Children subjected to family violence: a retrospective study of life situation and trauma-focused treatment

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Abstract

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Child maltreatment is a risk factor for developing serious psychopathology. Trauma-focused treatment is effective, but not all children benefit from it. The experiences of affected children are a vital source of knowledge for improving interventions, but research focusing on them is limited. The aim of this thesis was to investigate how treatment for children subjected to family violence can be improved by exploring the experiences of the children affected. The participating children were interviewed, retrospectively, about their experiences of the treatment they had been offered at the Child and Adolescent Mental Health Service (CAMHS) four–five years earlier, and about their life situation at the time. The material in studies I and II was analysed using inductive thematic analysis. In Study III a convergent mixed-method design was employed, separately analysing both qualitative and quantitative data, followed by a synthesis of both methodologies. **Study I** focused on the children's life situation before and while they were receiving interventions from the CAMHS. Thirteen children were interviewed, and the results indicated that many had continued to live in unsafe circumstances, and that experiences of ongoing conflict and violence at home and elsewhere were common. **Study II** focused on the experiences of the treatment the children had been offered at the CAMHS. Seventeen children were interviewed, many of whom emphasized the importance of receiving treatment for children subjected to family violence. The importance of the therapeutic relationship being characterized by empathy and curiosity was highlighted. Their own agency and motivation had been decisive for many, but other factors, such as the family situation, had influenced their ability to engage in therapy. **Study III** aimed to gain a deeper understanding of changes in trauma-related symptoms in children and youths who had taken part in trauma-focused cognitive behavioural therapy (TF-CBT) four–five years earlier. Nine participants were assessed and interviewed. The analysis revealed that, while the majority still reported being affected by the violence, most reported a reduction in symptoms immediately after treatment and at the follow-up years later. However, participants who did not report any immediate reduction in symptoms often presented trauma-related symptoms, frequently accompanied by additional severe mental health issues, at the follow-up. In conclusion, the findings emphasize the importance of not viewing children as isolated units, detached from their broader life context. Many children continued to live in chaotic environments, sometimes enduring violence at home during treatment without the therapist's knowledge. This underscores the need to understand the complexities faced by children subjected to family violence and illuminates the importance of, in addition to providing trauma-focused treatments such as TF-CBT, recognizing the need for parental interventions and safety measures. In implementing treatments for children affected by family violence, these children's agency and the many factors that influence their life circumstances and overall well-being should also be acknowledged.

Swedish summary

Barn som utsätts för våld riskerar att utveckla både fysiska och allvarliga psykiatriska problem. Våldsutsatthet inom ramen för anknytningsrelationer tycks vara särskilt skadligt för barn och kan medföra livslånga svårigheter i förmågan att ingå i trygga och tillitsfulla relationer. Bristen på tillit kan även påverka förtroendet för vårdpersonal. Barn och unga som kommer i kontakt med barn- och ungdomspsykiatrin (BUP) har ofta erfarenheter av direkt våld och/eller har bevittnat våld mellan omsorgspersoner. Många har upplevt flera former av våld både inom familjen men även utsatts för våld utanför familjen, som sexuellt våld och mobbning. Den höga prevalensen av våldsutsatthet och risken för allvarliga konsekvenser gör det angeläget att utveckla fungerande psykologisk behandling. Även om många barn kan tillgodogöra sig traumafokuserad behandling så som traumafokuserad kognitiv beteendeterapi (TF-KBT) eller Eye Movement Desensitization and Reprocessing terapi, blir inte alla barn hjälpta. Traditionellt har studier om behandlingseffektivitet utgått från kvantitativa mätningar av psykiatriska symtom och ofta fokuserat på föräldrars bild av barnets mående. Under de senaste åren har dock intresset för barns subjektiva upplevelser ökat. När det gäller traumafokuserad behandling har studier visat att många barn upplever samtalen som en fristad, där deras erfarenheter blivit validerade. Att terapeuten upplevts som empatisk och neutral, samt framstått som expert på området har också lyfts fram som betydelsefullt. Fokuset på de traumatiska upplevelserna, trots att det varit plågsamt, har upplevts som hjälpsamt, men behovet av anpassningar utifrån den individuella situationen har betonats. När det gäller traumatisering orsakad av våldsupplevelser inom familjen är dock forskningsstödet fortsatt begränsat. Barn som bedöms tillhöra sårbara grupper tillfrågas sällan om sina upplevelser av insatser, trots att det ofta är just de barnen som påverkas mest av dessa.

Det övergripande syftet med denna avhandling var att öka kunskapen om hur barn och unga med erfarenheter av våld i familjen har upplevt de insatser de erbjudits inom BUP. Fokus låg dels på deras livssituation under tiden för behandling, dels på hur de generellt upplevt behandlingen. Avhandlingen innehåller även en långtidsuppföljning av hur måendet utvecklats över tid hos deltagare som genomgått TF-KBT-behandling, samt i vilken mån behandlingsmålen för TF-KBT tycks ha uppnåtts.

Avhandlingen består av tre studier som alla bygger på en tidigare randomiserad klinisk behandlingsstudie genomförd mellan 2012 och 2014, där TF-KBT testades mot förstärkt

ordinarie behandling vid en BUP-mottagning i Göteborg. Deltagarna i de två första studierna genomgick antingen TF-KBT eller förstärkt ordinarie behandling, medan de som ingick i studie tre enbart utgjordes av barn som genomgått TF-KBT. Barnen i studierna intervjuades retrospektivt om sina erfarenheter av den behandling de fått fyra till fem år tidigare, samt om deras livssituation vid den tiden. Studie tre inkluderade även en psykiatrisk diagnostisk intervju med deltagarna, samt formulär om traumasymtom och psykosomatiska symtom. Materialet i studie I och II analyserades med induktiv tematisk analys. I studie III användes en konvergent mixed- method design, där kvalitativa och kvantitativa data analyserades separat, följt av en syntes av båda metoderna.

Studie I undersökte hur barn som utsatts för familjevåld i efterhand beskrev sin livssituation före och parallellt med att de hade kontakt med BUP. Tretton barn och ungdomar intervjuades och materialet analyserades med tematisk analys. Resultaten visar att många barn fortsatte att uppleva våld, konflikter och otrygghet hemma, i skolan samt i andra sammanhang. Resultaten pekar på vikten av att i framtida interventioner inte betrakta barnet som en isolerad enhet, samt att beakta komplexiteten i deras livssituationer. **Studie II** syftade till att retrospektivt undersöka hur barn som utsatts för familjevåld upplevt traumafokuserad behandling inom BUP. Sjutton barn och ungdomar intervjuades. Genom tematisk analys identifierades fem teman: förvirring, behovet av att bli hörd, rädsla för konsekvenser, känslor av smärta och att identifiera sig själv som en aktör. Resultaten betonar vikten av den terapeutiska relationen och att förtroende, genuint intresse och ömsesidighet är nödvändiga för att barnet ska engagera sig i behandlingen. Emellertid bör varken barnets egen agens eller en otrygg livssituation, såsom fortsatt utsatthet för våld, underskattas när det gäller barnets förmåga att engagera sig i behandlingen. **Studie III** syftade till att undersöka långsiktiga förändringar i traumarelaterade symtom bland barn och ungdomar som genomgått TF-KBT på grund av familjevåld. Nio deltagare bedömdes och intervjuades. Analysen visade att de flesta deltagare beskrev att de i någon mån fortfarande påverkades av våldet. För de deltagare som rapporterade en minskning av symtom direkt efter behandlingen, kvarstod förbättringen i de flesta fall 4–5 år senare. De som däremot inte rapporterat någon minskning av symtom i anslutning till behandlingen beskrev kvarstående symptom över tid, åtföljda av ytterligare allvarliga psykiska problem. Resultaten understryker behovet av att förstå den komplexitet som barn som utsätts för familjevåld möter och belyser vikten av att, förutom att erbjuda traumafokuserade behandlingar som TF-KBT, också uppmärksamma behovet av föräldrainterventioner och insatser för att öka tryggheten.

Resultatet pekar även på behovet av att erbjuda barn som inte är hjälpta av behandling andra former av insatser i syfte att förebygga att deras mående försämras ytterligare.
Sammantaget visade studierna att majoriteten av deltagarna hade upplevt behandlingen på BUP som hjälpsam, och flera betonade vikten av att barn som utsatts för familjevåld ska erbjudas stöd för att hantera smärtsamma känslor och reaktioner relaterade till våldet. Fortsatta konflikter med och mellan föräldrar var vanliga och hade orsakat deltagarna oro. Många uttryckte bekymmer över föräldrarnas mentala hälsa samt syskonens mående och säkerhet. Deltagarna uttryckte också återkommande önskemål om att deras föräldrar och syskon skulle fått behandling för egen del. Oron för familjemedlemmars mående och livssituation kan ha begränsat deltagarnas förmåga att tillgodogöra sig behandlingen och att agera på sätt som underlättade deras eget välbefinnande. Anmärkningsvärt var att många deltagare hade fortsatt att uppleva hot, otrygghet och våld även under behandlingen på BUP. Pågående våld i hemmet, trakasserier och utsatthet för sexuellt våld hade präglat mångas liv och beskrevs av flera som något som påverkat deras förmåga att engagera sig i behandlingen. Svårigheter att avslöja pågående våld och otrygghet beskrevs av några deltagare, som hade fruktat potentiella konsekvenser om de hade berättat. Mot denna bakgrund är det avgörande att nyfiket och empatiskt utforska barnens livssituation, särskilt för de barn som uttrycker tveksamhet kring att involvera föräldrarna i behandlingen, för att försöka förstå de bakomliggande orsakerna till deras motstånd. För de barn som genomgått TF-KBT-behandling tycktes fortsatt kontakt med en våldsam förälder, som förnekade eller förringade våldet barnet utsatts för, ha försvårat skapandet av en sammanhängande traumaberättelse. Deltagarna uttryckte förvirring och en högre förekomst av kognitiva förvrängningar angående eget ansvar för våldet och skuldkänslor över det de utsatts för. Vissa uttryckte stor besvikelse över förälderns brist på beteendeförändringar och ansvarstagande.

Barns upplevelser av behandling är en ovärderlig källa till information vid utformandet och implementeringen av terapeutiska interventioner. Barn är inte passiva mottagare, utan aktiva agenter – i sina familjer, i behandlingsmiljön, samt i samhället i stort. Förhoppningsvis kan resultatet av denna avhandling bidra till en djupare förståelse för de specifika behov barn som utsatts för familjevåld har och för deras livsomständigheter.

Preface

This thesis consists of a summary and the following three studies, which are referred to by their Roman numerals:

I Onsjö, M., Strand, J., & Axberg, U. (2022). No child is an island: The life situation before and during treatment for children exposed to family violence. *Human Systems*, *2*(2), 64–81. https://doi.org/10.1177/26344041221078221

II Onsjö, M., Strand, J., & Axberg, U. (2023). Children subjected to family violence: A retrospective study of experiences of trauma-focused treatment. *Clinical Child Psychology and Psychiatry*, *28*(3), 1135–1149. https://doi.org/10.1177/13591045231169147

III Onsjö, M., Axberg, U., Hultmann, O., & Strand, J. A mixed-method evaluation of long-term outcomes after trauma-focused cognitive behavioural therapy for children subjected to family violence. Manuscript submitted.

Contents

Acknowledgements iii

Introduction 1

Mental illness and child abuse 2
Definitions of child abuse and maltreatment 3
Prevalence of children's exposure to violence 3
Family violence 6
Caregiver risk factors for child maltreatment 7

Attachment, emotion regulation, and trauma 9
Attachment theory 10
Attachment and trauma 12

Consequences of childhood trauma 13
Brain development 13
Developmental trauma 15
Physical and mental illness 16
Posttraumatic stress disorder 19
Dissociation 20
Poly-victimization and complex PTSD 21

Child psychotherapy 24
Moving towards evidence-based treatments 24
Psychological treatments for traumatized children 26
Child–parent psychotherapy. 27
Eye movement desensitization and reprocessing therapy 29
Trauma-focused cognitive behaviour therapy. 30
Children's perspectives on treatment 36

Idiographic and nomothetic approaches in psychological research 38
Epistemology 38
Data collection methods 39
Different approaches to evaluating change at the group and individual levels 40
Qualitative analysis methods: an overview of interpretative phenomenological analysis and thematic analysis 42
Interpretative phenomenological analysis. 42
Thematic analysis. 42
Mixed-method approaches in psychological research 44
Mixed-method designs. 44

Ethics in research 46
Childhood as a concept 46
Children in research 47

Aim 49

Methods 49

Procedure 51
Qualitative data collection 51
Quantitative data collection 52

The studies 54

Study I 54
Aim 54

Methods ... 54
Main findings ... 54
Conclusion ... 56

Study II ... *56*
Aim ... 56
Methods ... 57
Main findings ... 58
Conclusion ... 59

Study III ... *60*
Aim ... 60
Methods ... 60
Main findings ... 61
Conclusion ... 63

General discussion ... **63**

Ongoing violence and stress impede recovery ... *64*

Agency and motivation in therapeutic relationships ... *65*

Social struggles: loneliness and experiences of bullying ... *67*

Confusion and difficulties in navigating context ... *68*

Decline in symptoms, non-responders, and the risk of escalating mental health issues ... *69*

Methodological considerations and reflexivity ... *70*

Limitations and strengths ... *72*

Ethical considerations ... *73*

Conclusions and clinical implications ... *74*

Future research ... *75*

References ... **76**

Appendix 1 ... **104**

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Introduction

Over the past 30 years, there has been an increase in the number of children and adolescents reported to suffer from mental disorders (Piao et al., 2022). Mental disorders, along with substance abuse problems, are among the leading causes of disability in children and young people, particularly in high-income countries, where they are the main cause of the overall health burden (Castelpietra et al., 2022; Erskine et al., 2015). One of the main causes of the development of mental disorders in later life is child maltreatment (Teicher et al., 2016), which has a serious negative impact on both the psychological and physiological well-being of those who are maltreated (Gilbert et al., 2009; Lippard & Nemeroff, 2020). Exposure to child maltreatment in the attachment relationship appears to be particularly damaging and often leads to complex trauma, causing self-regulation problems and negative self-perceptions, and negatively affecting the individual's ability to maintain relationships (World Health Organization, 2022).

Although several trauma-focused treatments, including trauma-focused cognitive behavioural therapy (TF-CBT) – the most widely researched and recommended treatment for trauma-related symptoms – reduce symptoms, not all children benefit from them (NICE, 2018). Given the profound consequences of trauma, the development of effective interventions for affected children and their families is crucial.

The overarching aim of this thesis was to retrospectively explore how traumatized children in the Child and Adolescent Mental Health Service (CAMHS), who had been subjected to family violence, experienced treatment in general and, specifically, to assess the well-being of children who underwent TF-CBT. The thesis begins by describing the prevalence and definitions of child abuse, followed by a discussion of attachment and emotion regulation, which are central to understanding trauma. The subsequent sections address the consequences of trauma and relevant treatment approaches, before presenting the studies conducted as part of this work. Study I investigated how children described their life situations before and during their contact with the CAMHS. Study II examined the children's experiences of treatment provided at the CAMHS. Study III employed a mixed-method approach to gain a deeper understanding of changes in trauma-related symptoms in children and youths who had taken part in TF-CBT four–five years earlier.

Mental illness and child abuse

Worldwide, there has been a large increase in the reported number of children and adolescents suffering from mental illnesses in the past 30 years (Piao et al., 2022). The reported prevalence of anxiety, depression, conduct disorders, and eating disorders has increased and, globally, and nearly nine per cent of children and adolescents have been diagnosed with a mental illness (Piao et al., 2022). Whether these figures truly reflect an actual increase in mental illness or instead mirror the prevailing zeitgeist has been debated (Bremberg et al., 2015). Some argue that the focus on explaining perceived difficulties as being caused by diseases or psychiatric conditions risks pathologizing, for example, even appropriate grief reactions or normal nervousness before public speaking (Horwitz, 2017).

Regardless of the underlying causes, an increasing number of Swedish children report mental health issues, such as stress, anxiety, and sleep disturbances, with the highest prevalence observed among adolescent girls and young women (Public Health Agency of Sweden, 2023). In 2017, one out of ten adolescents suffered from mental illness (Swedish National Board of Health and Welfare, 2017). Among young women, the proportion was even higher, with 15 per cent reporting mental illness (Swedish National Board of Health and Welfare, 2017). Additionally, there has been a rise in the number of children receiving psychiatric care (Public Health Agency of Sweden, 2023). According to a report from the Swedish National Board of Health and Welfare (2024), there has been a slight decrease in the incidence of first-time cases of mental health disorders among young adults. A corresponding decrease was not observed among children, however, and 12 per cent of children aged ten–17 years had received health care for mental health disorders (National Board of Health and Welfare, 2024). One of the main causes of the development of mental disorders later in life is child maltreatment (Teicher et al., 2016), which has a serious negative impact on both the psychological and physiological well-being of those who are maltreated (Gilbert et al., 2009; Lippard & Nemeroff, 2020).

The Child and Adolescent Mental Health Service (CAMHS) is a specialized part of the Swedish health-care system, consisting of outpatient and inpatient care for children up to 18 years old (SBU, 2018). A Swedish study indicated that approximately half of all children referred to major clinics in southern Sweden had experienced intimate partner violence (IPV) and/or child abuse (Hultmann et al., 2016). Child maltreatment, including physical and emotional abuse and neglect, is a major preventable risk factor for subsequent mental health issues and substance abuse, contributing to around 45 per cent of the population-related risk of these outcomes (Teicher et al., 2016). Risk factors, such as child abuse and IPV, increase the

likelihood of a negative outcome, and when multiple risk factors converge, the overall likelihood of harm is further heightened (Finkelhor et al., 2009).

Definitions of child abuse and maltreatment

In 2015, all members of the United Nations adopted the sustainable development goal aiming to ensure every child's right to safety. This goal states that efforts to end violence against children should be a priority in all arenas: school, home, the community, and online (United Nations, 2015). Article 19 of the Convention on the Rights of the Child also highlights that measures should be taken to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, and maltreatment or exploitation, including sexual abuse (United Nations Commission on Human Rights, 1990). However, there is currently no international agreement on how to define child abuse or maltreatment in research, and definitions differ between countries and studies.

Smith and Pollack (2021) argued that there is inherent difficulty in attempting to categorize different types of adversities, such as child abuse, in order to examine how different experiences affect the developing child. They noted that the definition of violence, for example, is a socially constructed concept that differs depending on the time and context (Smith & Pollak, 2021). Another complicating factor is that children exposed to one type of abuse often experience other types of childhood maltreatment, and emotional abuse/neglect and physical abuse often co-exist (Brown et al., 2019). This co-existence makes it difficult to draw a sharp line in an attempt to differentiate among various experiences and adversities.

One of the most widespread definitions of child maltreatment is the World Health Organization's (WHO's) definition: "Child maltreatment is the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (WHO, 2022). The Swedish Ministry of Health and Social Affairs (SOU, 2001), on the other hand, defines child abuse as: "a child [being] exposed to physical or psychological violence, sexual abuse and/or violations by an adult or an adult neglecting to meet the basic needs of the child". Individuals under the age of 18 years are considered children, according to the UN declaration as well as the Swedish law.

Prevalence of children's exposure to violence

Studies mapping the prevalence of child maltreatment indicate that the problem is widespread, but the figures vary as differences in categories, instruments, terminology, and the complexity

surrounding different forms of child maltreatment complicate investigations of the extent of the phenomenon (Massullo et al., 2023). Stoltenborg et al. (2012) pointed out that prevalence research has traditionally focused on sexual abuse, suggesting that its implications for children's development might be more severe, so sexual abuse has received more attention. The religious and political zeitgeist might be another possible explanation, as sexual abuse may be easier to explore and define than other forms of child maltreatment (Stoltenborg et al., 2012). However, according to WHO (2022), "nearly 3 in 4 children – or 300 million children – aged 2–4 years regularly suffer physical punishment and/or psychological violence at the hands of parents and caregivers".

A systematic review indicated that at least half of all children in Asia, Africa, and North America had experienced physical, sexual, emotional, or multiple types of violence in the past year (Hillis et al., 2016). Globally, over half of all children (one billion children) between two and 17 years old have experienced violence, including experiences of bullying and dating violence. The numbers reported were higher in Africa, Asia, and North America, exceeding 50 per cent; lower numbers, exceeding 30 per cent, were reported in Latin America, and even lower numbers, exceeding ten per cent, were reported in Europe. The risk of being subjected to violence was higher for children in developing countries. Hillis et al. (2016) emphasized several limitations of their study, noting that it likely underreported the prevalence of violence for various reasons. For instance, many surveys include data on only specific types, perpetrators, and locations of violence, resulting in base estimates often being calculated from just one type of violence. Additionally, the study underestimated prevalence due to a lack of data for certain age groups (Hillis et al., 2016). In a review of the results of a series of meta-analyses of the prevalence of child sexual, physical, and emotional abuse, as well as physical and emotional neglect, Stoltenborgh et al. (2015) concluded that child maltreatment was a widespread global phenomenon affecting the lives of millions of children worldwide.

