S. (1996). Mother–infant reengagement following the still-face: The role of maternal emotional availability in infant affect regulation. *Infant Behavior & Development, 19*(3), 359-370. doi:10.1016/s0163-6383(96)90034-x

Koverola, C., Papas, M. A., Pitts, S., Murtaugh, C., Black, M. M., & Dubowitz, H. (2005). Longitudinal Investigation of the Relationship among Maternal Victimization, Depressive Symptoms, Social Support, and Children's Behavior and Development. *Journal of Interpersonal Violence, 20*(12), 1523-1546. doi:10.1177/0886260505280339

Lamb, M. E., & Brown, D. A. (2006). Conversational apprentices: Helping children become competent informants about their own experiences. *British Journal of Developmental Psychology, 24*(1), 215-234.

Lamb, M. E., Sternberg, K. J., Orbach, Y., Esplin, P. W., Stewart, H., & Mitchell, S. (2003). Age differences in young children's responses to open-ended invitations in the course of forensic interviews. *Journal of Consulting and Clinical Psychology, 71*(5), 926-934. doi:10.1037/0022-006x.71.5.926

Lambert, M.J., & Ogles, B.M. (2004). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.), *Garfield and Bergin's handbook of psychotherapy and behavior change* (pp. 139-193). New York: Wiley.

Lambert, M. J., & Ogles, B. M. (2009). Using clinical significance in psychotherapy outcome research: The need for a common procedure and validity data. *Psychotherapy Research, 19*(4-5), 493-501. doi:10.1080/10503300902849483

Lambert, W., Salzer, M. S., & Bickman, L. (1998). Clinical outcome, consumer satisfaction, and ad hoc ratings of improvement in children's mental health. *Journal of Consulting and Clinical Psychology, 66*(2), 270-279. doi:10.1037/0022-006x.66.2.270

Lei, H., Nahum-Shani, I., Lynch, K., Oslin, D., & Murphy, S. A. (2012). A "SMART" Design for Building Individualized Treatment Sequences. *Annual Review of Clinical Psychology, 8*(1), 21-48. doi:10.1146/annurev-clinpsy-032511-143152

Levendosky, A. A., Bogat, G. A., & Huth-Bocks, A. C. (2011). The influence of domestic violence on the development of the attachment relationship between mother and young child. *Psychoanalytic Psychology, 28*(4), 512-527.

Levendosky, A. A., Bogat, G. A., & Martinez-Torteya, C. (2013). PTSD symptoms in young children exposed to intimate partner violence. *Violence Against Women, 19*(2), 187-201.

Levendosky, A. A., & Graham-Bermann, S. A. (2001). Parenting in battered women: The effects of domestic violence on women and their children. *Journal of Family Violence, 16*(2), 171-192. doi:10.1023/a:1011111003373

Levendosky, A. A., Huth-Bocks, A., & Semel, M. A. (2002). Adolescent Peer Relationships and Mental Health Functioning in Families With Domestic Violence. *Journal of Clinical Child and Adolescent Psychology, 31*(2), 206-218.

Levendosky, A. A., Huth-Bocks, A. C., Semel, M. A., & Shapiro, D. L. (2002). Trauma symptoms in preschool-age children exposed to domestic violence. *Journal of Interpersonal Violence, 17*(2), 150-164. doi:10.1177/0886260502017002003

Levendosky, A. A., Huth-Bocks, A. C., Shapiro, D. L., & Semel, M. A. (2003). The impact of domestic violence on the maternal-child relationship and preschool-age children's functioning. *Journal of Family Psychology, 17*(3), 275-287. doi:10.1037/0893-3200.17.3.275

Levendosky, A. A., Leahy, K. L., Bogat, G. A., Davidson, W. S., & Von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology, 20*(4), 544-552.

Lieberman, A., & Knorr, K. (2007). The Impact of Trauma: A Developmental Framework for Infancy and Early Childhood. *Pediatric Annals, 36*(4), 209-215. doi:10.3928/0090-4481-20070401-10

Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-Parent Psychotherapy: 6-Month Follow-up of a Randomized Controlled Trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(8), 913-918. doi:10.1097/01.chi.0000222784.03735.92

Lieberman, A.F., Ghosh Ippen, C., & Van Horne, P. (2015). *Don't hit my mommy! : a manual for child-parent psychotherapy with young children exposed to violence and other trauma.* Washington, DC: Zero to Three.

Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward Evidence-Based Treatment: Child-Parent Psychotherapy with Preschoolers Exposed to Marital Violence. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(12), 1241-1248. doi:10.1097/01.chi.0000181047.59702.58

Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive Intervention and Outcome with Anxiously Attached Dyads. *Child Development, 62*(1), 199-209. doi:10.2307/1130715

Lilienfeld, S. O. (2007). Psychological Treatments That Cause Harm. *Perspectives on Psychological Science, 2*(1), 53-70. doi:10.1111/j.1745-6916.2007.00029.x

Lobatto, W. (2002). Talking to children about family therapy: a qualitative research study. *Journal of Family Therapy, 24*(3), 330-343. doi:10.1111/1467-6427.00221

Macfie, J., Fitzpatrick, K. L., Rivas, E. M., & Cox, M. J. (2008). Independent influences upon mother–toddler role reversal: infant–mother attachment disorganization and role reversal in mother's childhood. *Attachment & Human Development, 10*(1), 29-39. doi:10.1080/14616730701868589

Manashko, S., Besser, A., & Priel, B. (2009). Maltreated children's representations of mother and an additional caregiver: A longitudinal study. *Journal of Personality, 77*(2), 561-599.

Mannarino, A. P., Cohen, J. A., Deblinger, E., Runyon, M. K., & Steer, R. A. (2012). Trauma-Focused Cognitive-Behavioral Therapy for Children. *Child Maltreatment, 17*(3), 231-241. doi:10.1177/1077559512451787

Marchand, E., Stice, E., Rohde, P., & Becker, C. B. (2011). Moving from efficacy to effectiveness trials in prevention research. *Behaviour Research and Therapy, 49*, 32-41. doi:10.1016/j.brat.2010.10.008

Margison, F. R., Barkham, M., Evans, C., McGrath, G., Clark, J. M., Audin, K., & Connell, J. (2000). Measurement and psychotherapy. Evidence-based practice and practice-based evidence. *British journal of psychiatry 177*, 123-130.

Margolin, G., & Vickerman, K. A. (2007). Posttraumatic stress in children and adolescents exposed to family violence: I. Overview and issues. Professional Psychology: *Research and Practice, 38*(6), 613-619. doi:10.1037/0735-7028.38.6.613

Martinez-Torteya, C., Bogat, G. A., von Eye, A., & Levendosky, A. A. (2009). Resilience among Children Exposed to Domestic Violence: The Role of Risk and Protective Factors. *Child Development, 80*(2), 562-577. doi:10.1111/j.1467-8624.2009.01279.x

McCloskey, L. A., & Stuewig, J. (2001). The quality of peer relationships among children exposed to family violence. *Development and Psychopathology, 13*(1), 83-96.

McFarlane, J., Fredland, N. M., Symes, L., Zhou, W., Jouriles, E. N., Dutton, M. A., & Greeley, C. S. (2017). The Intergenerational Impact of Intimate Partner Violence against Mothers on Child Functioning over four Years. *Journal of Family Violence, 32*(7), 645-655. doi:10.1007/s10896-017-9913-8

Metel, M., & Barnes, J. (2011). Peer-group support for bereaved children: a qualitative interview study. *Child & Adolescent Mental Health, 16*(4), 201-207. doi:10.1111/j.1475-3588.2011.00601.x

Midgley, N., Target, M., & Smith, J. (2006). The outcome of child psychoanalysis from the patient's point of view: A qualitative analysis of a long-term follow-up study. *Psychology and Psychotherapy: Theory, Research and Practice, 79*(2), 257-269. doi:10.1348/147608305x52694

Miller-Graff, L. E., Galano, M., & Graham-Bermann, S. A. (2016). Expression of re-experiencing symptoms in the therapeutic context: a mixed-method analysis of young children exposed to intimate partner violence. *Child Care in Practice, 22*(1), 64-77. doi:10.1080/13575279.2015.1064360

Miller, L. E., Howell, K. H., & Graham-Bermann, S. A. (2012). Potential mediators of adjustment for preschool children exposed to intimate partner violence. *Child Abuse & Neglect, 36*(9), 671-675. doi:http://dx.doi.org/10.1016/j.chiabu.2012.07.005

Montgomery, C. (2002). Role of dynamic group therapy in psychiatry. *Advances in Psychiatric Treatment, 8*(1), 34-41. doi:10.1192/apt.8.1.34

Moore, L., & Seu, I. B. (2011). Giving children a voice: children's positioning in family therapy. *Journal of Family Therapy, 33*(3), 279.