A Swedish survey of adolescents showed that almost 40 per cent had experienced neglect, had suffered psychological, physical, or sexual violence at the hands of an adult, or had witnessed violence against a parent (Jernbro et al., 2023). Close to 30 per cent had experienced violence perpetrated by a parent. One in ten, with girls being significantly more represented than boys, reported experiences of physical and/or psychological violence between adults in the family, with the mother predominantly being the victim. The authors of the study noted that the figures may be misleading, as a relatively larger proportion of those exposed to violence may be included among the non-responders. The survey was conducted in schools, and participants experiencing maltreatment may have higher absenteeism than their peers, or they may be more

likely to refrain from responding to such surveys (Jernbro et al., 2023). The Swedish National Council for Crime Prevention showed in a report from 2022 that there has been an increase in reports to the police concerning abuse of children up to six years old from 2012 to 2022 (Swedish National Council for Crime Prevention, 2022). Most of the reported crimes were committed by a parent. The high prevalence of physical violence towards children in Sweden is, according to the authors, explained by the broad definition of violence used, which includes forms of violence that are legal and accepted in other countries but are illegal in Sweden (Jernbro et al., 2023).

One of the most influential retrospective studies of childhood maltreatment is the Adverse Childhood Experience (ACE) study, which has been replicated in different settings around the world (Felitti et al., 1998, 2009). The original ACE study was conducted over 20 years ago, aiming to determine the prevalence of ACEs in a general population and how these experiences manifested in adults decades later. Of the 13,494 individuals invited to participate, 9508 agreed and completed a mailed questionnaire about their experiences of ACEs: physical, sexual, and emotional abuse; neglect; a parent suffering from mental health conditions and/or alcohol or drug abuse; a family member being imprisoned; parental abandonment; and/or domestic violence (Felitti et al., 1998). The authors' initial publications focused on the unrecognized prevalence of ACEs, while later work examined the strong dose–response relationships of ACEs to adult emotional states, coping mechanisms, biomedical disease, and premature death (Felitti, 2019). The results indicated that half of the respondents had experienced at least one category of adversity during childhood (Felitti et al., 1998). One out of ten had experienced psychological violence, the same proportion reported experiences of physical violence, and over 20 per cent reported being sexually abused as children. One out of four had lived with an adult who suffered from substance abuse and 18 per cent had experienced mental illness in a household member. Experiences of mothers (or stepmothers) being treated violently were reported by 12 per cent, and three per cent had experiences of a household member being imprisoned. The authors highlighted several potential limitations of the study. The data were based on self-reported, retrospective information, which can only show associations between childhood exposures and adult health outcomes. Additionally, participants with health issues may have been more or less likely to report ACEs, and there is also the possibility of over- or under-reporting disease conditions on medical questionnaires. Lastly, there may be other mediating factors, such as attitudes towards health care or physiological changes, that influenced the relationship between ACEs and adult health outcomes beyond the risk factors examined in the study (Felitti et al., 1998).

Lacey and Minnis (2020), in line with Massulo et al. (2023), emphasized that there is currently no international consensus on what should be considered adverse experiences. A consequence of this lack of agreement is that questions asked in ACE surveys around the world are formulated differently. Given this, it is difficult to compare results across countries and settings. Another concern regarding the design of ACE questions is that responses are often limited to binary yes/no options. This approach risks producing arbitrary answers and fails to account for the severity or frequency of the experiences (Lacey & Minnis, 2020).

Family violence

Family violence is a broad concept ranging from direct physical and psychological violence between partners, to different forms of neglect and violence from caregivers directed at children. Children witnessing or in other ways exposed to violence between caregivers or experiencing maltreatment and/or violence towards or from a sibling are also included (Kong & Goldberg, 2022).

Exposure to intimate partner violence (IPV), i.e., witnessing or in other ways being aware of abuse between adults within the family, can be considered a specific form of child abuse (Kimber et al., 2018). In the context of IPV, parenting is negatively affected, increasing the risk of children being exposed to physical aggression and neglect (Chiesa et al., 2018; Parrish et al., 2015). IPV is also associated with less nurturing behaviour from the parent, decreased communication, and elevated risk of abuse and aggression towards the child (Sousa et al., 2021). Depending on the location and on the formulation of questions, studies indicate prevalence rates of children experiencing IPV in their families ranging from nearly eight per cent (Afifi et al., 2014) to almost 24 per cent (Radford et al., 2011). In a Swedish survey, ten per cent of ninth-grade students reported having witnessed violence between adults in the family (Jernbro et al., 2023), with a higher number having witnessed the father subjecting their mother to violence than the reverse. A total of 2.4 per cent had witnessed repeated physical violence, and girls reported having witnessed violence between adults in the home to a significantly greater extent than did boys (Jernbro et al., 2023).

Mothers affected by IPV often report that their children are unaware of the occurrence of the violence, describing their children as asleep or occupied by watching TV during the abuse (Bayarri et al., 2011). However, a review examining children's perspectives on domestic violence and abuse showed that children were, in fact, aware of the abuse and could describe detailed experiences of various forms of violence, such as shouting, objects being thrown, controlling behaviour, and physical violence (Arai et al., 2021).

The ways children describe and understand domestic violence have been examined in several studies showing that children are far from passive spectators (Fusco & Fantuzzo, 2009; Øverlien & Hyden, 2009). Younger children, under the age of six, are frequently involved in the events preceding the violence due to their dependence on and physical proximity to their caregivers (Fusco & Fantuzzo, 2009). Many children are actively engaged during violent incidents and employ various strategies to avoid harm, such as physically intervening to stop the violence or calling for help (Fusco & Fantuzzo, 2009; Øverlien & Hyden, 2009). Children report attempting to minimize harm to themselves, while simultaneously seeking to protect siblings, mothers, and pets (Arai et al., 2021). Furthermore, many children devise strategies to act protectively in anticipation of future violent episodes (Øverlien & Hyden, 2009).

Children with experiences of co-victimization, i.e., experiences both of direct violence and of witnessing domestic violence, display higher levels of trauma-related symptoms (Hultmann et al., 2016), as do children who perceive themselves as having control over the violent situations (Spilsbury et al., 2007). Children who tried to avoid the violent situation by hiding still describe having painful auditory memories of the events (Øverlien & Hyden, 2009). Furthermore, children report having witnessed more violence directed towards their mothers than towards their fathers, and girls are more likely to report experiences of witnessing IPV than are boys (Hietamäki et al., 2021). The difference might depend on gendered expectations, as boys and girls might also interpret and recognize violence in different ways (Hietamäki et al., 2021).

Since 2021, there has been a Swedish law stating that it is a criminal offence to expose children not only to violence directed at them but also to IPV (Swedish Parliament, 2021). If the crime is considered serious, the penalty can be up to four years of imprisonment and children who are deemed victims of crime have the right to claim indemnity.

Caregiver risk factors for child maltreatment

Attempts to understand the factors that contribute to vulnerability in children require a broad perspective on the interactions between individuals and their environments. Bronfenbrenner's (1977) ecological model has been influential in attempts to understand the interplay between human development and environmental factors. The model describes four levels of analysing this interplay, namely, the micro, meso, exo, and macro levels. It suggests that individuals shape and are shaped by relationships in their environment, for example, with family and school at the micro level, which are in turn influenced by other microsystems at the meso level, such as the family in relation to relatives or school in relation to friends. The exo level includes the

broader social context with its limitations and resources, while the macro level encompasses the social and cultural frameworks within which the individual and the other systems operate (Bronfenbrenner, 1977). Bronfenbrenner (1986) continued to expand his ecological model to include chronosystems, which emphasize the importance of life transitions and the timing of their occurrence. Expected transitions might include entering school, puberty, and retirement, while less expected transitions could involve the loss of a family member, serious illness, and divorce. Bronfenbrenner (1986) argued that transitions occur throughout the lifespan and often serve as direct catalysts of developmental change in the individual, while also exerting indirect effects by influencing, for example, family dynamics. Later Bronfenbrenner and Ceci (1994) also explored the influence of heredity on psychological characteristics, emphasizing how the environments and contexts in which individuals live enable and enhance the realization of certain innate capacities and behavioural traits. He highlighted how specific environmental characteristics become more prominent than others in determining which of a range of innate traits have the greatest likelihood of being actualized (Bronfenbrenner & Ceci, 1994). Tudge et al. (2016) emphasized that Bronfenbrenner's bio–ecological theory constituted a four-element model comprising synergistic links among proximal processes, personal characteristics, context, and time. These four elements influence development simultaneously, and their effects are not merely additive but rather are part of an interactive system (Tudge et al., 2016).

The influences of different levels of individual characteristics, the environment, and timing are evident when examining factors that increase the risk of child maltreatment and abuse. For example, parental health problems increase the likelihood of children being physically and psychologically abused, subjected to corporal punishment, and experiencing supervisory neglect (Wolf et al., 2021). The risk of children encountering IPV or child abuse also rises if parents face issues such as relationship difficulties, psychopathology, anger, or hyper-reactivity (Dixon et al., 2007; Stith et al., 2009). There is also an elevated risk of physical neglect if a parent is taking prescribed medications (Wolf et al., 2021).

Exposure to family violence during childhood appears to be linked to later involvement in violence (Milaniak & Widom, 2015). Individuals with a history of child abuse or neglect are more likely to perpetrate violence as adults, a phenomenon commonly referred to as the "cycle of violence". This cycle encompasses various forms of violence, including criminal violence, child abuse, and IPV (Milaniak & Widom, 2015). Additionally, childhood exposure to IPV is associated with IPV perpetration in adulthood, according to a review by Kimber et al. (2018). Of the 19 studies included, 16 found a significant and positive association between childhood exposure to IPV and adult IPV perpetration, indicating up to a fourfold increase in the odds of

perpetrating some form of IPV in adulthood. Three studies, however, reported no significant findings. The authors emphasized that the association between childhood exposure to IPV and adult IPV perpetration should be viewed as uncertain or preliminary due to several limitations in the studies reviewed. For example, none of the studies examined exposure to sexual or financial IPV, nor did they differentiate how seeing, hearing, or merely being aware of violence between caregivers affected the risk. Additionally, inconsistent classification of IPV perpetration may have affected the reliability of the findings (Kimber et al., 2018). A review by Mulder et al. (2018) identified parent-related risk factors for child neglect, emphasizing that individuals with personal experiences of childhood abuse, along with a history of antisocial behaviour or criminal activity and ongoing mental or psychiatric problems, are more likely to neglect their own children. Additionally, Gilbar et al. (2019) found that men who were perpetrators of domestic violence reported higher rates of exposure to childhood physical and sexual abuse, particularly exposure to childhood physical abuse, than did members of the general population. A review of ten studies by Bland et al. (2018) found a relationship between child neglect and later adult violence, just as experiencing violence during childhood and/or adolescence is highly predictive of IPV in young adulthood (Gomez, 2011).

Child age has been identified as a risk factor for maltreatment. Infants under six months of age are particularly vulnerable to injury or death resulting from physical abuse (Sibert et al., 2002). Younger children, as well as those with disabilities, are also more susceptible to repeated maltreatment (White et al., 2015). Additional risk factors include poverty, poor parent–child relationships, low levels of support, single parenting, and parental mental health problems. Conversely, factors such as the caregiver's age, employment status, or ethnicity do not appear to influence the risk of maltreatment, whereas the involvement of medical and/or legal services is associated with reduced risk (White et al., 2015).

Attachment, emotion regulation, and trauma

Human relationships are essential for a child's development, as they provide safety and guidance in the identification and regulation of emotions. Growing up in an unsafe environment can have detrimental effects on a child's physical and emotional well-being, leading to challenges such as traumatization and difficulty forming healthy relationships. Attachment theory provides a possible explanation of why abuse and maltreatment within an attachment context are specifically traumatic, as they create an unresolvable situation for the child, who is biologically predisposed to approach the parent for security, while being simultaneously predisposed to flee the threat the parent poses (Hesse & Main, 1999).

Attachment theory

Attachment theory underscores the importance of early relationships in shaping individuals' scripts for how they interpret themselves and others throughout life in future relationships. This theory was introduced in the mid-20th century by the British psychoanalyst and child psychiatrist John Bowlby and the Canadian psychologist Mary Ainsworth (Forslund & Duschinsky, 2021). Bowlby (1982) described how he became interested in Harlow's (1958) studies of the effect motherly deprivation had on rhesus monkeys, in parallel to the different ways human children were affected when deprived of maternal care.

Attachment theory implies an evolutionary viewpoint, seeing humans as born with a repertoire of behaviours, or instincts, the main purpose of which is securing closeness to attachment figures to ensure survival (Bowlby, 1989). Bowlby emphasized that the child, when perceiving danger, exhibits a range of inherited human behaviours that ensure proximity to caregivers and thereby survival (Shaver et al., 2021). The theory originates from observations of how young children act when separated from their caregiver and highlights how treatment by the caregiver exerts a powerful influence on the child's development. The theory also encompasses possible explanations of certain patterns of intra- and interpersonal behaviours in childhood and adulthood (Bowlby, 1989).

Ainsworth introduced the "strange situation procedure" as a means to empirically investigate Bowlby's theory by observing how exploratory versus attachment behaviour in children is affected by the presence or absence of the mother (Ainsworth & Bell, 1970). The procedure studied the child's use of the mother as a secure base and how separation evokes attachment behaviours, as well as the behaviour of the child upon reunion with the mother. Based on these observations, children were classified as exhibiting either a pattern of secure attachment to the mother or one of two patterns of insecure attachment: anxious-avoidant or anxious-resistant (Bowlby, 1989).

Both Bowlby (1989) and Ainsworth (Ainsworth & Wittig, 1969) highlighted the role of having a secure base in the child being able to explore and learn. Ainsworth stressed the importance of caregiver sensitivity in noticing and interpreting the child's signals and behaviour, as well as in adapting to their socioemotional development. A sensitive caregiver constitutes both a secure base from which the child can explore their surroundings and develop competence, and a safe haven to which the child can return for comfort and protection when needed (Forslund & Duschinsky, 2021).

Attachment, internal working models, and emotions

An individual who experiences fear tends to seek closeness to their attachment figure primarily for security and comfort, making exploratory, affiliative, or sexual behaviours less of a focus (Mikulincer & Shaver, 2019). This self-centeredness and mental preoccupation with fear can lead to a diminished ability to empathize with others at the time. Once a sense of security is restored, the individual is better able to engage in activities beyond merely seeking comfort. Mikulincer and Shaver (2019) emphasized that although almost all children are born with a typical attachment system, which motivates them to seek safety and proximity to their attachment figure in times of distress, the maintenance of that proximity and the attainment of security also depend on the responsiveness of the attachment figure. Children who interact with attachment figures who are responsive when the child is in need develop a sense of attachment security (Shaver & Mikulincer, 2006). Furthermore, attachment figures provide an emotional and physical "safe haven", helping the child to down-regulate negative affect states and, once safe, encouraging the child to attain positive affect states, paving the way for exploration, learning, and the development of skills and knowledge (Shaver & Mikulincer, 2006). A sense of security arises from positive mental representations of the self and important others, referred to as internal working models. These internal working models also shape expectations of later close relationships (Shaver & Mikilencer, 2006).

When attachment figures are unavailable or fail to alleviate the child's distress, the child may develop insecure internal working models and adopt defensive attachment strategies. These strategies include the hyperactivation and deactivation of the attachment system. Hyperactivation is characterized by intense efforts to gain proximity to attachment figures to obtain more satisfying comfort. Hyperactivated attachment strategies may involve clinging, attempts to control the attachment figure, and the up-regulation of negative affect. Deactivation, on the other hand, involves inhibiting proximity-seeking behaviours, striving to handle situations independently, suppressing perceived threats, and down-regulating both positive and negative emotions. People who use deactivation strategies tend to maximize autonomy and distance in relationships, experiencing discomfort in closeness (Shaver & Mikulincer, 2006). However, Bowlby emphasized that these models and strategies are dynamic and adaptable and can change in response to new experiences (Owens et al., 2021).

Shemmings and Shemmings (2017) discussed the role of attachment in the development of emotion regulation, suggesting that children learn to identify and internalize strategies for regulating emotions through the responses of their caregivers. The caregivers' availability and responsiveness to the infant's signals and needs are considered essential for comprehending

how individuals experience and regulate their emotions (Mikulincer & Shaver, 2019). Attachment orientation affects how emotions are interpreted, expressed, and communicated to others. Individuals with a more secure attachment orientation seem to have a more positive view of themselves, trusting in others and being confident in their own abilities to regulate distress. In contrast, individuals with a more insecure attachment orientation often struggle more with regulating distressing emotions and managing stress (Mikulincer & Shaver, 2019). Avoidance and attachment system deactivation lead the individual to suppress or deny feelings of vulnerability, viewing themselves as autonomous and relatively unemotional (Shaver & Mikulincer, 2007). Avoidance strategies emerge from the child's experiences of attachment figures reacting negatively to expressions of need, negative emotions, or vulnerability. Attachment anxiety and attachment system hyperactivation, on the other hand, often stem from attachment figures reacting inconsistently to the child's expressions of need and negative emotions, sometimes offering comfort, while at other times expressing frustration or disengagement. This inconsistency leads the individual to constantly worry and express anger, vulnerability, or need, as these behaviours sometimes capture the attention of the attachment figure (Shaver & Mikulincer, 2006).

Attachment and trauma

Bowlby (1989) criticized psychoanalysts and psychotherapists for their traditional lack of interest in the impact that experiences of violence had on the developing child. Statements of violence had been interpreted as the fantasies and imaginings of the patient, and the therapist was not to take sides or to make "scapegoats of perfectly decent parents" (Bowlby, 1989, p. 78). Bowlby (1989) noted the importance of taking violence into account in the clinical setting, both in trying to help families in which abuse had already occurred, but primarily to prevent future trauma and attachment issues.

Bowlby's theory was extended with a fourth attachment pattern – disorganized/disoriented attachment – which was identified by the American psychologist Mary Main (Main & Solomon, 1990). The defining feature of disorganized attachment is the absence of a coherent strategy for interacting with and responding to a caregiver in times of stress (Main & Solomon, 1990); it is characterized by experiences of intense emotions and difficulty monitoring one's self and others (Beeney et al., 2017).

Children exposed to violence, or who are otherwise frightened by the actions of their caregivers, end up in an unresolvable situation (Hesse & Main, 1999). IPV might be viewed as an assault on the caregiving system, as the caregiver subjected to violence is prevented from

responding to the distress of the child in an appropriate way (Levendosky et al., 2012). The parent's frightening behaviour inevitably places the child in a challenging position, in which the attachment figures are simultaneously both a safe haven and a source of fear. Hesse and Main (2006) referred to this as a situation of "fright without solution", as it creates an irresolvable approach–flight paradox for the child. Hesse and Main (1999) also emphasized that caregivers' own experiences of child maltreatment can negatively affect their interactions with their children. Maltreated parents, when triggered by trauma-related symptoms, may exhibit frightened, dissociative, or otherwise deviant behaviours during interactions, adversely affecting their child's ability to manage stress (Hesse & Main, 1999).

Exposure to child maltreatment within the attachment relationship can be especially harmful as it negatively affects the individual's expectations of future relationships and creates a self-image characterized by feelings of incompetence and unworthiness (Toth & Manly, 2019). Cook et al. (2005) regarded child maltreatment within the attachment relationships as complex trauma that might lead to a loss of self-regulation capacities and the ability to form close, positive relationships. Children exposed to complex trauma often experience lifelong problems of attachment security, affect and behaviour regulation, dissociation, cognition, and self-concept (Cook et al., 2005).

Consequences of childhood trauma

Exposure to child maltreatment and abuse can negatively affect aspects of the developing child. Psychopathological consequences such as posttraumatic stress disorder (PTSD), depression, complex posttraumatic stress, and developmental trauma can be the outcome (Øverlien & Holt, 2019). Additionally, there is an increased risk of poor school performance, medical disorders, substance abuse, and physical illness.