Mudaly, N., & Goddard, C. (2009). The ethics of involving children who have been abused in child abuse research. *International Journal of Children's Rights, 17*(2), 261-281. doi:10.1163/157181808x389920

Murray, K. W., Bair-Merritt, M. H., Roche, K., & Cheng, T. L. (2012). The impact of intimate partner violence on mothers' parenting practices for urban, low-income adolescents. *Journal of Family Violence, 27*(6), 573-583. doi:10.1007/s10896-012-9449-x

National Scientific Council on the Developing Child. (2005/2014). *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3*. Updated Edition. http://www.developingchild.harvard.edu

NCK-rapport 2014:1 (2014). *Våld och hälsa – en befolkningsundersökning om kvinnors och mäns våldsutsatthet samt kopplingen till hälsa.* [Violence and health – a population-based investigation on men's and women's exposure to violence and its associations with health.] Uppsala: Uppsala University, Nationellt centrum för kvinnofrid, NCK.

Ng, M. Y. and Weisz, J. R. (2016), Annual Research Review: Building a science of personalized intervention for youth mental health. *Journal of Child Psychology and Psychiatry, 57*, 216-236. doi:10.1111/jcpp.12470

Nilsson, D., Gustafsson, P. E., & Svedin, C.-G. (2012). The psychometric properties of the Trauma Symptom Checklist for Young Children in a sample of Swedish children. *European Journal of Psychotraumatology, 3*(1), doi:10.3402/ejpt.v3i0.18505

Nilsson, D., Nordås, E., Pribe, G., & Svedin, C. G. (2017). Child physical abuse – High school students' mental health and parental relations depending on who perpetrated the abuse. *Child Abuse & Neglect, 70*(Supplement C), 28-38. doi:https://doi.org/10.1016/j.chiabu.2017.05.007

Nixon, R. D. V., Sterk, J., & Pearce, A. (2012). A Randomized Trial of Cognitive Behaviour Therapy and Cognitive Therapy for Children with Posttraumatic Stress Disorder Following Single-Incident Trauma. *Journal of Abnormal Child Psychology, 40*(3), 327-337. doi:10.1007/s10802-011-9566-7

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York, NY, US: W W Norton & Co.

Olofsson, N., Lindqvist, K., Gådin, K., Bråbäck, L., & Danielsson, I. (2011). Physical and psychological symptoms and learning difficulties in children of women exposed and non-exposed to violence: a population-based study. *International Journal of Public Health, 56*(1), 89-96. doi:10.1007/s00038-010-0165-0

Onyskiw, J. E. (2002). Health and use of health services of children exposed to violence in their families. *Canadian Journal of Public Health, 93*(6), 416-420. doi:10.17269/cjph.93.388

Osofsky, J. D. (2003). Prevalence of children's exposure to domestic violence and child maltreatment: Implications for prevention and intervention. *Clinical Child and Family Psychology Review, 6*(3), 161-170.

Osofsky, J. D. (2017). *Treating infants and young children impacted by trauma: Interventions that promote healthy development*. Washington: American Psychological Association.

Overbeek, M. M., de Schipper, J. C., Lamers-Winkelman, F., & Schuengel, C. (2012). The effectiveness of a trauma-focused psycho-educational secondary prevention program for children exposed to interparental violence: study protocol for a randomized controlled trial. *Trials, 13*, 12-12. doi:10.1186/1745-6215-13-12

Paul, M., Foreman, D. M., & Kent, L. (2000). Out-patient clinic attendance consent from children and young people: Ethical aspects and practical considerations. *Clinical Child Psychology and Psychiatry, 5*(2), 203-211.

Rivara, F. P., Anderson, M. L., Fishman, P., Bonomi, A. E., Reid, R. J., Carrell, D., & Thompson, R. S. (2007). Intimate partner violence and health care costs and utilization for children living in the home. *Pediatrics, 120*(6), 1270-1277.

Rizo, C. F., Macy, R. J., Ermentrout, D. M., & Johns, N. B. (2011). A review of family interventions for intimate partner violence with a child focus or child component. *Aggression and Violent Behavior, 16*(2), 144-166.