Brain development

Trauma, such as childhood abuse and neglect, can alter brain structure and function, heightening the risk of psychiatric issues later in life (Teicher et al., 2016; Teicher & Samson, 2016). Trauma may impair the brain's ability to interpret and manage threats, and can disrupt the functioning of regulatory and reward systems, increasing vulnerability to mental health disorders (Teicher et al., 2016). However, in a review by Teicher et al. (2016), the authors highlighted that individuals who exhibit brain changes due to experiences of child maltreatment are often reported to be adaptable, showing no past or present symptoms of psychopathology. Other neurobiological or molecular alterations are likely present, enabling these individuals to effectively compensate for stress-related neurobiological impairment. The authors also

emphasized that studying the effects of maltreatment on the brain is challenging due to several limitations in the relevant published research. Many studies use small sample sizes, increasing the risk of misleading results. Most studies are cross-sectional, which allows for multiple interpretations, including the possibility of pre-existing familial abnormalities that increase the risk of abuse. Additionally, many studies rely on retrospective self-reports of maltreatment, which can introduce bias. Furthermore, socioeconomic and IQ differences between maltreated individuals and control groups complicate the interpretation of results and make it challenging to determine the true impact of maltreatment (Teicher et al., 2016).

A review by McEwen (2007) examined how early life events shape lifelong emotional patterns, alter stress responsiveness, and influence the rate of brain and body aging. Stressful experiences, such as maltreatment and child abuse, can disrupt the hormonal system, increasing susceptibility to illness and worsening disease severity. The review emphasized that stress-induced structural changes in key brain regions – such as the hippocampus, amygdala, and prefrontal cortex – affect behavioural and physiological responses. McEwen underscored the role of both environmental factors and individual experiences in shaping health outcomes, while also acknowledging the significant influence of genetic differences and the growing body of research in this area. Additionally, the author highlighted that many of the hypotheses regarding the effects of stress on the human brain have been derived from animal studies, and it remains unclear to what extent these findings can be directly generalized to humans (McEwen, 2007).

Schore (2013, 2009) suggested that early abuse and neglect can cause overwhelming distress, leading to a high activation state that becomes imprinted in the brain. For example, evidence indicates that individuals who experienced childhood maltreatment prefer greater interpersonal distances and feel discomfort with certain types of touch, these outcomes being linked to dysregulation in specific brain regions (Maier et al., 2020). Moustafa et al. (2018) also concluded that there is strong evidence of increased vulnerability to substance abuse in individuals with a history of childhood maltreatment. This vulnerability may stem from changes in the brain's stress-response systems and hormonal alterations, which heighten the reinforcing effects of drugs. Furthermore, child abuse is associated with reduced cortical thickness in certain brain regions, which may mediate the link between child maltreatment and future externalizing psychopathology (Gold et al., 2016).

Child maltreatment and sexual abuse risk having negative effects on school performance and academic achievement. A systematic review showed that the severity of maltreatment was decisive for cognitive functioning, suggesting a dose–response relationship between the timing and duration of maltreatment, and the impairment of cognitive functioning (Young-Southward

et al., 2020). Although concurrent maltreatment at the time of testing has been identified as a predictor of low cognitive functioning, poverty appears to have an increasingly significant impact on cognitive functioning over time (Hong et al., 2018). Maltreated children in general have poorer test results and grades, less engagement, a higher risk of being absent from school and dropping out, and less likelihood of attending and graduating from college (Coohey et al., 2011; Hagborg et al., 2018; Mitchell et al., 2021). However, a review by Domhardt et al. (2015) found that the percentage of individuals who experienced sexual abuse as children and later achieved a normal level of functioning ranged from ten to 53 per cent, with education identified as one of the most influential protective factors. Additionally, refocusing on healthy activities, such as academic achievement, can serve as a coping strategy for children dealing with ongoing sexual abuse (Bogar & Hulse-Killacky, 2006).

Developmental trauma

Nordanger and Braarud (2017) discussed the role of regulation as a key concept in child development and considered how experiences of trauma affect regulation. In line with the ideas underlying attachment theory, they argued that, during childhood, it is crucial for a child's inner experiences and emotions to be understood and regulated by a caregiver. Through the caregiver's regulation system, the child learns to interpret physiological sensations as emotions and, with increasing maturity, learns to regulate and express emotions in socially acceptable ways (Nordanger & Braarud, 2017). A child exposed to frightening experiences, such as neglect or abuse, and whose emotions are not regulated within safe and caring relationships might suffer from what the authors referred to as developmental trauma (Nordanger & Braarud, 2017). Ford (2021) proposed a specific diagnosis for developmental trauma – developmental trauma disorder (DTD) – for children who have experienced traumatic victimization, particularly when attachment bonding with primary caregivers has been compromised. However, DTD is not an official diagnosis in diagnostic manuals, such as the DSM-5 or ICD-11.

The proposed DTD diagnosis is based on two criteria: first, exposure, either directly or by witnessing, to repeated and severe episodes of traumatic interpersonal victimization; and, second, the traumatic disruption of protective caregiving due to changes in the primary caregiver, such as separation, impairment, or emotional abuse (Ford, 2021). Examples of victimization include children who experience abuse from a primary caregiver and/or are exposed to family violence while having an incapable caregiver (Ford, 2021) or attachment disorders, such as traumatic separation from the primary caregiver (Spinazzola et al., 2021). In

DTD, the child displays symptoms of difficulties with affect regulation, cognitive and behavioural regulation, as well as self- and relationship regulation (Spinazzola et al., 2021).

Physical and mental illness

Children living in stressful environments often exhibit elevated cortisol levels, which can aversely affect the immune system over time (Carlsson et al., 2014). A Swedish study aimed to examine the association between high psychological stress in the family and immune response. The study compared immune markers in blood samples from children experiencing high psychological stress in the family and from children with low psychological stress in the family. The results indicated that children exposed to high psychological stress exhibited changes in their immune systems, and the children were found to secrete higher levels of cortisol but lower levels of C-peptide than the children in the control group. The authors concluded that elevated levels of psychological stress may influence both the functioning of children's immune systems and their responses to diseases such as diabetes (Carlsson et al., 2014).

A substantial body of research indicates that experiences of maltreatment and abuse are linked to a higher vulnerability to various major medical conditions, including asthma, diabetes, stroke, and certain cancers (Lippard & Nemeroff, 2020). Studies have also identified connections between mental health issues such as substance abuse, anxiety, behavioural disorders, and psychotic conditions, and physical health problems such as asthma, gastrointestinal disorders, and chronic muscle pain (myalgia) in adolescents (e.g., Agnafors et al., 2019).

Gilbert et al. (2009) concluded in a literature review that the relationship between exposure to different types of maltreatment at various developmental stages and adverse mental health outcomes is complex. However, early and cumulative maltreatment appears particularly detrimental to brain development. Evidence consistently shows that both physical and sexual abuse double the risk of attempted suicide in individuals followed into their late 20s. The review emphasized the need for greater focus on neglected children, as emerging evidence suggests that the effects of neglect can be as harmful as, if not more so than, physical or sexual abuse. Additionally, the authors highlighted the importance of considering the potentially different needs of maltreated boys and girls.

A systematic review and meta-analysis by Hughes et al. (2017), involving 37 studies and over 253,000 participants, found that individuals with at least four adverse childhood experiences (ACEs) faced a significantly increased risk of a range of negative health outcomes compared with those having no ACEs. These included poor self-rated health, cancer, heart

disease, respiratory disease, mental health issues, sexual risk behaviours, problematic alcohol and drug use, as well as interpersonal and self-directed violence. However, the authors noted several limitations, such as the reliance on retrospective ACE reports, which may be affected by recall biases, and variation in how ACEs were measured. Additionally, most studies were conducted in high-income countries, leaving gaps in understanding how ACEs affect health outcomes in low-income, high-violence settings. Genetic and environmental factors, including sociodemographics, were inconsistently controlled for or unmeasured, emphasizing the need for further research in diverse contexts (Hughes et al., 2017).

A meta-analytic review found that approximately 63 per cent of children exposed to IPV fared more poorly than the average child, demonstrating negative psychosocial outcomes (Kitzmann et al., 2003). These included psychological issues, emotional and behavioural problems, social challenges, and academic difficulties. However, the authors also noted that about 37 per cent of the children exhibited outcomes similar to, or better than, those of children who had not been exposed to violence. Protective factors appear to be associated with less exposure to violence, fewer fears and worries regarding the father's potentially harmful or frightening behaviours towards the child or mother, and fewer concerns about the mother's well-being, such as feelings of sadness or fear (Graham-Bermann et al., 2009). Additionally, mothers with better mental health and parenting skills contribute to these protective factors.

Child maltreatment can negatively affect sleep quality, emphasizing the importance of considering trauma in the treatment of insomnia (Pfaff & Schlarb, 2022). Youth with chronic pain reported significantly higher levels of PTSD symptoms than do their pain-free peers, with both affected youth and their parents reporting clinically significant elevations in symptoms (Noel et al., 2016). These youths also reported a greater number of stressful life events, which correlate with higher levels of PTSD symptoms. Elevated PTSD symptoms are associated with poorer health-related quality of life and increased pain intensity, unpleasantness, and interference in daily activities. This indicates that PTSD symptoms are common among youth with chronic pain and contribute to reduced functioning (Noel et al., 2016). There are also indications of shortened life expectancy due to trauma. One study showed that six or more traumatic events can shorten lifespan by up to 20 years (Brown et al., 2009). One possible explanation for how childhood trauma may lead to premature aging and reduced life expectancy is that it accelerates puberty and sexual maturation. In dangerous environments, this response could provide an evolutionary advantage by increasing the likelihood of early reproduction (Teicher et al., 2016).

Numerous studies show that experiences of child abuse and neglect increase the likelihood of developing mental illness. For example, one study found an overrepresentation of major depressive disorder in young adults exposed to trauma, with depressive symptoms often appearing earlier than in non-abused children (Widom et al., 2007). Experiences of child maltreatment can also contribute to the onset of psychotic symptoms and psychotic disorders, according to a literature review by Kaufman and Torbey (2019). The authors noted that the mechanisms linking child maltreatment to an increased risk of psychotic disorders are still unclear, highlighting the need for further research. They suggested that neuroimaging studies indicate that individuals with psychotic disorders and a history of child maltreatment may form a distinct subgroup with unique neurobiological correlates. However, they emphasized that many of these neuroimaging results have also been observed in healthy controls and non-psychotic patients with a history of abuse. This suggests that some of the brain imaging findings may serve as transdiagnostic vulnerability markers of various psychopathologies, rather than as specific markers of psychotic disorders (Kaufman & Torbey, 2019).

Studies show that children with a history of multiple adverse childhood experiences (ACEs) are more likely to receive diagnoses of various psychiatric disorders, including PTSD, attention-deficit/hyperactivity disorder (ADHD), anxiety, depression, and dissociative disorders, suggesting a potential dose–response relationship (Briscoe-Smith & Hinshaw, 2006; Dube et al., 2002; Endo et al., 2006; Gomez et al., 2011; Webster, 2001; Weinstein et al., 2000). Additionally, the likelihood of developing borderline personality disorder (BPD) is heightened, particularly following childhood experiences of emotional abuse and neglect, according to a meta-analysis of 97 studies by Porter et al. (2020). The results indicated that patients with BPD were over 13 times more likely to report childhood adversity than were non-clinical controls and that emotional abuse and neglect were particularly elevated in BPD samples. The authors emphasized that a limitation of most studies was the retrospective assessments of childhood adversity, and could only identify two prospective-design studies in the literature (Porter et al., 2020). Jowett et al. (2020) conducted a systematic review of 33 studies that included over 10,000 cases, aiming to explore the similarities and differences in trauma history and clinical presentation among individuals with comorbid BPD and PTSD versus those with either disorder alone. Their results suggested that individuals in the comorbid BPD/PTSD group had been exposed to higher rates of multiple and interpersonal trauma in both childhood and adulthood than had those with only BPD or PTSD. Emotional dysregulation was identified as a core symptom, and the authors emphasized that addressing difficulties in emotion regulation may promote recovery from symptoms of both PTSD and BPD. The authors highlighted that one

limitation in summarizing the evidence in their area of research was the wide range of measurement tools employed to assess the same construct (Jowett et al., 2020).

Bonanno (2021) argued that predictors of negative impacts, such as adverse health outcomes, from potential trauma generally have small effects, suggesting that the most important factor is the individual's capacity for flexible self-regulation. Behavioural adjustment to traumatic stress is an ongoing process involving multiple interacting components. Flexible self-regulation refers to the individual's ability to assess, moment by moment, the most effective response to events and to engage accordingly (Bonanno, 2021).

Posttraumatic stress disorder

Posttraumatic stress disorder (PTSD) is a common trauma-related mental health condition (Alisic et al., 2014; American Psychiatric Association, 2013). Among children exposed to trauma, over 15 per cent develop PTSD, while approximately 50 per cent exhibit at least one symptom and 20 per cent will meet full criteria (Alisic et al., 2014; McLaughlin et al., 2013). PTSD is characterized by four symptom clusters: intrusion, avoidance, negative changes in cognition and mood, and alterations in arousal and reactivity (American Psychiatric Association, 2013). Intrusion includes nightmares and flashbacks, while avoidance involves steering clear of trauma-related thoughts, feelings, or places. Negative changes in cognition and mood can lead to self-blame and negative affect, while changes in arousal and reactivity may cause exaggerated startle responses or hypervigilance.

The development of PTSD in children after trauma varies by gender and trauma type (Alisic et al., 2014). Girls exposed to interpersonal trauma face the highest risk, while boys exposed to non-interpersonal trauma have the lowest risk. Additionally, maternal PTSD symptoms and having multiple siblings are linked to a higher risk of PTSD symptoms in children (Birmes et al., 2009). Untreated PTSD in children can persist and lead to chronic PTSD, increasing the likelihood of experiencing additional traumatic events (Perkonigg et al., 2005) and posing a significant risk of persistent psychological impairment (Le Roux & Cobham, 2022).

Hoeboer et al. (2021) examined PTSD symptoms in 287 children who had experienced either emotional abuse or other forms of child maltreatment. The findings indicated that emotional abuse was associated with more severe PTSD symptoms and showed the strongest correlation with PTSD compared with other types of childhood maltreatment. The authors suggested that parental emotional abuse may impair key resources necessary for coping with additional traumatic events. Even when other traumas are unrelated to the abuse, the authors

discussed how emotional abuse can contribute to more severe PTSD symptoms due to diminished social support from parents and impaired emotion regulation abilities resulting from the abuse (Hoeboer et al., 2021). In contrast, Maneta et al. (2017) found that repeated experiences of IPV and physical aggression between parent and child negatively affected children's externalizing and internalizing symptoms, but in different ways. Parent-to-child violence was found to be the more potent form of violence, and when both forms occurred simultaneously, they had an additive effect on developmental outcomes (Maneta et al., 2017). Child maltreatment negatively affects the parent–child relationship and increases levels of conflict, both factors associated with an increased risk of suicide (Handley et al., 2019). In line with this, abuse and maltreatment elevate the likelihood of later suicidal ideation and behavioural problems (Fuller-Thomson et al., 2016, Lippard & Nemeroff, 2020, 2016; Miller et al., 2013), particularly among youths who display heightened both externalizing and internalizing symptoms (Duprey et al., 2020).

Cook et al. (2005) argued that the PTSD diagnosis does not fully capture the diverse impacts of trauma exposure on developing children. Children who have been separated from primary caregivers and experienced violence and maltreatment often meet the criteria for various psychiatric diagnoses, each only reflecting parts of the dysfunctions affecting the child's self-regulation capacity and relational abilities. The authors identified six domains impaired in children exposed to complex trauma: attachment, biology, affect regulation, dissociation, behaviour control, cognition, and self-concept. Consequently, interventions for complex trauma must incorporate multiple modalities tailored to the individual child's needs (Cook et al., 2005).

Dissociation

Dissociation is frequently observed in children and adults who have faced complex trauma, particularly in contexts where safety and security are consistently threatened (Hagan et al., 2015; Vonderlin et al., 2018). Dissociative disorders are defined as a "disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour" (American Psychiatric Association, 2013, p. 291). Dissociative symptoms are often part of trauma-related disorders and can take various forms, such as amnesia, flashbacks, numbing, and depersonalization/derealization. Depersonalization consists of experiences of unreality or detachment from one's mind, self, or body, while derealization involves experiences of unreality or detachment from one's surroundings, and individuals can experience both depersonalization and derealization. While

the experiences can be confusing, they are accompanied by intact reality testing. Dissociative amnesia can be localized to an event or period of time, selective of a specific aspect of an event, or generalized to identity or life history (American Psychiatric Association, 2013).

Vonderlin et al. (2018) performed a meta-analytic review of 65 studies, including studies of abused or neglected individuals (n = 7352 participants), hypothesizing that individuals with experiences of abuse and neglect would report more adult dissociation than would individuals without these experiences. The results indicated that sexual and physical abuse were related to a greater presence of dissociation than were emotional abuse and neglect, but no overall differences between samples of neglected versus abused subjects were evident. Individuals who had experienced a combination of physical and sexual abuse reported notably higher dissociative scores. The age of onset, abuse duration, combination of abuse types, and relationship between victim and perpetrator were related to the severity of the dissociative experiences (Vonderlin et al., 2018).

Woolard et al. (2024) emphasized that untreated dissociation can have a detrimental impact on the affected children and their lives, highlighting the need for effective interventions for children and adolescents with dissociative pathology. They performed a systematic review aiming to identify the existing body of literature on current treatments applied within child and adolescent populations diagnosed with a dissociative disorder. They were able to identify only seven studies, five of which were case studies and two of which were over 20 years old, underscoring the lack of empirical clinical research on children and adolescents experiencing dissociation (Woolard et al., 2024).

Poly-victimization and complex PTSD

Experiences of accumulating trauma are associated with increased risk of psychological and physiological impairment, substance abuse, interpersonal violence, and self-harm (Hughes et al., 2017). Intergenerational trauma and developmental factors throughout life significantly affect individual outcomes (Bryce & Collier, 2022). The importance of not focusing solely on one form of traumatic experience was stressed by Finkelhor et al. (2009), who emphasized that children exposed to one form of violence often experience other forms of potential traumas, in what is referred to as poly-victimization. Their study involved interviews with and assessments of over 1400 children, focusing on different types of victimization experiences in the previous year and at any time in their lives. The results indicated that the weighted sum of various lifetime victimizations was a strong predictor of distress and traumatic symptoms in children. The exposure to multiple traumas tended to cause more severe symptoms. Child maltreatment

and sexual assault exhibited particular traumatic salience, contributing significantly to the prediction of trauma symptoms, even after controlling for lifetime poly-victimization. The authors emphasized that more severe cases of mental health issues may have been missed due to the sample being based on a nationally representative community group. They also noted that the results were unstable when multiple variables were analysed simultaneously, highlighting the need for further research to confirm the current findings. Furthermore, the assessment was limited, and serious forms of victimization, such as emotional abuse and neglect, may not have been captured. A more comprehensive assessment could yield different results, according to the authors (Finkelhor et al., 2009).

In a Swedish study, Aho et al. (2016) found that 84 per cent of 17-year-olds reported experiencing victimization during their lifetime, and over ten per cent were categorized as poly-victimized. Poly-victimization proved particularly harmful to adolescent health and was reported to affect females more than males (Aho et al., 2016).

Poly-victimization contributes to the development of both mental and psychological health problems and child mortality (Felitti et al., 1998; Gilbert et al., 2009). Different forms of neglect are significantly associated with trauma symptoms, but children with experiences of poly-victimization exhibit the highest levels of symptoms (Turner et al., 2019). Children who experience child abuse, such as witnessing violence, have an increased probability of encountering additional trauma throughout their lives (Cook et al., 2005; Hamby et al., 2010). The overlap between exposure to IPV and being subjected to child abuse is significant (Hultmann & Broberg, 2016). Physical and supervisory neglect, such as failing to protect a child from dangerous situations or individuals, is strongly associated with other forms of victimization and maltreatment (Turner et al., 2019). Specifically, physical neglect is linked to child sexual abuse and witnessing the abuse of siblings within the family, while supervisory neglect heightens the risk of sexual abuse by adults outside the family (Turner et al., 2019).

A systematic review of factors associated with recurring child maltreatment, based on data from child protection services and encompassing 15 studies involving a total of 1.5 million cases, found that neglect was associated with higher recurrence rates than was physical abuse (White et al., 2015) Cases involving multiple forms of maltreatment also increased the risk, as did a history of repeated maltreatment episodes. The authors, however, framed their results as hypotheses requiring further empirical validation, emphasizing that the heterogeneity among the selected studies prevented a meta-analysis. As a result, they relied on non-statistical methods, such as box scores and quality evaluations, to identify common associations. Additionally, the reviewed studies did not differentiate between varying levels of risk of future

harm associated with different factors, making it impossible to categorize them as high, medium, or low risk (White et al., 2015).

Children exposed to IPV face a greater likelihood of experiencing other forms of maltreatment (Hamby et al., 2010; Kimber et al., 2018). The presence of either IPV or child maltreatment is a significant predictor of the occurrence of the other form of violence, with multiple experiences of IPV further elevating the risk of child maltreatment (Sijtsema et al., 2020). Additionally, Hultmann and Broberg (2016) suggested that exposure to domestic violence may precede subsequent exposure to violence outside the family.