Roberts, Y. H., Campbell, C. A., Ferguson, M., & Crusto, C. A. (2013). The Role of Parenting Stress in Young Children's Mental Health Functioning After Exposure to Family Violence. *Journal of Traumatic Stress, 26*(5), 605-612. doi:10.1002/jts.21842

Rydell, A.-M., Berlin, L., & Bohlin, G. (2003). Emotionality, emotion regulation, and adaptation among 5- to 8-year-old children. *Emotion, 3*(1), 30-47. doi:10.1037/1528-3542.3.1.30

Sackett, D. L. (1997a). Evidence-based medicine. *Seminars in Perinatology, 21*(1), 3-5. doi:10.1016/S0146-0005(97)80013-4

Sackett, D. L. (1997b). Evidence-based medicine and treatment choices. *The Lancet, 349*(9051), 570. doi:https://doi.org/10.1016/S0140-6736(97)80122-5

Sackett, D.L., Straus, S.E., Richardson, W.C., Rosenberg, W., & Haynes, R.M. (2000). *Evidence-based medicine: How to practice and teach EBM*. New York: Churchill Livingstone.

Salisbury, E. J., Henning, K., & Holdford, R. (2009). Fathering by Partner-Abusive Men. *Child Maltreatment, 14*(3), 232-242. doi:10.1177/1077559509338407

Salloum, A., & Overstreet, S. (2012). Grief and trauma intervention for children after disaster: Exploring coping skills versus trauma narration. *Behaviour Research and Therapy, 50(*3), 169-179. doi:http://dx.doi.org/10.1016/j.brat.2012.01.001

Schechter, D. S., Coates, S. W., Kaminer, T., Coots, T., Zeanah, C. H., Davies, M., . . . Myers, M. M. (2008). Distorted Maternal Mental Representations and Atypical Behavior in a Clinical Sample of Violence-Exposed Mothers and Their Toddlers. *Journal of Trauma & Dissociation, 9*(2), 123-147. doi:10.1080/15299730802045666

Schechter, D. S., & Willheim, E. (2009). Disturbances of Attachment and Parental Psychopathology in Early Childhood. *Child and adolescent psychiatric clinics of North America, 18*(3), 665-686. doi:10.1016/j.chc.2009.03.001

Schechter, D. S., Willheim, E., McCaw, J., Turner, J. B., Myers, M. M., & Zeanah, C. H. (2011). The Relationship of Violent Fathers, Posttraumatically Stressed Mothers and Symptomatic Children in a Preschool-Age Inner-City Pediatrics Clinic Sample. *Journal of Interpersonal Violence, 26*(18), 3699-3719. doi:10.1177/0886260511403747

Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Guthrie, D. (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: A randomized clinical trial. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 52*(8), 853-860.

Scheeringa, M. S., & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. Journal of Traumatic Stress, 14(4), 799-815. doi:10.1023/A:1013002507972

Scheeringa, M. S., Zeanah, C. H., Myers, L., & Putnam, F. W. (2005). Predictive validity in a prospective follow-up of PTSD in preschool children. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(9), 899-906.

Schore, A. N. (2013). Relational trauma, brain development, and dissociation. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models.* (pp. 3-23). New York, NY, US: Guilford Press.

Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal, 36*(1), 9-20.

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are (2nd ed.).* New York, NY, US: Guilford Press.

Silverman, W., Ortiz, C., Viswesvaran, C., Burns, B., Kolko, D., Putnam, F., & Amaya-Jackson, L. (2008). Evidence-Based Psychosocial Treatments for Children and Adolescents Exposed to Traumatic Events. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 156-183.

Smedje, H., Broman, J. E., Hetta, J., & von Knorring, A. L. (1999). Psychometric properties of a Swedish version of the 'Strengths and Difficulties Questionnaire.'. *European Child & Adolescent Psychiatry, 8*(2), 63-70. doi:10.1007/s007870050086

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*(1), 39-54. doi:10.1191/1478088704qp004oa

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis : theory, method and research*. Los Angeles : Sage.

Solberg, A. (2014). Reflections on interviewing children living in difficult circumstances: courage, caution and co-production. *International Journal of Social Research Methodology, 17*(3), 233-248. doi:10.1080/13645579.2012.729788

SOU, 2001:72 82001) *Barnmisshandel - Att förebygga och åtgärda. Slutbetänkande från Kommittén mot barnmisshandel.* [Chlid maltreatment Pprevention and intervention. Final report from the committee´ of child maltreatment.] (Governmental official reports) Retrieved from: http://www.regeringen.se/rattsdokument/statens-offentliga-utredningar/2001/08/sou-200172/

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & Human Development, 7*(4), 349-367.