Exposure to poly-victimization, particularly traumas occurring within attachment relationships, is associated with more severe psychological outcomes, including the development of complex PTSD. In the 11th revision of the *International Classification of Diseases* (ICD-11), complex post-traumatic stress disorder (CPTSD) was introduced alongside PTSD (World Health Organization, 2022). CPTSD is a disorder in which the difficulties the individual exhibits extend beyond the symptoms of PTSD. The condition develops after exposure to one or a series of events of an extremely threatening or horrific nature, usually prolonged or repeated, from which it is difficult or impossible to escape. Long-term exposure to domestic violence and repeated sexual or physical abuse in childhood are examples of events that can lead to CPTSD. In addition to meeting all the criteria for PTSD, CPTSD is characterized by severe and persistent: (1) problems with affect regulation; (2) perceptions of oneself as diminished, defeated, or worthless, accompanied by feelings of shame, guilt, or failure related to the traumatic event; and (3) difficulties in maintaining relationships and feeling close to others. These symptoms must cause significant impairment in key areas of functioning for the individual to be assessed as fulfilling the criteria for CPTSD (World Health Organization, 2022). CPTSD is primarily associated with prolonged exposure to chronic or repeated traumatic events or victimization persisting over months or years (Maercker et al., 2022). The onset of symptoms may occur at any stage of life, with a reported prevalence of one to eight per cent in the general adult population and up to 50 per cent among individuals in mental health care. When evaluating CPTSD in younger individuals, it is critical to account for developmental factors, as symptom expression is highly sensitive to the individual's age and stage of development (Maercker et al., 2022).

Surveys of the prevalence of complex PTSD have so far largely been based on self-reported symptoms in children and adolescents from non-clinical populations, and the results appear to vary between countries and age groups (Kazlauskas et al., 2024). Of Irish children aged 11–19 years, 3.4 per cent report such symptoms (Redican et al., 2022), while 12.3 per cent

of Lithuanian 13–18-year-olds and 4.1 per cent of Japanese adolescents aged 12–18 years report symptoms consistent with a CPTSD diagnosis (Kazlauskas et al., 2022).

Based on a literature review and meta-analyses of psychotherapies for adults, Cloitre (2021) suggested that CPTSD, compared with PTSD, may require a longer course of treatment. Furthermore, treatment might benefit from a broader range and greater diversity of interventions, particularly targeting disturbances in self-organization. The findings also emphasized the importance of tailoring interventions to address ongoing stressors and the specific type of trauma experienced (Cloitre, 2021).

Child psychotherapy

The reported global rise in mental illness among children and adolescents presents significant challenges to public health, highlighting the urgent need for effective interventions for prevention and treatment (Piao et al., 2022). Addressing this issue necessitates a multifaceted approach that encompasses not only policy changes and community support but also targeted psychological interventions. Psychological treatment for children and adolescents plays an important role in providing tailored support that addresses individual needs and promotes resilience.

Historically, the importance of psychological interventions for children has been recognized since the early 20th century, when pioneering psychoanalysts such as Hermine Hug-Hellmuth, Melanie Klein, and Anna Freud utilized children's play as a therapeutic tool with which to access and understand their inner worlds (Goodman, 2022). This approach laid the groundwork for contemporary practices, emphasizing that effective psychological treatment involves understanding and engaging with the unique emotional and developmental needs of young individuals.

Moving towards evidence-based treatments

In the 1950s, there was a general movement towards using evidence and research to substantiate the effectiveness of psychological interventions (Forte et al., 2014). The term "empirically supported" was introduced, and categories of treatments were established, with "well-established" treatments being those proven effective in at least one randomized controlled trial (RCT) adhering to rigorous experimental standards. To be considered well-established, a treatment must demonstrate statistically significant superiority over a placebo or an alternative treatment, or be equivalent (if not superior) to an already established treatment.

The concept of evidence-based therapy implies that an intervention has shown beneficial outcomes across multiple samples and, ideally, across various settings. In recent years, the field

of clinical child and adolescent psychology has experienced significant growth (Roberts & Steele, 2020). While many children are helped, not all children benefit from empirically supported therapies. Interventions might need to be personalized to become more effective (Weiss et al., 2019), and there is an ongoing need for the development, dissemination, and implementation of treatments with demonstrated efficacy across a broader range of mental health conditions (Roberts & Steele, 2020).

Exposure interventions, both imaginal and in vivo, are an integral part of cognitive behavioural treatments and are efficacious in treating various fears and phobias across all ages (Bouchard et al., 2004; Ramnerö, 2023). Hazlett Stevens and Craske (2008) described systematic desensitization as a procedure in which the patient undergoes real-life exercises in gradual steps of increased intensity, known as in vivo exposure. These exercises can be performed during relaxation, but the authors emphasized that in vivo exposure alone seems to be just as effective (Hazlett Stevens & Craske, 2008). Imaginal exposure is utilized, for example, in prolonged exposure therapy, in which the patient is asked to recount memories of traumatic experiences (Foa et al., 2009). If the patient has difficulty verbalizing the memory, alternative options may include writing it down, drawing it in various pictures, or recounting it in the form of stories. Each imaginal exposure is followed by emotional processing of the memory and the challenging of unhelpful thoughts. The premise underlying the efficacy of exposure therapy is that, although it is initially uncomfortable, the experience is manageable (Bouchard et al., 2004). As the fear decreases, the assumption is that inaccurate cognitions will be disproven as the individual is repeatedly exposed to a feared stimulus without experiencing the anticipated negative consequences (Bouchard et al., 2004).

Emotional processing theory, developed by Foa and Kozak (1986), provides a framework for understanding pathological anxiety, how it is maintained through avoidance, and the mechanisms involved in treating anxiety with exposure interventions. According to the model, fear is stored in memory as a cognitive structure that includes information about the feared stimuli, fear responses, and the meaning attributed to the fear experienced. These elements are interconnected, and when a stimulus or response in the environment matches those within the fear structure, the entire structure is activated. In situations that are in fact dangerous to the individual, the activation of the fear structure will lead to adaptive responses. However, when the fear structure is activated by safe stimuli, it becomes pathological. Pathological fear tends to overgeneralize safe stimuli as dangerous and is manifested through excessive physical reactions, such as racing heartbeats and hypervigilance. To modify pathological fear structures, emotional processing theory states that two conditions must be met. First, the fear structure

must be activated through exposure to information similar to what triggers the fear structure. Second, new information that contradicts the pathological elements of the fear structure must be introduced during exposure and integrated into it. This incorporation of new information modifies the pathological elements of the structure, which is the core of emotional processing and leads to a reduction in pathological fear through exposure. The authors argued that the relevance of learning principles and habituation is strong in the study of anxiety, particularly in the context of PTSD, given the clear underlying factors associated with its development. They noted that PTSD is the only anxiety disorder with diagnostic criteria requiring an identifiable event prior to the onset of the disorder (Foa & Kozak, 1986).

Psychological treatments for traumatized children

In working with children in therapy, developmental challenges must be considered. In treatment, children think, behave, and respond differently from adults, and therapists need to understand the child's developmental stage and individualize treatment accordingly (Bouchard et al., 2004). Younger children often need a stronger behaviourally based component, such as repeated exposure to bodily sensations or places, along with more extensive caregiver involvement than do older children. Caregiver involvement can also be important in the treatment of traumatized children by supporting and encouraging change in a child's avoidant tendencies and helping the child to manage homework. Caregivers may sometimes find themselves allowing their child to avoid certain situations in an effort to alleviate their anxiety, which can unintentionally reinforce the child's avoidance behaviours. Additionally, caregivers who experience anxiety themselves may model avoidant behaviours, making it challenging for them to encourage their child to face stressful situations when they see the distress their child experiences in confronting feared stimuli (Bouchard et al., 2004).

Several psychological treatment interventions have been shown to be effective in treating PTSD, but their effectiveness varies depending on age, the nature of the trauma, and the child's context. Many studies and meta-studies support the effectiveness of psychological interventions in reducing symptoms of PTSD, anxiety, and depression (Gutermann et al., 2016). Individual cognitive behaviour therapy (CBT), especially when caregivers are involved in treatment, exhibits the greatest effect in reducing PTSD. Apart from caregiver involvement, age is a moderating factor, as older children tend to attain better treatment results than do younger children (Gutermann et al., 2016). This suggests that it might be more difficult for younger children to fully understand the interventions, or that the assessment instruments do not capture change in the symptoms of younger children (Gutermann et al., 2016).

TF-CBT is recommended by the Swedish National Board of Health and Welfare (2021) as a first-line treatment choice to be offered by the Child and Adolescent Mental Health Service. Eye movement desensitization and reprocessing therapy (EMDR) and short-term psychodynamic therapy (PDT) are recommended as second-choice treatments (Swedish National Board of Health and Welfare, 2021). Research supporting the effectiveness of psychopharmacological interventions in children is, however, scarce (Morina et al., 2016), and the sole use of medication is not recommended (Swedish National Board of Health and Welfare, 2021). The international guidelines of the National Institute for Health and Care Excellence (NICE) state that the scientific support for pharmacological-only interventions for children suffering from PTSD is limited, highlighting the risk of medical interventions replacing effective trauma-focused treatment (NICE, 2018).

Below is an overview of child–parent psychotherapy (CPP), eye movement desensitization and reprocessing therapy (EMDR), and trauma-focused cognitive behavioural therapy (TF-CBT), all treatment methods used in Sweden to address trauma symptoms in children and adolescents. CPP is designed for infants and young children, while TF-CBT and EMDR are methods used from early childhood onwards. As previously mentioned, TF-CBT is the recommended first-line intervention and is the primary focus of the articles on which this thesis is based. Therefore, special attention will be paid to the prevailing research on TF-CBT.

Child–parent psychotherapy. Psychodynamic treatment has evolved over the years and developed different orientations, of which child–parent psychotherapy (CPP), created by Alicia F. Lieberman, Patricia van Horn, and Chandra Ghosh Ippen (Lieberman et al., 2005), is one. Ghosh Ippen and Lieberman (2024) described CPP as being rooted in psychodynamic theory and heavily influenced by the work of Fraiberg, as well as by the work of Lebovici, Stern, and Winnicott. Fraiberg's work centred on how parents' own painful experiences could later influence their own parenting, and she sought keys to interrupting the transmission of maladaptive parenting from generation to generation (Gosh Ippen & Lieberman, 2024). CPP stems from the premise that the quality of attachment is decisive for the child's responses to danger versus safety (Lieberman et al., 2006). The treatment is relationship based and trauma informed for children from birth through the age of five years, with the child's parent or primary caregiver actively participating in the treatment. The treatment aims at assisting the child–parent dyad to "speak the unspeakable", emphasizing that when shameful secrets are put into words in a safe and caring context, it opens the possibility of healing (Lieberman & Ghosh Ippen, 2024).

Initially, the therapist meets with the parent alone for assessment and to initiate a process of engagement. These meetings lead up to the therapist formulating possible explanations of the links between the traumatic events and the symptoms displayed by the child, a discussion of the parent's misconceptions, and the therapist informing the parent of treatment strategies that might be helpful (Lieberman & Ghosh Ippen, 2024). CPP is based and depends on the individual needs of the parent and child, and CPP interventions are specifically tailored (Lieberman et al., 2015). The core of CPP centres on the child's play (Lieberman & Ghosh Ippen, 2024), through which the child–parent dyad/relationship is used as an arena in which to improve the child's emotional, cognitive, and social functioning (Lieberman et al., 2006). The emotional quality of the child–parent dyad is the focus of treatment, which aims to increase safety, regulate affect, encourage developmentally appropriate interactions, and help the child and parent create a shared narrative of the traumatic experiences. Reactions to trauma reminders and maladaptive perceptions, child–parent interactions, as well as behaviours that promote fear, anger, and emotional withdrawal may also be central foci (Lieberman et al., 2006).

A study including 199 parent–child dyads receiving just over 20 sessions of CPP (Hagan et al., 2017) investigated whether the improvement of trauma symptoms would be greater for dyads in higher-risk settings, i.e., greater trauma exposure and lower income. Hagan et al. (2017) also examined if the outcome was influenced by whether the treatment was administered by a clinician or a trainee, and if symptom improvement varied as a function of treatment duration. Of those who entered treatment, about 40 per cent dropped out, which the authors claimed was consistent with similar earlier studies. The analyses revealed a considerable reduction in overall parental PTSD, and there was an indication that this was linked to change in the children's hyperarousal symptoms, but not to the children's re-experiencing or avoidance. Girls seemed to benefit more from treatment than did boys, and the overall decrease in trauma symptoms in both parent and child was greater in families who reported fewer traumatic life events for the parents, whereas the extent of the children's exposure to trauma was not related to symptom change. The authors suggested that this might be explained by parents' own higher level of trauma exposure due to more often living amid ongoing trauma exposure (Hagan et al., 2017).

In a qualitative study, Norlén et al. (2021) examined the experiences of caregivers participating in CPP alongside their children, emphasizing that the treatment addresses trauma in both caregivers and children. The sample comprised eleven child and non-offending parent dyads, all of whom had experienced interpersonal violence. While the parents generally appreciated the intervention, many found it complicated and painful to confront their parenting weaknesses. The treatment helped parents enhance their ability to observe and reflect on their

parental roles and increased their confidence. Parents noted that their children appreciated the treatment, showing improved verbalization of emotions and sharing of trauma histories. The use of play as a communication tool provided parents with valuable insights into their children's feelings and experiences, and they emphasized the importance of feeling supported, validated, and acknowledged by the therapist, as many struggled with insecurity and low parental confidence.

Many parents expressed a need for more one-on-one time with the therapist for discussion and reflection without the children present. They acknowledged the value of play as a communication tool, but emphasized the importance of more verbal communication. The need for increased support from employers and social services was also highlighted, as therapy is time consuming, requires practical arrangements, and can be financially burdensome. Additionally, obtaining consent for treatment from the other parent was seen as a challenging process that could hinder treatment. Concerns were raised about the other parent's negative attitude towards therapy, which could negatively affect the outcome (Norlén et al., 2021)

Eye movement desensitization and reprocessing therapy. Eye movement desensitization reprocessing (EMDR) therapy as a method to treat traumatization was accidently discovered by the American psychologist Francine Shapiro, who found that rhythmic multi-saccadic eye movement decreased the intensity of disturbing memories. Through self-examination, Shapiro (1989) initially noticed the effect that eye movement had on her own disturbing thoughts and began to make systematic use of the method on volunteers and clients to investigate its potential effects. From these clinical observations, the EMDR protocol was developed and tested in a clinical study, showing the effectiveness that one session of EMDR had on symptoms of trauma (Shapiro, 1989).

EMDR is described by Shapiro as a client-centred form of psychotherapy consisting of eight stages, integrating imagery, cognitions, emotions, somatic sensations, and behaviours linked to the trauma in treatment (Russell & Shapiro, 2022). In therapy, the most significant past, current, and future experiences contributing to the psychopathology are identified. The experiences are then targeted either in chronological order, starting with the earliest memory, or, alternatively, starting with the most distressing event, depending on the patient's choice. The therapist strives to instill feelings of trust and safety, viewing therapy as collaboration, and helps the patient to remember the distressing memories in a relaxed state (Russell & Shapiro, 2022). The relaxed state allows the patient to generate new thoughts and perspectives, facilitating the processing of traumatic memories (Shapiro, 2018). The effectiveness of bilateral stimulation (BLS), which involves alternating bilateral visual (eye movement), auditory, or

sensory stimulation in EMDR (Amano, 2016), is subject to debate and some argue that the technique is redundant in achieving results (Hornsveld et al., 2012).

EMDR was initially developed as a treatment for adults, but the protocol has been adapted and studied in the treatment of children and adolescents (Ahmad et al., 2007). A review of six studies showed EMDR to be associated with a greater reduction in PTSD symptoms, depression, and/or anxiety compared with other treatments and conditions (Chen et al., 2018). The reviewed studies included both adults and children (n = 231 participants, of whom 103 received EMDR) who had been subjected to complex childhood trauma such as physical/sexual abuse and neglect. However, only three studies investigated children, most of whom were adolescents. The majority of the adolescents had conduct problems apart from symptoms of trauma, and in one of the studies the participants received other interventions, such as group therapy, besides EMDR. In the one study involving children there was no significant difference between EMDR and the other treatment intervention, but EMDR had a greater effect size and the participants received fewer sessions (Chen et al., 2018). Caregiver participation, the use of pictures, and active support from the therapist in finding alternative cognitions connected to the traumatic event are examples of adaptations made to the child EMDR protocol (Ahmad et al., 2007).

Trauma-focused cognitive behaviour therapy. Trauma-focused cognitive behaviour therapy (TF-CBT) is designed to address symptoms of PTSD, depression, and anxiety as well as behavioural and emotional difficulties related to these conditions (Cohen et al., 2017). The treatment intervention was developed in the United States by Judith Cohen, Anthony Mannarino, and Esther Deblinger. Treatment is set up as gradual exposure and is phase based, with the first of three phases focusing on stabilization, the second phase consisting of trauma narration and processing, and the final phase focusing on integration and consolidation (Cohen et al., 2017). It is a component-based treatment with the number of sessions typically ranging from 12 to 15, tailored to the specific needs of the child and their family (Cohen et al., 2017). The model underlying TF-CBT is based on "reversing purported pathways for the development of PTSD and related problems in children and adolescents including 1) overgeneralized fear and associated avoidance; 2) physiological dysregulation; 3) maladaptive trauma-related cognitions; and 4) caregiver factors" (Brown et al., 2020, p. 40).

Initially designed to address trauma-related symptoms in pre-schoolers who have experienced sexual abuse (Cohen et al., 2017), TF-CBT has been modified for children aged 3–18 years with emotional and/or behavioural challenges due to diverse traumatic experiences (Cohen et al., 2017). TF-CBT, with modifications, has shown somewhat promising results in treating traumatization in preschool children, aged three to six years, but the evidence base is

still weak (McGuire et al., 2021). That age is a factor influencing the effectiveness is also evident in a meta-analysis examining the effectiveness of TF-CBT in maltreated children (Wang et al., 2023). The meta-analysis examined 18 studies, four of which were follow-up studies, and included a total of 965 participants, with a mean age of just over ten years. The results indicate support for TF-CBT in reducing emotional (symptoms of depression and anxiety) and behavioural problems and in improving positive psychosocial outcomes among abused children, although no effect on externalizing problems was found. The effects of treatment were more effective when delivered to older rather than younger children (Wang et al., 2023).

Peters et al. (2021) found TF-CBT to be clinically effective for youth aged 15–25 years who had experienced childhood physical or sexual abuse, maltreatment, or neglect. The study was small, however, consisting of 20 participants, 16 of whom met the full criteria for PTSD. Of the participants diagnosed with PTSD, one dropped out, while the remaining 15 achieved remission at the end of treatment. While a minority (n = 8) of participants reported a slight exacerbation of trauma-related symptoms during treatment, the majority (n = 17) found the intervention helpful, and most expressed a willingness to recommend the intervention to peers experiencing mental health issues following interpersonal trauma (Peters et al., 2021).

Longitudinal changes in brain function related to symptom improvement in youth with PTSD following TF-CBT were investigated by Garrett et al. (2019). The study included 20 youths with PTSD, and symptoms of PTSD improved significantly in 17 of them. The results indicated that, prior to treatment, the PTSD group had abnormal activation in the cingulate cortex, amygdala, hippocampus, and medial frontal cortex. When the symptoms of PTSD improved significantly, activation in these regions decreased to the level of the matched healthy control group. The remaining three patients showed no improvement or even worsening symptoms (Garrett et al., 2019).

According to the NICE (2018) guidelines, TF-CBT has the greatest empirical support among the interventions for children and young people with PTSD and is also considered the most cost-effective treatment. The guidelines indicate that the recommendation for TF-CBT is weaker for children aged five to six due to limited evidence, while it is stronger for those aged seven to seventeen (NICE, 2018). Investigations of the effectiveness and applicability of TF-CBT have also been conducted in a Nordic context, with clinical studies carried out in Norway and Sweden (Hultmann et al., 2023; Jensen et al., 2013, 2022).

TF-CBT for complex PTSD. Traditionally, in treating children suffering from complex trauma, the stabilization part is often extended, with an increased focus on safety and on

learning coping skills (Cohen et al., 2012). For children with multiple trauma experiences, the therapeutic relationship itself might be triggering, so there is an emphasis on creating a positive and safe setting in which to model a healthy way to interact with others. Rather than focusing on specific incidents, the treatment aims at identifying themes that emerge from the traumatic experiences in the child's life (Cohen et al., 2012).

Ross et al. (2021) investigated the effectiveness of TF-CBT for treating simple and complex PTSD (CPTSD). The study group initially consisted of 176 children aged 4–17 years, almost half of whom completed participation in the study. The nature of the traumas experienced, or whether the individual was assessed with simple or complex PTSD, did not predict dropout. However, there were significant differences concerning affect dysregulation, indicating a lower ability among dropouts to regulate affect and emotions in response to environmental changes. The overall results indicated statistically significant improvements in terms of reduced PTSD symptoms, reduced self-blame, improved emotion regulation, and reduced behavioural problems. The authors emphasized that the results imply that distinguishing between trauma history and the manifestation of PTSD may not be necessary for choosing between assessment and treatments (Ross et al., 2021).

Jensen et al. (2022) conducted a naturalistic observational study of a clinical sample of adolescents (n = 73) with a mean age of 15.4 years, aiming to examine the characteristics of adolescents who had developed CPTSD versus those with simple PTSD. The results indicated that 18 participants dropped out of treatment for various reasons. There was no evidence of systematic differences in the most relevant observed variables between those who dropped out and those who did not, or between participants who did and did not provide aftercare information. None of the participants assessed as having CPTSD before treatment met the criteria for a CPTSD diagnosis at follow-up; of these, three were reassessed as having PTSD. None of those diagnosed with PTSD before treatment met the criteria for the diagnosis after treatment. Comparisons between the groups revealed that participants with CPTSD displayed a steeper decline in both PTSD and CPTSD symptom severity over the period of treatment. The results also indicated that adolescents with CPTSD did not receive more treatment sessions, and the proportion of dropouts did not differ between the groups (Jensen et al., 2022).

Drop-out and non-responders in TF-CBT. As TF-CBT is the recommended first-line method for treating trauma-related problems in children and adolescents, and is also the focus of one of the studies in this dissertation, attempting to understand why some children terminate treatment prematurely or do not benefit from it is essential.

A meta-analysis by Simmons et al. (2021) examined data from 40 RCTs of PTSD treatments for children and adolescents, including TF-CBT and EMDR, aiming to examine drop-out rates. The authors found that the dropout rates were relatively low and comparable to those of other psychological treatment interventions. Dropout from all control groups was estimated to be just over 11.5 per cent. Dropout from TF-CBT and EMDR was slightly above 11 per cent, while dropout from non-trauma-focused treatments was just over 12.5 per cent. The results indicated that children and adolescents were less likely to drop out of group treatments than individual treatments, and that interventions delivered by lay community members were associated with lower dropout rates (Simmons et al., 2021).

Skar et al. (2022) investigated the effectiveness of TF-CBT. They found that one quarter of the children in the study were non-responders and that just over 13 per cent dropped out. Non-response to treatment and dropout were more likely if the number of traumatic experiences was three or more. Also, higher baseline PTSD symptom severity was linked to a greater likelihood of an ineffective treatment outcome. Neither therapist education nor child gender significantly affected the non-response or dropout rates. Dropout was most prevalent during the first two phases of treatment. The study identified higher child age and more severe PTSD symptom prior to treatment as risk factors for non-response (Skar et al., 2022).

Over 21 per cent of the participants were non-responders in a study by Lindebø Knutsen et al. (2020) examining the effectiveness of TF-CBT. Children with higher pre-treatment levels of PTSD symptoms and slower improvement over the course of treatment were more likely to be non-responders, as were girls. Based on the results, the authors suggested that girls and children with severe symptoms before treatment may be at greater risk of non-response and therefore should receive extra consideration when planning treatment (Lindebø Knutsen et al., 2020). The number of studies focusing on drop-outs among children and adolescents is, however, still limited.

TF-CBT in comparison with other treatments. Lewey et al. (2018) performed a meta-analysis of 30 studies, aiming to compare the effectiveness of TF-CBT and EMDR in children three–18 years of age. The findings indicated TF-CBT to be marginally more effective than EMDR in reducing the symptoms of posttraumatic stress. The authors emphasized, however, that the number of studies was unequal, with TF-CBT being over-represented compared with EMDR (Lewey et al., 2018). Another meta-analysis of eight studies found that both TF-CBT and EMDR were more effective than no treatment in reducing the symptoms of PTSD (large effect) and externalizing symptoms (medium effect) in adolescents (Hoogsteder et al., 2021). TF-CBT and EMDR seemed to be more effective in older than younger adolescents in one

study. However, neither of the treatments was found to be more effective than treatment as usual (Hoogsteder et al., 2021).

Diehle et al. (2015) compared the effectiveness of TF-CBT and EMDR in 48 children aged eight–18 years. Five children dropped out of the study, mostly from the EMDR group, within the first three sessions. The results indicated that both TF-CBT and EMDR were effective; however, the effect of TF-CBT was smaller than had been found in other studies, which the authors suggest might have been due to the shorter treatment duration in this particular study. The findings also indicated that EMDR did not effectively reduce comorbid problems reported by the parents, who noted issues such as conduct problems, hyperactivity, social phobia, and separation anxiety disorder. However, the children self-reported a general decrease in comorbid symptoms (Diehle et al., 2015).

A systematic review of 27 studies, 16 of which met the criteria to be included in a subsequent meta-analysis, aimed to evaluate the effectiveness of psychological interventions for PTSD symptoms in 2187 children, adolescents, and young adults (Bastien et al., 2020). The most frequently investigated psychological intervention was found to be TF-CBT followed by EMDR. The review supported the effectiveness of TF-CBT, but EMDR was more effective in reducing PTSD symptoms. The review concluded that there is a strong evidence base for the effectiveness of TF-CBT and some support for the effectiveness of EMDR. Despite the relatively small number of included studies and small sample sizes, the authors argued that the study provided evidence for the effectiveness of a range of psychological interventions, particularly TF-CBT and EMDR. They interpreted the results as further evidence and justification for the NICE guidelines (Bastien et al., 2020), suggesting that TF-CBT should be offered as first-line treatment to children and young people presenting with PTSD symptoms, with EMDR as a second intervention if the child does not respond to treatment (NICE, 2018).

There are studies specifically comparing TF-CBT with treatment as usual (TAU) or with commonly used treatments for children with PTSD in usual care. In a study by Lee and Lang (2023), commonly used treatments for comparison included cognitive behavioural therapy (CBT), solution-focused brief therapy, and motivational interviewing, and clinicians could provide multiple psychotherapy treatments to a single child. The study included 1861 children aged three–17 years, and showed that children who received TF-CBT made significantly greater improvements in problem severity and functioning than did children who received other types of TAU (Lee & Lang, 2023). These results are in line with a study from Norway that compared TF-CBT and TAU in terms of effectiveness for symptoms of posttraumatic stress, depression, anxiety, and general mental health functioning (Jensen et al., 2013). Initially, 156 multi-

traumatized youth participated, of whom 11 in TF-CBT and 12 in TAU dropped out prior to session six. Youths in both treatment groups showed significant improvement from pre- to post-therapy, but TF-CBT produced greater improvement. In contrast, a Swedish study compared TF-CBT and TAU in 89 children and adolescents, aged five–17 years, who had been subjected to interpersonal violence and/or child abuse and exhibited trauma-related symptoms (Hultmann et al., 2023). At the six-month follow-up, eight per cent of the participants had dropped out; in the remaining participants, both TF-CBT and TAU produced small to medium effects on symptoms of posttraumatic stress and general psychiatric symptoms in the participants (Hultmann et al., 2023).

Caregiver involvement in TF-CBT. The NICE (2018) guidelines concluded that the involvement of the child's or young person's caregivers should be considered and integrated into the treatment as appropriate and useful (NICE, 2018). A non-offending caregiver is included throughout TF-CBT treatment, aiming to create a setting where communication about the traumatic events is possible, to reduce conflicts in the family, and to help the parent cope with cognitive distortions of their own concerning the child's trauma (Cohen et al., 2017). As parental psychopathology is associated with the severity of symptoms in children, and as drop-out rates and improvement in children's symptoms are mediated by the caregivers' support and own perceptions of the trauma, their participation in TF-CBT is a priority (Brown et al., 2020). However, a meta-analysis of 25 randomized trials showed little evidence of moderating effects of the involvement of caregivers in TF-CBT (de Haan et al., 2024).

A review of 18 studies by Martin et al. (2019) examined whether caregiver psychopathology inhibited the effectiveness of TF-CBT for children. The review also explored TF-CBT treatment outcomes in both the participating caregiver and the child, and further investigated whether any studies assessed caregiver psychopathology and its potential relationship to children's trauma symptoms. The results provided preliminary support for TF-CBT in reducing caregiver psychopathology, including symptoms of depression, PTSD, and emotional distress related to the child's trauma. Furthermore, the review offered some evidence that caregiver depression, rather than PTSD or distress, may be a key factor influencing child treatment outcomes (Martin et al., 2019).

Cohen et al. (2011) specifically investigated the effectiveness of TF-CBT provided at a community women's centre and shelter for children (aged seven–14 years) who had experienced interpersonal violence (IPV). Notably, among treatment completers, 89 per cent reported ongoing contact with IPV perpetrators and 66 per cent experienced new traumas during treatment. The TF-CBT model was revised to address the needs of this specific group, focusing

on how children could feel safer amidst ongoing danger. Revisions included differentiating between real and generalized fears, teaching safety and relaxation strategies, and facilitating direct conversations with mothers about IPV experiences. The number of sessions was also shortened from the standard twelve to eight. Despite these adaptations, the dropout rate was relatively high, approaching 40 per cent. The authors suggested that this high dropout rate might be explained by participants facing severe concurrent challenges such as homelessness, maternal drug addiction and/or mental illness, and ongoing contact with perpetrators. Nevertheless, the study demonstrated that TF-CBT improved children's PTSD and anxiety related to IPV. However, improvement was modest relative to that found by previous TF-CBT studies of children experiencing sexual abuse and multiple traumas (Cohen et al., 2011).

Long-term effects of TF-CBT. Although numerous studies have demonstrated the effectiveness of TF-CBT in reducing trauma symptoms in children, empirical research examining its long-term effectiveness beyond 12 months remains scarce. A Norwegian study by Jensen et al. (2017) represents one of the longest follow-ups, investigating whether the effects of TF-CBT were maintained at an 18-month follow-up and whether co-occurring depression influenced treatment outcomes. The results indicated that youth receiving TF-CBT experienced more substantial improvements in trauma-related symptoms than did those receiving treatment as usual. These improvements were sustained after 18 months, and youth with serious co-occurring depression also benefited from TF-CBT (Jensen et al., 2017).

Deblinger et al. (2006) found that the positive effects of TF-CBT persisted at six- and 12-month follow-ups in children who had been sexually abused. Both children and caregivers continued to report fewer PTSD symptoms, reduced feelings of shame, and lower levels of abuse-specific parental distress (Deblinger et al., 2006). These results are in line with another study by Mannarino et al. (2012), who conducted six- and 12-month follow-up assessments of children who had experienced sexual abuse. Results indicated that the significant improvements observed after treatment were sustained at the follow-ups, with additional improvements in child self-reported anxiety and parental emotional distress noted at the 12-month follow-up (Mannarino et al., 2012). The current findings regarding the effectiveness of treatment are promising, but the number of studies including long-term follow-up remains limited, underscoring the importance of ongoing research in this area.

Children's perspectives on treatment

As mentioned above, important aspects of the design of effective interventions are the opinions and experiences of the children affected. However, children's opinions have traditionally been

marginalized, both because children have been viewed as inadequate informants and because research involving them entails extra ethics considerations. Articles 12 and 13 of the UN Convention on the Rights of the Child (1990) emphasize children's right to influence matters that concern them, and in recent decades, studies of children's experiences have proliferated, showing children to be capable of making decisions concerning participation in research and of expressing their opinions (Bucknall, 2014; Evang & Øverlien, 2015).

Children who are perceived as the most vulnerable, poorly functioning children, children suffering from illness (Carter, 2009), children from refugee families, and younger children are, however, less likely to be asked to participate in research (Pascal & Bertram, 2014). Consequently, those who are most likely to encounter health care, social services, etc., are the ones whose opinions are least likely to be heard (Carter, 2009). In line with this, research on the effectiveness of treatment traditionally focuses on quantifiable treatment results, whereas studies exploring children's experiences of treatment are scarce (Persson et al., 2017; Stafford et al., 2016). When children are asked about their experiences, many highlight the importance of feeling accepted and listened to by the therapist, and of being seen as an individual and multifaceted person (Hartzell et al., 2009; Persson et al., 2017). Feelings of engagement with and commitment to treatment are more likely to emerge if children feel that their individual needs are being met and they feel validated in their experiences (Donnellan et al., 2013; Harper et al., 2014). This is in line with research supporting the impact of relational aspects such as therapeutic alliance, goal consensus, empathy, and expectations of treatment outcome (Wampold, 2015).

Children typically find trauma-focused treatment helpful, particularly emphasizing the relief of discussing their traumas (Dittmann & Jensen, 2013). Neelakantan et al. (2019) specifically examined children's and their carers' experiences of TF-CBT in a review, finding that many children initially felt unsure about the treatment. However, therapists' focus on early engagement and addressing concerns strengthened the therapeutic alliance. Once reassured, many children then viewed treatment as a safe space for validation, appreciating the therapist's competence and confidentiality (Neelakantan, 2019). During the narration phase, negative emotions and self-blame associated with PTSD are addressed, and cognitive distortions are challenged (Cohen et al., 2017). Children report positive changes in self-perception, feeling more contented and less depressed, largely attributing these improvements to TF-CBT, while others attribute such changes to parental support or reconnecting with friends (Dittmann & Jensen, 2013). Knutsen and Jensen (2019) investigated changes in the trauma narrative in youths receiving TF-CBT. Their results suggest that creating a more organized and coherent

trauma narrative can help children organize their thoughts and strengthen their internal focus (Knutsen & Jensen, 2019). Some children, however, experience TF-CBT as unhelpful, specifically describing the narration phase as exacerbating distress (Dittmann & Jensen, 2013).

In designing more effective treatment for children and families affected by IPV and/or CA, evaluations could benefit from not only measuring symptoms but also taking account of the children's experiences of the interventions. Improved knowledge of how children exposed to IPV and/or child abuse describe their experiences and of how the child's general life situation may affect the outcome is important in improving treatment interventions for this vulnerable group (Felitti et al., 1998). Research specifically investigating the long-term outcomes of TF-CBT and the experiences of treatment for children subjected to family violence still remains limited.

Idiographic and nomothetic approaches in psychological research

During the emergence of psychology as a research field, various approaches have risen and declined in popularity, and the methods employed to address research questions have shifted over time, reflecting underlying epistemological and ontological positions.

Idiographic and nomothetic approaches represent two contrasting perspectives in the study of personality and behaviour (Ashworth, 2024). The idiographic approach focuses on how individual-specific factors interact to shape the personality and behaviours of the individual. The nomothetic approach is more concerned with explaining an individual's behaviour through general laws, emphasizing that science should attempt to discover these universal principles.

Smith (2024) has argued that psychological research has traditionally been characterized by quantitative, nomothetic methods, although qualitative research has gained increasing prominence in recent years. Depending on the research approach, the questions posed differ as does the analysis of the material; notably, quantitative research seeks to reduce phenomena to numbers and measurable entities to enable statistical calculations. In contrast, qualitative research aims to interpret meaning rather than measure phenomena, with understanding, sense-making, experiences, and communication often being central to the approach (Smith, 2024).

Epistemology

The way the world is philosophically understood and the methods used in attempting to explain it vary depending on the prevailing paradigm and the specific context (Johnson & Gray, 2010). The researcher's choice of approach in the study of a phenomenon is determined by the epistemological position, which reflects assumptions and beliefs about what data can reveal

(Smith & Nizza, 2022). Epistemology, as the theory of knowledge, deals with the nature of knowledge and how it can be explored. Ontology, a branch of philosophy concerned with the nature of reality, examines how reality and existence are defined and understood (Bourne et al., 2021).

Ashworth (2024) has outlined the progression of psychological research, starting from early experimentation involving self-observation, progressing to the study of consciousness, followed by controlled and quantified experiments and the rise of behaviourism and cognitivism. As a response to these trends, phenomenology, developed by Husserl, offered a different philosophical foundation for how science in general should be conducted. Husserl emphasized that knowledge of a phenomenon can only be acquired through the direct study of how the individual experiences the phenomenon. A key concept in this approach is that experiences should be examined from a first-person perspective, recognizing that individuals' understanding of the world is shaped by their personal experiences and rooted in their unique worldview. Any prior knowledge or elements that might distract or introduce preconceived notions to the researcher should be set aside or parenthesized when investigating an experience. The phenomenological approach aims to expose the taken-for-granted assumptions with which individuals understand and navigate their lifeworld (Ashworth, 2024).

Since the early days of psychology, there has been a focus on interpreting the individual's narrative about themselves and their experiences (Ashworth, 2024). The role of the researcher as an agent and the interpretations made during the collection and analysis of the researched material are emphasized in the concept of hermeneutics. The notion of the hermeneutic circle reflects how researchers move between examining the whole and the parts during the analytical process (Smith & Osborn, 2024). The resulting dynamic movement between looking at the whole through the interaction of the parts and the reverse leads to a more general claim as to the nature of the studied phenomenon.

Data collection methods

Thus, the research questions and the paradigm in which the research is conducted shape the use of methods in the data collection process. In quantitative research, the use of questionnaires or structured interviews is common (Creswell & Creswell, 2023). Questionnaires can facilitate studies examining attitudes, opinions, and trends by focusing on samples considered representative of the general population. The results are presented quantitatively, allowing for long-term monitoring and comparisons between groups.

Interviewing as a data collection method can be applied in both quantitative and qualitative research, taking different forms depending on the research question, the scale of the sample, and practical issues such as location (Flewitt, 2014). Interviews can be structured, as is often the case in large studies, using a predetermined questionnaire, sometimes with predefined answers for participants to choose from. Material gathered through structured interviews can be used in quantitative research, while semi-structured and unstructured interviews usually provide material for qualitative research. Semi-structured interviews offer a flexible approach in which the interviewer is free to formulate follow-up questions, allowing participants latitude to provide personalized answers (Flewitt, 2014). Additional types of material that can be used for high-quality research are different types of media content, existing texts, images, diaries, social media posts, etc. (Creswell & Creswell, 2023).

Different approaches to evaluating change at the group and individual levels

Lambert and Ogles (2009) described the three groups of statistical measures that are often used to express the effects of psychotherapy on patients: statistical significance of within-group and between-group differences, effect size (ES), and clinical significance. Data produced in research projects aimed at evaluating the efficacy or effectiveness of therapy typically undergo statistical significance tests (Lambert & Ogles, 2009). If the size of the mean difference is greater than what would be expected by chance, the result is considered statistically significant. However, the authors argued that relying solely on statistical significance is problematic, as it can lead to treatment differences being interpreted as substantial when, in reality, they may be clinically insignificant. Statistics that include ES can deepen our understanding by providing an index of the magnitude of the average change. ES has proven particularly valuable in meta-analyses, as it allows researchers to summarize and average treatment effects across different measures and studies. ES also makes it possible to estimate the proportion of patients benefiting from treatments, with a small effect indicating a smaller difference in group means compared with a large effect. However, neither statistical significance nor ES provides insights into changes at the individual level, as these measures focus primarily on group values (Lambert & Ogles, 2009). This means that some individuals may report significant improvements, while others exhibit no change or even deterioration. In contrast, the clinical significance approach considers changes at the individual patient level. Estimates of clinical significance are particularly useful in studies with small samples, in which detecting statistical differences is challenging and individual changes may be hidden in group variance (Lambert & Ogles, 2009).

Carey et al. (2023) emphasized the importance of contextualizing the use of ES, noting that interpretations can be misleading if applied in the wrong context. The authors argued that for clinicians, when assessing individual patient changes, a small ES can be irrelevant as minor score differences on questionnaires do not necessarily mirror a change in the patient's well-being. However, for a public health specialist the approach to ES is different, as even small effects, when applied at the population level, can lead to significant outcomes due to the large number of individuals affected. As a result, the importance of a small ES grows with the size of the population (Carey et al., 2023).

Jacobson and Truax (1991) were pioneers in discussing the usefulness of statistical significance tests for evaluating treatment effects. They argued that group-level comparisons offer limited insight into how psychotherapy affects the well-being of the individual. While statistical significance can indicate whether a treatment effect exists at the group level, it does not account for the variation in individual responses within the sample. Thus, statistical significance is limited in disclosing the clinical significance of the changes experienced by individuals. In light of this, Jacobson and Truax (1991) introduced the reliable change index (RCI), which has proven well suited for assessing clinically meaningful change at an individual level (Wolpert et al., 2015).