Staf, A. G., & Almqvist, K. (2015). How children with experiences of intimate partner violence towards the mother understand and relate to their father. *Clinical Child Psychology and Psychiatry, 20*(1), 148-163. doi:10.1177/1359104513503352

Sternberg, K. J., Baradaran, L. P., Abbott, C. B., Lamb, M. E., & Guterman, E. (2006). Type of violence, age, and gender differences in the effects of family violence on children's behavior problems: A mega-analysis. *Developmental Review, 26*(1), 89-112. doi:http://dx.doi.org/10.1016/j.dr.2005.12.001

Sternberg, K. J., Lamb, M. E., Greenbaum, C., & Dawud, S. (1994). The effects of domestic violence on children's perceptions of their perpetrating and nonperpetrating parents. *International Journal of Behavioral Development, 17*(4), 779-795.

Sternberg, K. J., Lamb, M. E., Guterman, E., & Abbott, C. B. (2006). Effects of early and later family violence on children's behavior problems and depression: A longitudinal, multi-informant perspective. *Child Abuse & Neglect, 30*(3), 283-306. doi:http://dx.doi.org/10.1016/j.chiabu.2005.10.008

Sternberg, K. J., Lamb, M. E., Guterman, E., Abbott, C. B., & Dawud-Noursi, S. (2005). Adolescents' perceptions of attachments to their mothers and fathers in families with histories of domestic violence: A longitudinal perspective. *Child Abuse & Neglect, 29*(8), 853-869. doi:http://dx.doi.org/10.1016/j.chiabu.2004.07.009

Stith, S. M., Rosen, K. H., McCollum, E. E., Coleman, J. U., & Herman, S. A. (1996). The voices of children: Preadolescent children's experiences in family therapy. *Journal of Marital and Family Therapy, 22*(1), 69-86. doi:10.1111/j.1752-0606.1996.tb00188.x

Stover, C. S., Meadows, A. L., & Kaufman, J. (2009). Interventions for intimate partner violence: Review and implications for evidence-based practice. *Professional Psychology: Research and Practice, 40*(3), 223-233. doi:10.1037/a0012718

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scales (CTS2). *Journal of Family Issues, 17*(3), 283-316.

Strickland-Clark, L., Campbell, D., & Dallos, R. (2000). Children's and adolescents' views on family therapy. *Journal of Family Therapy, 22*(3), 324-341. doi:10.1111/1467-6427.00155

Swanston, J., Bowyer, L., & Vetere, A. (2014). Towards a richer understanding of school-age children's experiences of domestic violence: the voices of children and their mothers. *Clinical Child Psychology and Psychiatry, 19*(2), 184-201. doi:10.1177/1359104513485082

Teicher, M. H., Andersen, S. L., Polcari, A., Anderson, C. M., Navalta, C. P., & Kim, D. M. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience & Biobehavioral Reviews, 27*(1), 33-44. doi:http://dx.doi.org/10.1016/S0149-7634(03)00007-1

Teicher, M. H., & Samson, J. A. (2016). Annual Research Review: Enduring neurobiological effects of childhood abuse and neglect. *Journal of Child Psychology and Psychiatry, 57*(3), 241-266. doi:10.1111/jcpp.12507

Telman, M. D., Overbeek, M. M., de Schipper, J. C., Lamers-Winkelman, F., Finkenauer, C., & Schuengel, C. (2016). Family Functioning and Children's Post-Traumatic Stress Symptoms in a Referred Sample Exposed to Interparental Violence. *Journal of Family Violence, 31*, 127-136. doi:10.1007/s10896-015-9769-8

Terrelonge, D. N., & Fugard, A. J. B. (2017). Associations between family and clinician ratings of child mental health: A study of UK CAMHS assessments and outcomes. *Clinical Child Psychology and Psychiatry, 22*(4), 664-674. doi:10.1177/1359104517713240

Thakar, D., Coffino, B., & Lieberman, A. F. (2013). Maternal Symptomatology and Parent–Child Relationship Functioning in a Diverse Sample of Young Children Exposed to Trauma. *Journal of Traumatic Stress, 26*(2), 217-224. doi:10.1002/jts.21799

Toth, S. L., & Manly, J. T. (2011). Bridging research and practice: Challenges and successes in implementing evidence-based preventive intervention strategies for child maltreatment. *Child Abuse and Neglect, 35*(8), 633-636.

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Development and Psychopathology, 14*(4), 877-906.