In efforts to identify evidence-based treatments in psychology, there has been comprehensive discussion of study design, focusing on the distinction between efficacy and effectiveness (Singal et al., 2014). Kazdin (2008) summarized the two sides as *efficacy studies* (i.e., Does the treatment work?) and *effectiveness studies* (i.e., Do the findings extend to practice settings?). Expanding on this, Hunsley and Lee (2007) described efficacy studies, or RCTs, as aiming to develop evidence-based psychological treatments under conditions adjusted to fit the study. In this approach, the researchers strive to control the setting to ensure that the observed effects can be attributed to the treatment itself. However, as therapists and participants are often selected to fit the study design, they may not always represent the clinical contexts where the treatment is intended to be performed (Hunsley & Lee, 2007). Both efficacy and effectiveness studies play important roles in evaluating interventions, but they serve different purposes and generate different types of data (Singal et al., 2014). Efficacy studies focus on optimizing the assessment of an intervention's effect, whereas effectiveness studies provide a more comprehensive view of how patient-, provider-, and system-level factors may influence outcomes in real-world clinical settings.

Qualitative analysis methods: an overview of interpretative phenomenological analysis and thematic analysis

Qualitative data can be analysed in a range of ways and, as mentioned earlier, the phenomena being researched and the research questions posed depend on the theoretical foundation of the studies, i.e., the epistemology (Smith, 2024). Two distinct methods within qualitative research that are frequently used to analyse and interpret text-based data (e.g., interviews and documents) are interpretative phenomenological analysis (IPA) and thematic analysis (TA) (Smith, 2024). Other examples of qualitative methods are narrative analysis, grounded theory, and discourse analysis (Smith et al., 2022). IPA and TA are the two qualitative methods employed in this thesis and will be described in more detail below.

Interpretative phenomenological analysis. Interpretative phenomenological analysis (IPA) is a research method specifically designed for understanding participants' lived experiences and how participants make sense of them (Smith, 2009). It is rooted in phenomenology, hermeneutics, and ideography (Smith et al., 2022). IPA focuses on exploring how a phenomenon is experienced from the participant's perspective, with the researcher adopting an interpretative stance to comprehend the participant's experiences within their unique context (Smith, 2022).

The earlier-mentioned concept of the "hermeneutic circle" is integral to IPA, illustrating the dynamic process of shifting perspectives. This involves moving between analysing individual statements and considering them within a broader context. Researchers alternate between focusing on the significance of specific statements and understanding these statements in relation to the overall context. This iterative, or cyclic, process is captured by the term "circle" (Smith & Osborn, 2024).

Initially developed for psychological research, IPA has since expanded to other disciplines and is now employed to explore a wide range of research questions (Smith et al., 2022). While the primary data source for IPA is usually in-depth, semi-structured interviews, the method can also incorporate focus groups as well as diaries, drawings, or photography as ways for participants to express their inner experiences (Smith et al., 2022). Additionally, in mixed-method studies that combine quantitative and qualitative data to foster a comprehensive understanding of findings, IPA can be effectively applied to analyse the qualitative material (Creswell & Plano Clark, 2017).

Thematic analysis. Thematic analysis (TA), developed by Braun and Clarke (2006), can be adapted to various theoretical perspectives and research designs. Braun and Clarke's 2006 article "Using thematic analysis in psychology" has had a major impact on the research

community. In the article, the authors described the method as flexible and useful, regardless of the theory or epistemology from which the research question arises. Furthermore, they explained that "thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 70). TA consists of six phases, during which the generation, reviewing, and naming of themes leads to the final report. The authors emphasized the need for the researcher to be aware of the theoretical framework within which the study is conducted, to match the method to the research question, and to be mindful of the choices made (Braun & Clarke, 2006).

The creators of the method have more recently highlighted that the flexibility and popularity of the method have led to a somewhat unfortunate situation in which a great variety of studies claim to have conducted TA without accounting for or discussing how the actual analysis was carried out (Braun et al., 2024). They also problematized that TA is "mashed up" with other methods without the researcher being deliberate and reflexive about it. This has led to confusion as to what TA actually is, and the developers have suggested that TA now, rather than a single method, constitutes a family of methods, divided roughly into three approaches: coding reliability TA, codebook TA, and reflexive TA, of which reflexive TA is the most commonly used (Braun et al., 2024).

Braun et al. (2024) highlighted the need for an open, flexible approach to coding in which the researcher is seen as an active participant in the process, interpreting the material, in contrast to the more descriptive position often seen in more post-positivistic research. They emphasized that in reflexive TA there is no underlying "truth" to be discovered by the researcher and that the themes will not "emerge" from the data (Braun et al., 2024).

Depending on the scientific perspective applied, thematic analysis will be conducted in different ways – for example, depending on whether the material is analysed inductively or deductively (Braun et al., 2024). Inductive analysis assumes that what is said is important and strives to minimize the influence of the theoretical framework and the researcher's preconceptions about the phenomenon being studied. Deductive analysis, in contrast, examines the material through a theoretical lens, and this framework affects both the coding and themes. Additionally, the material may be analysed at a semantic level, where the focus is on what participants explicitly say, or at a latent level, where underlying meanings and what participants say are more extensively interpreted by the researcher (Braun et al., 2024).

Mixed-method approaches in psychological research

In the late 1980s, several researchers from different disciplines and countries independently came to a similar idea and began developing an approach that moved beyond using qualitative or quantitative data separately. Instead, they argued for ways to link, combine, integrate, or mix the methods, marking the beginning of mixed-method research (Creswell & Plano Clark, 2017). Mixed-method research, in which quantitative and qualitative methods are combined, is increasingly used in social scientific research (Timans et al., 2019). A fundamental idea of this approach is to choose the method based on the research question, rather than the other way around (Creswell, 2022; Gorard, 2010).

Advocates of mixed methods view the conflict between quantitative and qualitative methods as an unfortunate barrier to the quest for new knowledge (Shank, 2006). Rather than seeing the two research processes as opposites, mixed-method researchers argue that different ways of gaining knowledge enrich the overall picture and offer ways to achieve deeper and more complex understandings. The use of multiple worldviews is encouraged, with pragmatism as a key principle: determining the best possible way to answer the research question, identifying the necessary data, and choosing the most suitable methods, regardless of paradigm, to collect the required information (Creswell, 2022).

Mixed-method designs. Creswell (2022) introduced three core mixed-method designs and described ways to implement more complex, embedded designs if the research question demands it.

Convergent design is used to determine whether qualitative and quantitative research data are comparable: whether the results from each dataset validate each other, point in the same direction, or diverge. The data are collected separately and analysed either separately or together. By comparing and combining the results, a more comprehensive understanding of the investigated phenomenon is possible. Conclusions and interpretations are drawn from the combined results and are then discussed and explained (Creswell, 2022). Explanatory sequential design, according to Creswell (2022), aims to explain quantitative results using qualitative data. Initially, quantitative data are collected and analysed; interesting findings are then explored with follow-up questions directed at the research participants who are most likely to provide the desired information. The analysis of the qualitative data helps create a deeper and richer answer to the research questions (Creswell, 2022). Exploratory sequential design is primarily used to fill gaps in existing knowledge, aiming to better understand what questions to ask, and how, in subsequent quantitative research (Creswell, 2022). By exploring people's ideas,

vocabulary, and worldviews qualitatively, it is possible to adapt and create quantitative measures to investigate the phenomena of interest.

Creswell (2022) also suggested more complex, embedded, or triangulation designs in mixed-method research and advocates for their use when a project requires more than one core design. He noted that these designs can be applicable in research projects using various data collection methods, such as observations and experiments, in addition to quantitative and qualitative data (Creswell, 2022). Gorard (2010), however, questioned the entire idea of two separate paradigms, arguing that it is impossible to make a clear distinction between them. He argued that every attempt to apply a philosophical stance to a practical method is doomed to fail: a thematic analysis of interviews is still based on a somewhat quantitative analysis using measurements such as "some", "a few", and "many". Conversely, numbers are only numbers if they are not interpreted and given qualitative meaning. This led Gorard (2010) to question the need to specifically discuss mixed methods at all, since research, by definition, is already a mixed-method process. Others have highlighted that mixed methods are not a new approach, but rather had been used long before the late 1980s, although it had not yet been formalized as a research approach (Fàbregues et al., 2021).

Adu et al. (2022) emphasized that combining deductive and inductive approaches in studies is central to maximizing the use of data, with the benefits depending on the goals of the research project. However, they emphasized that the use of mixed-method research is surrounded by controversy and discussion. Abu et al. (2022) cited examples of three areas of discussion and controversy. First, some argue that the division paradigms and subsequent approaches and methods pose a serious challenge to mixed-method researchers, as the differing philosophical assumptions framing the research are often seen as incompatible. Second, the tendency of mixed-method research to focus more on one paradigm than the other has also been criticized, particularly for an overrepresentation of post-positivist ideologies. Finally, Abu et al. (2022) mentioned discussions of the challenges of validating mixed-method studies and the confusion possibly engendered by the use of different methods.

Fàbregues et al. (2021) examined issues in mixed-method research described by researchers in the field. Key concerns included the narrow definition of mixed-method research and the notion that viewing mixed methods as a distinct paradigm can create an artificial separation between quantitative and qualitative approaches. Additionally, problems related to typologies and the conceptualization of the method were highlighted, with concerns that the described processes may be too narrow and fail to capture the diversity of mixed-method practices in the field (Fàbregues et al., 2021).

Ethics in research

In the same way that prevailing paradigms and specific contexts influence views of how research should be conducted, perspectives on participants and their rights in research are affected by the zeitgeist. Johannisson (1991) wrote about Swedish public health from a historical perspective, stressing the evolution of ideas regarding human value in relation to prevailing societal norms. Racism, economic disparities, and mental and physical health relative to disease have influenced perceptions of human worth over time. Efforts to "correct" or modify individuals from less powerful groups have significantly shaped research on humans and human behaviour, leading to the prominence of ideas such as eugenics. At various times, science has seen it as its duty to influence political decisions to foster a strong state by optimizing the population and strengthening public health. Johannisson (1991) described how children received special attention in this endeavour, with the aim of preventing the development of mental and physical illness through careful control of children's living conditions.

Over time, as societal acceptance of ideas concerning equality and the intrinsic value of individuals grew, there was an increased emphasis on the ethical review of studies involving human subjects (Halse & Honey, 2007; Swedish Research Council, 2017). Previous research had often inflicted harm on and exploited marginalized groups such as women, children, prisoners, and people with disabilities, and was in retrospect viewed as unethical. Key documents such as the Nuremberg Code and the Declaration of Helsinki were established to safeguard the rights and welfare of research participants (Halse & Honey, 2007; Swedish Research Council, 2017).

Childhood as a concept

Throughout history, the perception of children and the concept of childhood have continuously evolved (Kellet, 2014). At certain times, the prevailing belief was that all humans were born sinful, and as a result, children were seen as inherently evil – a trait that the adult world needed to control. In other periods, the belief was that children were born pure, without inherent traits, and that their development was entirely shaped by their environment. At different times, children have also been viewed as possessing inherent goodness, with an innocence that should be protected as much as possible from the corruption and depravity of the adult world (Kellet, 2014). The legitimization of the systematic prejudices children face, being viewed somewhat as possessions or as inferior to adults, was proposed by Young-Bruehl (2012) to be defined as

"childism". Childism refers to the tendency to overlook the needs and opinions of children, sometimes even considering them an economic burden on society (Young-Bruehl, 2012).

Children in research

The Swedish Research Council (2017) stated in its report *God forskningssed* ("Good research practice") that individuals of all ages should be protected from harm and injuries from participating in research. As children are often viewed as a vulnerable group, they have historically been marginalized in research (Carter, 2009). In matters concerning children, their parents, therapists, or teachers have been used as informants rather than the children themselves.

Even when children participate in research, there is a risk of bias, as the experiences, perspectives, and opinions of some children are emphasized, while other children remain invisible (Schulte, 2022). Viewing children as a homogeneous group and considering research involving children as inherently risky might not only overlook the diversity and individuality of children but also jeopardize children's right to affect and be involved in the development of the community (Carter, 2009). This tendency poses a sharp contrast to Articles 12 and 13 of the UN Convention on the Rights of the Child (1990), which emphasize children's right to influence matters that concern them, and that the well-being of the child should be the focus of decisions and actions that affect them.

In recent decades, the emphasis has shifted away from children relying on adults to describe and account for their lives, as the voices of children have increasingly taken centre stage (Bucknall, 2014). Bucknall (2014) highlighted the issue that research on children's experiences is often framed as "giving children a voice". In this framing, children's participation in research is portrayed as a gift, something made possible solely through the generosity of adults. Simultaneously, she underscored the paradox that even such research emphasizes children's subordinate position relative to adults. It is in fact the adult researcher who leads the project, determines the area of focus, selects the methods used and questions to be addressed when giving the children "a voice" (Bucknall, 2014).

There are, however, examples of research conducted by children, with projects led and carried out by children, facilitated and financially supported by organizations. Clark et al. (2014) advocated for the use of interviews, observations, documents, and other artefacts in research involving children, emphasizing that methodological issues are more about flexibility and adaptation than about whether qualitative or quantitative methods are preferable (Clark et al., 2014).

Seeing children as agents with voices of their own offers important new perspectives but also poses questions about ethical issues (Eldén, 2013). In much research concerning children, informed consent has solely been obtained from the guardians; however, there is increasing interest in exploring how to obtain consent from even very young children (Smith & Coady, 2022). The "need-for-protection" argument is manifested in the requirement for custodian approval and points to the irony that children's opportunities to express their opinions are dependent on adult approval (Eldén, 2013). As parental consent is required for children to participate in research, it can complicate studies focusing on children's experiences of relationships and family dynamics as it involves the said guardians.

Davies (2017) has advocated for a holistic approach when researching children's experiences within the family. She discussed how children are positioned within the family, how they are influenced by and influence various relational contexts, including not only parents but also siblings, extended family, and grandparents, which may be part of their social network. The particular nature of family research, which seeks to explore family relationships, complicates an already complex ethical dynamic among the researcher, child, and parent/caregiver. The caregiver can feel that their privacy is being compromised and experience being judged or surveilled. As a consequence, children can be instructed not to disclose specific information to the researcher. This approach positions the child primarily as part of the family unit, rather than as an individual entitled to reflect and comment on family practices and relationships. Children also might disclose family secrets during the interview and regret it later, potentially leading to punishment or a strained relationship with their guardians. Consequently, a child's participation in research can have significant implications for family dynamics. Researchers must consider these issues and how to handle them prior to data collection. Davis (2017) asserts that researchers have an ethical obligation not only to the child but also to the child's relationships outside the research context, adhering to the principle of "do no harm" to participants.

In settings of domestic violence and child abuse, the need for guardian approval might imply that some experiences remain unheard, as samples are skewed to represent children who no longer have contact with the offending parent and live with a parent who is engaged in specialist violence interventions (Eliffe et al., 2020). In line with this, Evang and Øverlien (2015) highlighted several reasons why young children are often not used as informants in qualitative research. They mentioned the practical difficulties involved in arranging the interview situation and the challenges of analysing and understanding the child's narrative. Additionally, ethical concerns about the vulnerability of children and how they might react to participating in

research may also contribute to their exclusion from qualitative studies. However, the researchers found that children as young as four–seven years old were able to communicate important aspects of what it meant for them to live in a family with domestic violence and were found to regulate, limit, and take the lead in the interviews. Considering this, the researchers emphasized the importance of including small children in research and challenging the view of children as helpless (Evang & Øverlien, 2015).

Aim

The overarching aim of this thesis was to retrospectively explore how traumatized children in the Child and Adolescent Mental Health Service (CAMHS), who had been subjected to family violence, experienced treatment in general and, specifically, to assess the well-being of children who underwent trauma-focused cognitive behavioural therapy (TF-CBT). Study I aimed to explore how these children described their life situations before and during their contact with the CAMHS. Study II examined how the children experienced the treatment they were offered at the CAMHS. Study III aimed to gain a deeper understanding of changes in trauma-related symptoms in children and youths who had taken part in TF-CBT four–five years earlier.

Methods

The three studies included in this thesis are based on interviews with children and adolescents who, due to experiences of family violence, had participated in an RCT (Hultmann et al., 2023) at a CAMHS unit four–five years earlier. In this earlier RCT, all participants had been assessed as having trauma-related symptoms. The assessments from the follow-up were included in Study III. In the RCT, the participants were randomized to either TF-CBT or enhanced treatment as usual (eTAU). A total of 93 participants were recruited in the RCT, 78 of whom completed their participation. An overview of the studies included in the thesis is presented in Table 1.

Table 1. Overview of the studies included in the thesis.

	STUDY I	STUDY II	STUDY III
AIM	*To explore how children exposed to family violence described their life situation, before and during their contact with the Child and Adolescent Mental Health Service (CAMHS)*	*To explore how children exposed to family violence experienced treatment at the CAMHS*	*To gain a deeper understanding of changes in trauma-related symptoms in children and youths who had taken part in TF-CBT four–five years earlier*
DESIGN	Qualitative retrospective study	Qualitative retrospective study	Convergent mixed-method design
PARTICIPANTS	13 participants aged 12–25 years (M = 20.2; 11 female and 2 male)	17 participants aged 12–25 years (M = 19.8; 13 female and 4 male)	9 participants aged 14–23 years (M = 16.6; 7 female and 2 male)
DATA COLLECTION	Semi-structured interviews 4–5 years after treatment	Semi-structured interviews 4–5 years after treatment	Quantitative data: pre-treatment, 6 and 12 months after pre-treatment data were collected, and 4–5 years after TF-CBT treatment Structured clinical interview: pre-treatment, 6 months and 4–5 years after treatment Semi-structured interviews 4–5 years after treatment
DATA ANALYSIS	Inductive thematic analysis	Thematic analysis using a phenomenological approach	*Quantitative analysis:* The reliable change index (RCI), descriptive analysis *Qualitative analysis:* interpretative phenomenological analysis (IPA) *Synthesis:* Integration of qualitative and quantitative data into a synthesis that summarizes each participant's background information, changes in symptoms during and after treatment, and an interpretation of participants' experiences and narratives through a trauma-focused lens

Procedure

As all three studies referred to in this thesis are based on interviews with an overlapping sample, the procedure and method are described together. The research commenced after receiving ethical approval from the regional ethical review board in the designated research area (Dnr: 806-16). In the initial RCT study, 93 children were enrolled, with 47 randomized to TF-CBT and 46 to eTAU. The study included children and adolescents aged nine–17 years who had experienced interpersonal violence and/or child abuse and exhibited trauma-related symptoms (see Hultmann et al., 2023, for further details).

At the follow-up, contact information was available for 40 potential participants. All were contacted by telephone and given brief information about the aim and procedure of the studies. A total of 17 participants volunteered, while 13 declined; the remaining ten could not be reached after the initial phone call. Those who agreed to participate were sent written information via email and were contacted again by telephone to confirm their interest and to schedule an appointment for data collection. Both verbal and written information about the aims of the study, the interview procedure, and the assessment forms was given to the potential participants. It was emphasized that participation was voluntary and that the participants could decline to answer certain questions and/or terminate their participation without explanation and without consequences for their treatment. The participants were also informed, both verbally and in writing, that all the collected data would be anonymized and kept confidential.

The interviews were conducted on an ongoing basis, resulting in 13 participants in Study I, with an additional four participants interviewed by the time of Study II. In Study III, only participants from the TF-CBT condition were included, resulting in a total of nine participants, as one of the original ten declined to participate in the assessment. In the summary of the three studies below, descriptions of the samples are presented separately. A flow chart of the participants in all studies is presented below, se figure 1.

Qualitative data collection

The interviews were conducted by me and a former female colleague. Both of us are psychologists, have been working at the the CAMHS for many years, and have a thorough understanding of the therapeutic work and the patient group. Due to the sensitive subject matter of the study, the interviewers did not strive to display distance during the interviews; instead, we aimed to create an empathic, human atmosphere characterized by curiosity and openness. The interviews ranged from half an hour to two hours in length. Depending on what was most suitable for the participant, the interview was carried out in the participant's home or at the

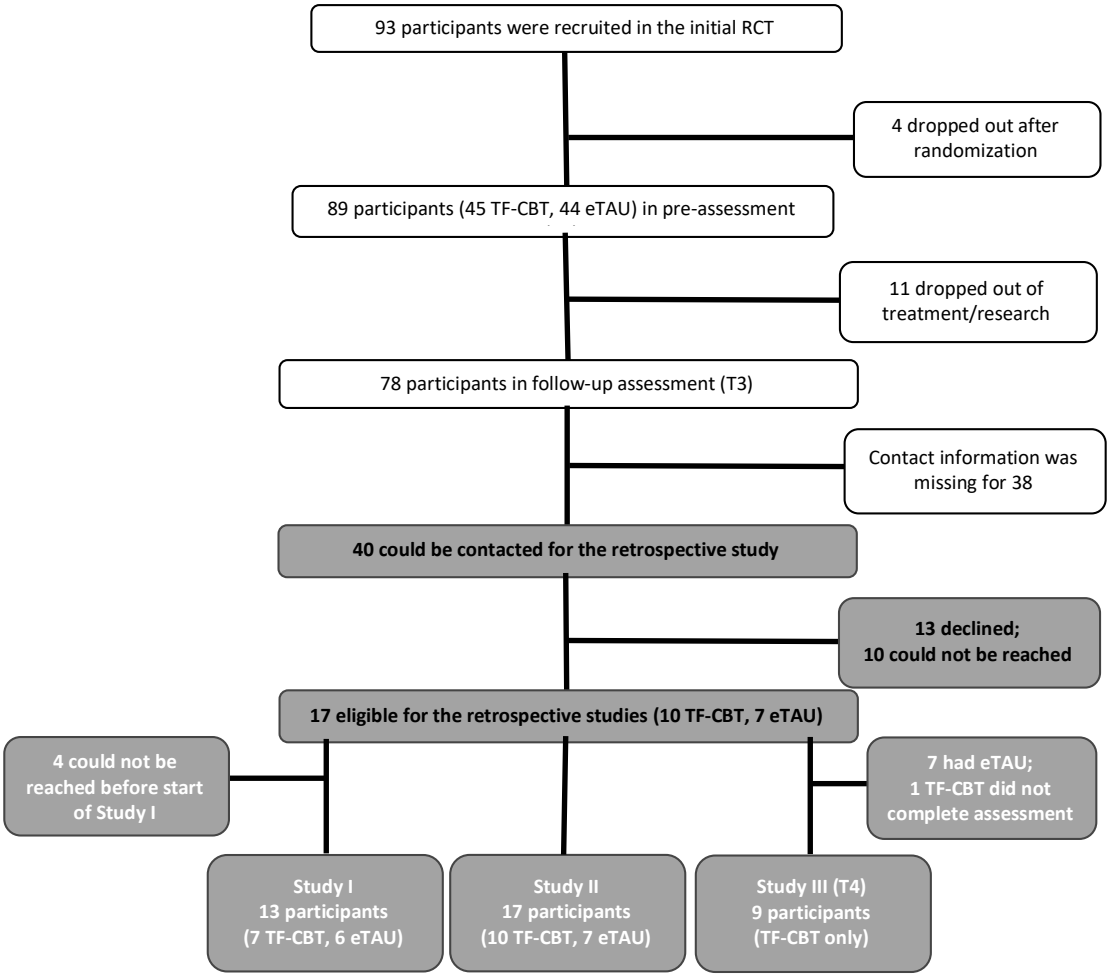
CAMHS. As compensation for their participation, all participants received two cinema tickets at the end of the interview.

All three studies are based on material from the same interviews, but different sections were used depending on the method and aim of each study. The interviews followed a semi-structured interview guide (see Appendix 1) that included thirteen questions about experiences of the treatment at the CAMHS, the life situation during the treatment period, and experiences of the social services and the justice system. Follow-up questions were asked to clarify answers and to gain a deeper understanding of the participants' experiences. Examples of questions and follow-up questions are: What did you think of the interventions you received at the clinic? Do you remember if you experienced anything in particular as good/bad, and was there anything you would like to change? All interviews were recorded and transcribed verbatim.

Quantitative data collection

The dataset for Study III consists of assessment forms, diagnostic interviews, and follow-up interviews of nine individuals who underwent TF-CBT in the RCT. The initial study included three assessment points: pre-treatment, a six-month follow-up, and a 12-month follow-up (Hultmann et al., 2023). Participants underwent a structured clinical interview using the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS-PL) (Kaufman & Schweder, 2004) at both the pre-treatment and six-month follow-up assessment points, and completed questionnaires at all three assessment points. The assessments and interviews before treatment and at the six- and 12-month follow-ups were conducted by therapists at the CAMHS. Study III integrates data collected through K-SADS-PL interviews, questionnaires, and additional interviews and assessments conducted four–five years after the initial RCT participation. The assessments were conducted by my former colleague or me concurrently with the semi-structured interviews.

Figure 1. Flow chart of participants.



The studies

Study I

Aim

The aim of the study was to explore how children exposed to family violence described their life situation, before and during their contact with the CAMHS.

Methods

The data consisted of interviews with 13 participants aged 12–25 years (M = 20.2; 11 girls/young women and two young men). At the time of the interview, most participants lived with their mother (n = 5) or father (n = 4). One alternated living with each of her parents; one lived with a partner, one with her grandmother, and one in a former foster family. Most were students (two enrolled in and five having completed elementary school; one enrolled in and one having completed high school; and three enrolled in municipal adult education) and one was working.

Previous assessment forms, current interviews, and record reviews showed that 12 participants had experienced physical violence, nine had experienced psychological violence, and seven had experienced sexual violence; five had experienced adults abusing drugs/alcohol, seven had witnessed violence in the family and six had attempted suicide at least once.

The data were analysed using an inductive thematic approach intended to capture the participants' experiences and perspectives following the six phases of analysis described by Braun and Clarke (2006). During the analysis, I read and reread all interviews, noting initial thoughts and reflections, only coding the parts relevant to the study's aim (i.e., concerning the participants' life situation before and during their contact with the CAMHS). In a parallel process, my main supervisor coded every third interview to ensure that my preconceptions of the group did not influence the analysis. Codes were subsequently compared and discussed to find those most suitable for the content, and these were then listed and structured into potential themes. Together with my second supervisor, we collaborated multiple times in reviewing the potential themes and in defining and naming the final themes.

Main findings

The analysis of the interviews resulted in three main themes and seven sub-themes, presented below.

Home and family. This main theme was based on the participants' narratives about the ongoing vulnerability they experienced during treatment. The first sub-theme was named

ongoing conflicts and distress, as many participants, despite feeling loved and supported by the parent they lived with, also experienced ongoing conflicts with one or both parents and/or the parents' partner. Although most participants reported no physical violence during treatment, many described their relationship with one or both parents in terms of insecurity or fear. A second sub-theme identified was *losses and feelings of betrayal*, as many described their relationship with one or both parents in terms of disappointment and betrayal, as they had experienced their parents vanishing, lying, or trying to manipulate them. Although sadness, confusion, and fear of losing the parent were predominant feelings, some described a parallel feeling of relief. *Concern for parents and siblings* was identified as the third sub-theme, as several participants expressed having felt concerned about their family members throughout their upbringing, even when in treatment. Many had parents and/or siblings who suffered from recurrent mental health issues, serious illness, or drug abuse. These children were frustrated by their inability to help the persons they loved.

School and friendships. This main theme concerned experiences related to school and friendships before and during the treatment at the CAMHS. With a few exceptions, the participants described their school experiences as negative. Most participants characterized their time at school as dominated by feelings of insecurity and vulnerability. As many described experiences of severe bullying and professionals who had failed to protect them or to offer the support they needed, this sub-theme was named *being bullied, feeling let down, and not talking about violence*. The second sub-theme, *feeling different and alone*, captures the participants' feelings of being deviant because of their turbulent family situation, receiving treatment, and feeling inferior. Several participants described having had a lonely, friendless childhood dominated by sadness. They explained their lack of friends in different ways, but many blamed themselves for having behaved strangely or aggressively or having caused chaos. Those who reported having friends, described their friendships as ranging from being sources of support to being liabilities, as their friends often had problems of their own.

Social services and the legal system. This final main theme captures the participants' experiences of their contact with social services, police, and the judiciary. For some, these were recurring encounters throughout their childhood, sometimes while they were in treatment.

When participants talked about their contact with the social services, fear and powerlessness were recurring. Many described having been subject to decisions without their input or consent, and the identified sub-theme was named *powerlessness versus agency*. The importance of agency – the possibility of participating in decisions – recurred in the participants' accounts, and some described their life situations as having been changed dramatically without

anyone consulting them. Participants who had been given an opportunity to recount events and incidents in their meetings with social services said that this had been important.

Of the participants who had been in contact with the police and/or legal system, a majority characterized the encounters in terms of *fear and disappointment*, which is the name of the last sub-theme. Some said that although the police had come to their home multiple times, the situation had remained the same. This lack of action had led to mistrust and fear of the police. Participants described experiences of interrogating police officers as dismissive and cold, and legal trials as stressful. Although there were exceptions, many reported that they had been ignored or been given incorrect information about their legal rights.

Conclusion

Many participants reported that they still were subjected to stressors and ongoing violence in their family, at school, or elsewhere while they were in contact with CAMHS. This illustrates the importance of therapists not assuming that the child is automatically secure because the violence has been discovered. Rather, the results point to the vital importance of continuously addressing issues of safety and safety planning when working with children who have experienced family violence.

The fact that children exist in a context that affects their well-being is highlighted by the results. Worries about parents or siblings suffering from physical or psychiatric illness and problems with friends or at school are likely to increase the burden on the child in treatment. Eventually, a child who is treated in isolation from their social context risks receiving ineffective interventions that do not help them with challenges in important, but unacknowledged, parts of their life situation. Additionally, children who have experienced family violence would likely benefit from increased collaboration, not only with the various actors who have a direct effect on their situation, but also with those providing interventions to their parents and siblings.

Study II

Aim

The aim of the study was to, retrospectively, explore how children exposed to family violence experienced treatment at the CAMHS. The following research question was investigated: What do children who have received treatment at the CAMHS perceive as helpful versus hindering?

Methods

The data consisted of interviews with 17 young people (13 female and four male) aged 12–25 years (M = 19.8). At the time of the interview, all participants' parents had divorced, and the majority lived either with their mother (*n* = 9) or father (*n* = 4). One participant alternated living with each of her parents, one lived with a partner, one lived with her grandmother, and one lived with a former foster family. Most (*n* = 9) were students: two in elementary school, one in high school, and three in municipal adult education. Five had finished elementary school and one had just finished high school. Of the 17 participants, ten had been randomized to TF-CBT treatment and seven to eTAU. Two participants dropped out of the study before the first follow-up assessment. The remaining 15 participated in 11–58 sessions (M = 23). The participant who had had the most sessions had first received TF-CBT followed by eTAU.

The assessment, interviews, and clinical records revealed that the participants had experienced physical violence (*n* = 15), psychological violence (*n* = 12), and/or sexual abuse (*n* = 7). Some had had adults in their family with drug or alcohol abuse or/and had witnessed family violence. Of all participants, more than half (*n* = 8) had made at least one suicide attempt.

All had been assessed prior to treatment, with 11 of 17 meeting the diagnostic criteria for PTSD. Four participants were also diagnosed with depression and/or anxiety, one met the diagnostic criteria for attention deficit hyperactivity disorder (ADHD), and two were diagnosed with oppositional defiant disorder (ODD). Five participants did not meet the criteria for any psychiatric diagnosis.

The material was analysed using thematic analysis (Braun & Clarke, 2006); a phenomenological (Spinelli, 2005) approach was considered suitable as the intention was to capture the participants' lived experiences and subjective perspectives. Initially, all interviews were transcribed, and the analysis followed the six phases described by Braun and Clarke (2006, 2024).

The transcripts were read several times, and I took notes recording my initial thoughts and impressions. Of the material in the interviews, only those parts relevant to the research question (i.e., concerning the participants' experience of the CAMHS) were thoroughly analysed. The data were systematically analysed and coded inductively according to the content. To prevent my preconceptions of the group from influencing the analysis, the process was closely monitored and supported by my supervisors. For example, eight interviews were parallel coded by my supervisors and all codes were later compared and discussed together. During the coding, ideas for themes and assumptions possibly influencing the reading of the data were also noted. Subsequently, we listed and structured the codes into potential themes,

aiming to find a thematic structure that included as much of the coded data as possible. All three authors discussed and agreed on the five final themes, and names were selected to capture the essence of all themes.

Main findings

The participants generally described their experiences of treatment at the CAMHS as positive, and often mentioned being met with kindness and feeling listened to by the therapists. Some described the therapeutic work as helpful in improving their relationship with a parent, and some even described it as life changing. The five themes described below are, however, selected to point out areas for improvement, as this was the focus of the study.

It was confusing. A prominent theme of many interviews was the participants' confusion about contact with the CAMHS. Many described going there with only a vague idea of having to talk to someone, but the purpose of the visits and what was expected of them were often unclear. Several described taking part in meeting after meeting, answering question after question, and filling in assessment forms with no understanding of why these procedures were supposed to be helpful. Some expressed confusion and a sense of injustice at receiving a diagnosis and a feeling of not being seen as an individual, but as a diagnosis – i.e., they were defined as the problem when, in fact, someone else had been violent towards them. Some had perceived specific treatment interventions as confusing or strange. Few, however, had questioned the interventions since they had difficulty grasping their aims.

I felt listened to. With few exceptions, the therapists were perceived as having been patient and friendly, and many described the importance of being treated with empathy. Recurrently seeing the same therapist had been a precondition for some to feel safe enough to engage in therapy. For others, being able to replace a therapist they did not feel connected to allowed them to give therapy a second chance. Most wanted a therapist whom they perceived as a genuine listener and who would give them the time and latitude to express their own views of their situations and problems. Many appreciated being asked about specific things (e.g., about how they preferred to learn new things) or being offered choices as to how to clarify family relations in the therapeutic work, but many said they had felt relieved at not having to make decisions about the treatment itself.

I was afraid. Ongoing exposure to abuse and a need to keep it secret from the therapists had made it difficult for some to engage in treatment. Some described siblings controlling the family with violence and parents handing out punishments after meetings at the CAMHS, harassing and threatening them. Fear of the potential consequences of disclosure, of worsening

punishments, of the family turning its back on them, or of the social services being contacted had made it impossible for them to be open about their situation. For some, it was clear that the secrets they kept had hindered the therapy's success.

It was painful. A recurring theme was the pain of feeling different from others. Many described how their self-image had been negatively affected when they came to the CAMHS, saying that they felt ashamed, disgusting, and broken. Many blamed themselves for being sexually abused or for not being able to prevent the violence against themselves or others. Some depicted themselves as stupid or crazy, both as victims of abuse and for the reactions they suffered after the abuse. Being a patient at the CAMHS and being diagnosed had sometimes reinforced their distress at feeling different, and the setting had made some feel even more alienated than before. Although their understandings of the purpose of therapy differed, some said that re-experiencing the violence in therapy was part of a process that made their pain understandable, and that the pain had decreased as the work progressed. Others never understood why they had to talk about the events over and over again and they felt no relief from the therapy. Parents' participation in the treatment had been appreciated, but several participants said they had wanted their parent to receive more support of their own.

I was the agent. Throughout the interviews, the participants highlighted their own attitude and motivation as the most important factors determining whether or not the work at the CAMHS had been successful. They identified as agents. Some described being reluctant at first to participate in therapy, but changing their minds once they developed a trusting relationship with the therapist. For those who were motivated from the beginning, the relationship and personality of the therapist had been less important: they had decided that therapy was going to help them and been determined to go through with it no matter what. Others said that all the efforts of the therapist at the CAMHS had been wasted, since they had entered the situation determined not to participate. Being too young, too impatient, and unable to listen were all described as hindrances to the therapy's success. Ongoing drug addiction, eating disorders, or other psychiatric symptoms had also made it hard for some to engage in treatment.

Conclusion

Children's experiences of treatment seem to depend heavily on relational aspects. Therapists perceived as friendly, patient, and genuinely interested were able to create a setting trusting enough for the child to face painful experiences. This requires therapists, as well as organizations, to create treatment settings characterized by curiosity, playfulness, and exploration, regardless of the treatment methods. The results highlight the importance of not

viewing children as passive recipients in their encounters with health care and the outer world; rather, they are agents with agendas of their own. Their motivation and commitment to therapy were first established when they felt respected and treated as individuals, not as problems to be solved. It therefore seems essential to give children a therapeutic setting characterized by patience, understanding, and latitude to share their views, experiences, and ideas of what might help them.

Study III

Aim

The aim of the study was to gain a deeper understanding of changes in trauma-related symptoms in children and youths who had taken part in TF-CBT four–five years earlier. The following research questions were addressed:

- Do children and youths who have taken part in TF-CBT meet the criteria for PTSD according to a diagnostic interview and/or self-rated symptoms, four–five years after treatment is terminated? To what extent do they report other mental health symptoms and/or psychosomatic problems?
- To what extent has the goal of TF-CBT, aimed at reducing trauma symptoms by facilitating the coherent narration and communication of traumatic events, been achieved over time?

Methods

The data consisted of interviews and assessments with nine participants from the TF-CBT condition. In the initial treatment study, three assessment points were included: pre-treatment, a six-month follow-up, and a 12-month follow-up. At both the pre-treatment and six-month follow-up assessment points, participants underwent a structured clinical interview and completed questionnaires. The quantitative data, in addition to the diagnostic interview, included the following questionnaires: the Lifetime Incidence of Traumatic Events (LITE), the Trauma Symptom Checklist for Children (TSCC), and the Psychosomatic Problem Scale (PSP), designed to assess psychosomatic health problems. LITE was used as one source of information to map the participants' trauma experiences.

The present study integrates data from the diagnostic interviews and questionnaires conducted before treatment and at the six-month follow-up with additional diagnostic interviews, assessments, and semi-structured interviews carried out four–five years after the

initial study participation. A convergent mixed-method design was employed, allowing for the collection and analysis of both qualitative and quantitative data.

Initially, the quantitative data were analysed using the reliable change index (RCI) to explore changes of clinical significance in self-reported trauma symptoms using the TSCC. Changes in experiences of psychosomatic problems were investigated using the PSP. The qualitative interviews were analysed using interpretative phenomenological analysis (IPA), aiming to gain a deeper understanding of the participants' experiences and to interpret their narratives through a trauma-focused lens. Since the diagnosis of complex PTSD (CPTSD) offers a comprehensive depiction of the symptoms and challenges individuals face due to traumatic events, CPTSD was used as a framework for the theory-driven coding of trauma symptoms in the interviews. This approach was complemented by examining the goals of TF-CBT, which include creating a coherent narrative and enhancing communication between the child and caregiver. The qualitative and quantitative results were integrated in a synthesis summarizing each participant's background, the changes in symptoms during and after treatment, and the participant's experiences of TF-CBT.

Main findings

Although the results overlapped, a tendency towards two groupings could be discerned by combining the diagnostic interview, self-reported symptoms, and the interview. One group reported severe trauma symptoms and psychiatric diagnoses four–five years after treatment, indicating continued clinical concern. The remaining participants reported symptom relief.

Continued clinical concern. Some participants in this group met the criteria for PTSD before and after treatment, and continued to do so at the follow-up, when they also met the criteria for several other psychiatric diagnoses. One participant was assessed as meeting the criteria for PTSD before treatment. He reported no symptoms consistent with PTSD at the follow-up diagnostic interview, but described emotional avoidance, suggesting PTSD from a clinical perspective. He also reported symptoms of several other psychiatric diagnoses. Another participant experienced a decrease in trauma symptoms at the end of treatment, and at the follow-up, she no longer met the criteria for acute stress disorder. However, she did meet the criteria for depression and GAD. Her self-reported trauma symptoms had increased by the follow-up, as had the symptoms of psychosomatic problems. In this group, with one exception, all reported generally high psychosomatic symptoms. Ongoing trauma symptoms such as fragmented memories, sleep difficulties, and cognitive distortions about responsibility, feeling different, and inability to trust others were common in this group.

Among those who displayed more persistent trauma symptoms, experiences of treatment varied, with several perceiving the treatment goals as unclear. One participant did not find the treatment meaningful or helpful. Another participant experienced increased distress during treatment because the participating parent had subjected her to violence, of which the therapist was unaware. One participant appreciated treatment but never fully understood its purpose, while another felt she had benefited from it. Participants whose experiences had been dismissed by a violent parent were less able to contextualize their experiences, resulting in a more incoherent and fragmented narrative of violence and their overall life situation. All participants in this group, except for one, described ongoing contact with a parent who had subjected them to violence. However, the one who did not have contact with the perpetrator described being subjected to sexual harassment years after treatment had ended, which had exacerbated her symptoms.

For the participants experiencing symptoms of clinical concern, communication with the parent about the trauma was non-existent, with one exception. However, she described being able to talk about the abuse she had experienced, but not the violence that her mother's previous partner had subjected both her and her mother to. The remaining three participants described being silenced when bringing up the subject, with parents showing a lack of interest or questioning or dismissing their experiences.

Improved clinical outcome. Five participants did not meet the criteria for PTSD at the follow-up and reported few psychiatric symptoms overall. One, however, had been diagnosed with ADHD after treatment and reported quite high levels of psychosomatic symptoms at the follow-up. Sensitivity to stress as well as trauma symptoms such as fragmented memories, nightmares, and/or cognitive distortions were still present in most, with the one diagnosed with ADHD being the exception. Most of them expressed contentment with themselves, their relationships with family and friends, and their overall life situation.