Turner, H. A., Finkelhor, D., & Ormrod, R. (2010). Poly-Victimization in a National Sample of Children and Youth. *American Journal of Preventive Medicine, 38*(3), 323-330. doi:10.1016/j.amepre.2009.11.012

United Nations. (2014). *Convention on the Rights of the Child*. Retrieved from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

United Nations Children’s Fund (2017). *A Familiar Face: Violence in the lives of children and adolescents*. New York: UNICEF.

Van Ijzendoorn, M. H., Schuengel, C., Bakermans, & Kranenburg, M. J. (1999). Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae. *Development and Psychopathology, 11*(02), 225-250.

Vu, N. L., Jouriles, E. N., McDonald, R., & Rosenfield, D. (2016). Children's exposure to intimate partner violence: A meta-analysis of longitudinal associations with child adjustment problems. *Clinical Psychology Review, 46*(Supplement C), 25-33. doi:https://doi.org/10.1016/j.cpr.2016.04.003

Warren, J. S., Brown, C. R., Layne, C. M., & Nelson, P. L. (2011). Parenting self-efficacy as a predictor of child psychotherapy outcomes in usual care: A multi-dimensional approach. *Psychotherapy Research, 21*(1), 112-123.

Weiss, D. S. (2004). The Impact of Event Scale-Revised. In J. P. Wilson, T. M. Keane, J. P. Wilson, & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD (2nd ed.)* (pp. 168-189). New York, NY, US: Guilford Press.

Weisz, J. R., Kuppens, S., Ng, M. Y., Eckshtain, D., Ugueto, A. M., Vaughn-Coaxum, R., . . . Fordwood, S. R. (2017). What Five Decades of Research Tells Us About the Effects of Youth Psychological Therapy: A Multilevel Meta-Analysis and Implications for Science and Practice. *American Psychologist, 72*(2), 79-117. doi:10.1037/a0040360

Weisz, J. R., Sandler, I. N., Durlak, J. A., & Anton, B. S. (2005). Promoting and Protecting Youth Mental Health Through Evidence-Based Prevention and Treatment. *American Psychologist, 60*(6), 628-648. doi:10.1037/0003-066X.60.6.628

WHO (2002). World Report on violence and health. Geneva: World Health Organization.

Wolfe, D. A., Crooks, C. V., Lee, V., McIntyre-Smith, A., & Jaffe, P. G. (2003). The effects of children's exposure to domestic violence: A meta-analysis and critique. *Clinical Child and Family Psychology Review, 6*(3), 171-187.

World Health Organization (2011). *Violence against women. Intimate partner and sexual violence against women.* Fact sheet Nº239. Retrieved from: www.who.int/mediacentre/factsheets/fs239/en/index.html

Yakubovich, A. R., Stöckl, H., Murray, J., Melendez-Torres, G. J., Steinert, J. I., Glavin, C. E. Y., & Humphreys, D. K. (2017). Prospective risk and protective factors for intimate partner violence victimisation among women: a systematic review and meta-analysis. *The Lancet, 390*(Supplement 3), 13. doi:https://doi.org/10.1016/S0140-6736(17)32948-3

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215-228. doi:10.1080/08870440008400302

Yardley, L. (2008). Demonstrating validity in qualitative research. In J. A. Smith (Ed.) *Qualitative psychology: a practical guide to research methods.* London: Sage.

Ybarra, G., Wilkens, S., & Lieberman, A. (2007). The Influence of Domestic Violence on Preschooler Behavior and Functioning. *Journal of Family Violence, 22*(1), 33-42. doi:10.1007/s10896-006-9054-y

Zajac, K., Ruggiero, K. J., Smith, D. W., Saunders, B. E., & Kilpatrick, D. G. (2011). Adolescent distress in traumatic stress research: data from the National Survey of Adolescents-Replication. *Journal of Traumatic Stress, 24*(2), 226. doi:10.1002/jts.20621

Zeanah, C. H., Berlin, L. J., & Boris, N. W. (2011). Practitioner review: Clinical applications of attachment theory and research for infants and young children. *Journal of Child Psychology and Psychiatry, 52*(8), 819-833.

Zeanah, C. H., Danis, B., Hirshberg, L., Benoit, D., Miller, D., & Heller, S. S. (1999). Disorganized attachment associated with partner violence: A research note. *Infant Mental Health Journal, 20*(1), 77-86.

Zolotor, A. J., Theodore, A. D., Coyne-Beasley, T., & Runyan, D. K. (2007). Intimate partner violence and child maltreatment: Overlapping risk. *Brief Treatment and Crisis Intervention, 7*(4), 305-321. doi:10.1093/brief-treatment/mhm021