Descriptions of the treatment were generally positive, despite the treatment being challenging and confusing for some. A coherent narrative of the experienced violence was often associated with an understanding of the treatment as "a process". While some participants with lower levels of trauma symptoms continued to describe gaps in their memories of the violence, their descriptions were less fragmented and their ongoing symptoms were comprehended and integrated as matters to be addressed in their ongoing life situation. Except for one, none of the others had maintained contact with the person who had subjected them to violence within the family. One described, however, that she had experienced less direct physical violence herself, as her siblings had been the primary targets of the violence. None of the participants in this

group described being engaged in ongoing conversations with their parent about the violence they had experienced. Those who did not feel a need for further communication were part of this group of less clinical concern, but some also described not wanting to cause distress to the parent or, as in one participant's case, feeling dismissed by the parent.

Conclusion

The results build on findings of the initial RCT, which demonstrated that TF-CBT can be effective in treating children traumatized by family violence. Furthermore, most participants who reported positive change immediately after treatment also reported positive outcomes at the follow-up years later, supporting its clinical application. However, not all participants experienced a reduction in symptoms after treatment or at the follow-up. These findings suggest that when trauma symptoms do not decline during treatment, there is a risk of persistent symptoms and the potential development of additional psychiatric issues. This underscores the importance of ongoing close clinical attention to this group. The persistent post-treatment sleep difficulties emphasize the importance of early interventions targeting sleep. While many experienced improved communication during treatment, parent–child communication may deteriorate over time. Encouraging children to seek support from alternative avenues, such as support groups, could be beneficial. Ongoing contact with a violent parent may hinder the development of a coherent narrative and the processing of cognitive distortions. The challenges the child faces in understanding the parent's unwillingness to acknowledge and take responsibility for the violence, and in integrating this into their narrative, should be explicitly incorporated into the treatment plan, in addition to routine safety assessments and planning.

General discussion

The overarching aim of this thesis was to retrospectively explore how traumatized children, who had been subjected to family violence, experienced treatment in general and their life situation before and during their treatment at the CAMHS. It also aimed to gain a deeper understanding of changes in trauma-related symptoms in children and youths who had taken part in TF-CBT four–five years earlier.

The results will hopefully foster a deeper understanding of the specific needs and circumstances of children exposed to family violence, and of the needs of their families, which will allow for the development of more tailored treatment interventions.

Since all three studies are based on interviews with the same participating children and adolescents and the results are integrated, methodological and ethical considerations, along with conclusions drawn from the results of the three studies, are also included in the discussion.

Ongoing violence and stress impede recovery

The majority of participants found the treatment helpful and emphasized the importance of providing children exposed to family violence with support to manage painful feelings and reactions arising from experiences of violence. However, a notable finding was that many participants continued to experience stressors and violence while receiving interventions at the CAMHS. Ongoing violence at home, harassment, and sexual violence characterized the lives of many, adversely affecting their ability to engage in treatment. This aligns with studies indicating that witnessing IPV increases the risk of exposure to other forms of family violence, such as neglect and emotional or sexual abuse (Hamby et al., 2010).

Ongoing contact with a violent parent who denied or downplayed the violence appeared to impede the creation of a coherent narrative for participants in the TF-CBT condition. Participants who maintained contact expressed greater confusion and cognitive distortions regarding their own responsibility and feelings of guilt. Some participants voiced disappointment over the lack of behavioural change and accountability from the parent. Difficulties in disclosing ongoing violence and insecurity within the treatment were reported by some participants, who feared potential consequences. Given this context, it is imperative to consider the perspectives of children who are reluctant to involve their parents in treatment and to explore the underlying reasons for this resistance. In contrast to studies emphasizing the importance of parental involvement, some findings also suggest that TF-CBT may be equally effective in reducing trauma symptoms, regardless of caregiver involvement in the treatment (de Haan, 2024).

Many participants expressed a desire for their parents and siblings to receive treatment of their own. Ongoing conflicts with and between parents caused them worry and many expressed concerns about their parents' mental health and the safety of siblings. Preoccupation with the well-being of family members may have limited the participants' ability to benefit from treatment and to act in ways that promoted their well-being. Children suffering from mental illness often have a parent who is also mentally ill, which negatively affects the children's recovery (Campbell et al., 2021). Moreover, parents of children exposed to various traumatic events exhibit elevated levels of distress and guilt; specifically, parents of children who have experienced family violence report heightened levels of shame compared with those whose

children have faced other forms of trauma (Holt et al., 2014). Participants in the TF-CBT condition who presented a more fragmented narrative about their lives exhibited less comprehension of the treatment's purpose and were often preoccupied with their parents' reactions. This aligns with studies indicating that parents' reactions and their ability to support children significantly influence the effectiveness of trauma-focused treatment (Cohen & Mannarino, 2000), highlighting the importance of addressing parents' difficulties rather than focusing solely on the child. Many parents participating in TF-CBT report experiencing symptoms related to their own trauma histories, as well as reactions to their child's traumatic experiences (Tutus & Goldbeck, 2016). Therefore, parents' symptoms should be assessed prior to the child's treatment, as their mental health can affect both the development of the child's trauma symptoms and the overall effectiveness of treatment (Birmes et al., 2009). Holt et al. (2014) suggested that focusing on improving parental coping mechanisms and addressing parents' own feelings of anxiety, guilt, and shame in treatment may constitute important steps in the collaboration to alleviate the child's symptoms following traumatic experiences. Involving parents in treatment is also effective in improving the parent–child relationship and reducing parents' feelings of distress (Mastorakos et al., 2021).

Agency and motivation in therapeutic relationships

A prominent finding was the importance of agency, with participants' motivation being decisive for the therapeutic process. Some were determined from the onset to make their best effort in treatment, while others said that nothing could have persuaded them to give treatment a chance. Strong feelings of agency and the conviction that they alone had the power to change their lives align with how other vulnerable groups describe their processes of change (Jonsson et al., 2015). Given the importance the participants placed on their own engagement, it is noteworthy that some children who were initially unmotivated to participate changed their minds when they experienced the therapist as genuinely interested in them. Relational aspects, such as perceiving the therapist as patient, curious, and caring, were described by participants as prerequisites for confronting painful memories. Therapists who were attuned to their individual learning styles and capable of explaining exercises and adapting interventions were found to be motivating. Research indicates that trauma-focused treatment is more effective when youths have a positive experience of the therapeutic relationship (Ovenstad et al., 2021).

One of the primary functions of attachment is to create safety through relationships (Cassidy, 2016), and findings show that individuals function best when engaged in relationships that are perceived as safe and supportive (Hughes, 2017). The therapeutic relationship accounts

for client improvement, or lack of improvement, as much as does the particular treatment method (Norcross & Wampold, 2019). Also, the patient's attachment style can influence the psychotherapeutic process, affecting the reactions of patients and therapists, the quality of the therapeutic alliance, and the overall treatment outcome (Levy et al., 2019).

Many participants described how the violence they experienced had negatively affected their self-perception. For some, these feelings were exacerbated by a sense of being blamed, since they, not the perpetrator, were the ones undergoing treatment. Working with individuals subjected to violence in attachment relationships places significant demands on the therapist's ability to create a safe and positive atmosphere tailored to each individual. The need for encouragement and recognition of their efforts can be particularly prominent. Participants also emphasized the importance of therapists recognizing their distress and acknowledging their efforts, noting that small rewards, such as candy, provided encouragement. Such gestures have been previously highlighted as essential in fostering a "real" relationship (Wampold & Budge, 2012).

Therapists who, on the contrary, had come across as uninterested or as having their own agenda discouraged the child's engagement in treatment. For some participants, being given the opportunity to replace a therapist they did not feel connected to allowed them to give therapy a second chance. Several participants received TF-CBT or EMDR, which are manualized evidence-based treatments. Norcross and Wampold (2019) argued that guidelines for trauma treatment do not sufficiently focus on relational aspects, emphasizing that the therapeutic relationship serves as the foundational curative element of effective psychotherapy for trauma. The relationship is at the heart of healing trauma, and relational damage is the core of the trauma itself (Norcross & Wampold, 2019). While manualized treatments can ensure effectiveness, they also carry the risk of overlooking or minimizing individual needs (Kazdin, 2017). Reliance on a manual may hinder the therapist's ability to be open, flexible, and genuinely interested in the individual child (Weisz et al., 2019). Conversely, some studies suggest that the use of a manual in trauma-focused treatment does not compromise the development of a positive relationship between the patient and the therapist (Ormhaug et al., 2014).

Some participants said that it had been difficult to understand how "all the talking" was supposed to help, and some had mentioned positive alternatives such as role playing, drawing on a whiteboard, using dolls to re-enact events, or writing a book with the help of the therapist. Feeling that the therapist was trying to explore their individual learning styles and adjust the interventions accordingly was also motivating. This aligns with Bouchard et al. (2004), who emphasized the need to tailor therapy to each traumatized child's unique needs to prevent

treatment dropout. They highlighted the importance of making therapeutic activities playful and engaging to foster a positive experience and encourage ongoing participation (Bouchard et al., 2004). Trauma-sensitive yoga, which has shown benefits for PTSD in adults (Gallegos et al., 2017; Laplaud et al., 2023), could potentially complement trauma-focused therapies such as TF-CBT, providing an alternative to solely talk-based approaches.

Social struggles: loneliness and experiences of bullying

Experiences of violence and abuse had led many participants to feel different. Loneliness and a lack of friends were recurring themes, with some participants blaming themselves for behaving strangely, aggressively, or causing chaos. These findings align with existing knowledge that experiences of maltreatment negatively affect children's ability to form close, positive relationships within attachment contexts. Additionally, children exposed to complex trauma often encounter lifelong challenges related to attachment security and self-concept (Cook, 2005). Bath (2015) underscored the need to assist traumatized children in building positive relationships with adults and peers, and Wampold and Budge (2012) emphasized that specific therapeutic interventions can promote healthy activities. Supporting vulnerable children in creating strong social bonds may help counteract feelings of shame, difference, and exclusion (Bath, 2015).

Pain and distress were frequently evident in participants' descriptions of how the violence had affected them, and many described having a negative self-image. Participants in the TF-CBT condition who reported lower levels of trauma symptoms at the follow-up demonstrated a greater understanding and acceptance of their reactions, expressing fewer feelings of deviance. Although memories of the violence remained fragmented, contextualizing their experiences seemed to have allowed them to discuss the roles they had assumed and were currently assuming. This corresponds to the findings of Knutsen and Jensen (2019) indicating that narration can help children organize their thoughts and increase their internal focus by contributing to more organized and coherent trauma narratives.

Many participants experienced stress at school due to not achieving desired results, and several had faced bullying before and/or during their treatment. A recurring theme was the lack of support and protection from professionals in the school environment, with some feeling labelled as the problem. Several studies indicate that exposure to violence during childhood, particularly experiences of bullying, negatively affects educational outcomes (Fry et al., 2018). It is important for therapists to assess both current and previous school situations, as well as ongoing exposure to bullying or other abuse outside the home, as research indicates that

children who experience family violence are at an increased risk of encountering violence outside the home (Hultmann et al., 2016). They are more likely to become victims of bullying at school (Mohapatra et al., 2010) and face a heightened risk of becoming bullies themselves (Chesworth et al., 2019). School-based interventions for trauma-related symptoms have been shown to be effective (Dorado et al., 2016; Rolfsnes & Idsoe, 2011), and increased cooperation between CAMHS and schools may enhance support for children facing the complex circumstances associated with family violence.

While several participants in the TF-CBT condition experienced a temporary increase in communication with their parents during treatment, many reported a decline in communication over the years that followed. Källström (2023) emphasized that children's understanding and perception of violence in a family context greatly depend on how communication about the violence is carried out. For most children, family members are the primary people to turn to for this type of dialogue, and parents constitute models for children in how to behave and interact with others (Källström, 2023). Although some participants in the studies had shared their backgrounds with friends and romantic partners, many did not discuss their experiences of violence and abuse with anyone. The inherent complexity of family violence, which often involves traumas experienced by both the child and the accompanying parent, may pose significant obstacles to communication about the experiences of violence. This underscores the insufficiency of focusing solely on parental capacity and highlights the importance of providing children who have experienced family violence with additional sources of support. Access to supportive communities beyond the family may facilitate ongoing communication, offer opportunities to correct cognitive distortions, and reduce stigma and loneliness. This is supported by research showing that trauma-informed interventions for children within the welfare system have been shown to be effective in reducing symptoms of PTSD and behavioural problems and in improving emotional and behavioural well-being (Zhang et al., 2021).

Confusion and difficulties in navigating context

Participants from both treatment conditions expressed confusion regarding their treatment and contact with the CAMHS. Many found it difficult to understand how "all the talking" would help and struggled to distinguish between assessment and treatment. Uncertainty about what to expect and feelings of nervousness were recurring themes, with some participants preoccupied with trying to behave in ways they believed were expected. In the TF-CBT condition, descriptions of treatment were generally positive among those who reported fewer trauma

symptoms at the follow-up, despite the challenges and confusion some experienced. A coherent narrative of the violence they had endured was often associated with an understanding of treatment as "a process". In contrast, those displaying more persistent trauma symptoms reported varied experiences of treatment, with several perceiving the treatment goals as less clear. Difficulties in understanding why certain questions and assignments were part of the therapy align with previous research on children receiving treatment (Dittman & Jensen, 2013). For therapy to be effective, patients need to believe that it is meaningful and to view their progress as a result of their own efforts (Wampold, 2015). Therefore, it is crucial for both the child and the therapist to agree on therapeutic tasks and goals, and for the therapist to clarify how and why the therapeutic work will be conducted (Dittmann & Jensen, 2013). Bone et al. (2015) suggested a way to address nervousness, worry, and uncertainty about what to expect by providing families with information about the procedures before their first visit to the CAMHS.

In general, participants found it challenging to grasp the purpose of the numerous meetings involving school, health care, social services, and/or the legal system. Decisions made by social services and the legal system often felt disappointing and unjust. The stress and confusion associated with interactions with the legal system align with findings of Jouriles et al. (2020) indicating that children involved with police in relation to IPV incidents experience higher levels of anxiety symptoms. Other studies have shown that children often perceive police involvement as confusing and unhelpful (Øverlien & Aas, 2016). Children are affected by, and affect, various arenas in their life situations and the timing of events, in line with Bronfenbrenner's bio–ecological theory (Bronfenbrenner, 1977, 1986; Bronfenbrenner & Ceci, 1994). Many studied children continued to live in chaotic environments. In implementing effective treatment for children with experiences of family violence, it is crucial to recognize the many factors that affect their well-being and to acknowledge the complexity of their life situations.

Decline in symptoms, non-responders, and the risk of escalating mental health issues

The results for participants in the TF-CBT condition indicate that, although almost all participants reported ongoing effects of the violence they had experienced, the majority did not meet the criteria for PTSD or any other stress-related diagnosis. Most participants reported a decline in trauma symptoms six months after beginning TF-CBT, and generally lower symptom levels at the follow-up conducted years later. These findings align with meta-analyses indicating that TF-CBT can reduce trauma symptoms, particularly among maltreated children

(Wang et al., 2023), one year after treatment (Thielemann et al., 2024). Additionally, participants in the TF-CBT condition who reported lower levels of trauma symptoms at the follow-up also reported lower levels of other psychiatric issues, which aligns with studies demonstrating that TF-CBT can reduce depression and anxiety, in addition to trauma symptoms (Jensen et al., 2017).

In contrast to the group that reported lower symptoms of trauma at the follow-up, most participants who continued to meet the criteria for PTSD after treatment still met these criteria at follow-up several years later. In addition to PTSD, they also reported symptoms of other serious psychiatric diagnoses at the follow-up. This escalation of symptoms aligns with research highlighting the risk of chronic PTSD (Al Jowf et al., 2023), and the development of concurrent psychiatric issues alongside PTSD is well documented (Loewy et al., 2019; da Silva et al., 2024). In a clinical study, nearly one in four children showed no improvement in symptoms despite undergoing TF-CBT treatment, and more than one in ten dropped out of treatment (Skar et al., 2022). This underscores the need for further exploration of why some patients do not benefit from treatment. In the present study, one factor that appeared to be challenging for participants in the TF-CBT condition was ongoing contact with a violent parent who did not fully acknowledge the violence.

Sleep remained a persistent issue for many participants, regardless of treatment condition and other outcomes. Sleep disturbances are hallmark symptoms of PTSD and depression, indicating the importance of addressing sleep issues as part of prevention and intervention strategies (Fan et al., 2017). Moreover, sleep problems can also serve as indicators of underlying trauma, emphasizing the need for treatments to consider both trauma-specific interventions and insomnia management (Pfaff & Schlarb, 2022). Allocating time during the stabilization phase of trauma-focused treatment to establish healthy sleep routines, along with conducting regular follow-ups before concluding treatment, could be highly beneficial.

Methodological considerations and reflexivity

Qualitative research is often contrasted with quantitative approaches, but the notion of two separate paradigms is increasingly questioned, as the division between them is not always clear (Gorard, 2010). Qualitative research aims to foster a deep understanding through detailed descriptions of individual experiences, emphasizing voice, emotions, and meaning (Willig, 2019). Consequently, in research attempting to explore individuals' experiences of health care and psychological treatment, a qualitative research method is appropriate (Yardley, 2000). Since the aim of studies I and II was to explore the participants' experiences, a qualitative

research design was chosen. However, it is important to bear in mind that children tend to be eager to accommodate the preferences of adults and therefore may adjust their responses according to what they think the adults want to hear (Källström, 2023). Furthermore, children's voices and opinions will be filtered through the researcher's interpretation, which requires constant reflection on the part of the researcher and awareness that this probably affects the results (Källström, 2023).

Quantitative methods focus on specific variables and are backed by statistical analysis, allowing for generalization and the study of large samples, which is particularly useful in treatment research (Barker et al., 2003). In Study III both quantitative and qualitative data were integrated, occasionally revealing discrepancies in reported lingering symptoms of trauma. For instance, avoidance of emotions as a coping mechanism was mentioned by participants in interviews but might go unnoticed in self-report questionnaires. This underscores the benefits of integrating qualitative first-person analyses with standard quantitative outcome evaluation. The complexity of assessing symptoms aligns with the perspective of De Smet et al. (2019), who have advocated more multi-method and multi-perspective research to enhance our understanding of outcome and treatment effects.

Reflexivity in this type of research is important, particularly considering my background and expertise. In studies I and II a phenomenological (Spinelli, 2005) epistemological position was considered suitable as the intention was to capture the participants' subjective perspectives. However, a phenomenological approach requires that researchers be aware of and set aside their own preconceptions (Smith & Shinebourne, 2012). Although my intention was to focus on the experiences and feelings conveyed by the participants, my own knowledge of the life situation of children exposed to abuse and my experience as a therapist at the CAMHS were sometimes difficult to set aside. For example, the fact that I was one of the therapists who had conducted therapies in the prior treatment study entailed an obvious risk of preconceived notions and lack of objectivity. Follow-up questions might have been affected by my preconceptions and other areas might have been disregarded. My own interest in the experiences and lives of the participants may also have led the interview to deviate from the interview guide, even though I made continuous attempts to adhere to the guide. On the other hand, I hope the participants experienced the interviews as characterized by genuine curiosity and felt listened to.

Another phase in which my preconceptions had to be managed was the analytical process, particularly in Study III. Over the course of this thesis, I have become a trainer and supervisor in TF-CBT. My prior knowledge of the treatment's goals and methods, along with my personal investment in the approach, may have affected my ability to maintain an unbiased perspective

regarding participants' accounts of their symptoms and experiences. The intention throughout the analysis and when writing the study was to achieve balance between how the informants made sense of their experiences and how we as researchers made sense of their experiences.
In an attempt to limit the impact of my preconceptions on the analyses in all the studies, I constantly strove for awareness through self-reflection, parallel coding, and close supervision. However, I believe my in-depth understanding can also be seen as an advantage, as my knowledge of the treatment components and techniques helped me in contextualizing participants' responses. My extensive experience with TF-CBT was essential for data interpretation, as well as for understanding how traumatic experiences can manifest in children and adolescents, providing a necessary foundation for interpretation.

For transparency, I would like to mention that in writing this thesis, I used ChatGPT and MSWord's spell-checking function for spelling and grammar checks, as well as DeepL for translations. In accessing research literature, I used the Gothenburg University Library's search service, along with ChatGPT, Google Scholar, and Research Rabbit.

Limitations and strengths

A limitation meriting consideration is the number of participants. Contact information was obtained for 40 of the 93 children and adolescents who were recruited in the previous study, of whom 78 had completed their participation. Seventeen out of the 40 participants agreed to participate in the present research, thirteen declined, and the remaining ten could not be reached after the initial phone call. Studies I (n = 13) and III (n = 9) are based on interviews with even smaller samples of participants, partly because the interviews were carried out over a long period, and partly because only those in the TF-CBT sample were included in Study III. Another limitation of this research is the lack of a control group in Study III, which precluded the drawing of conclusions about changes over time. Consequently, the studies offer insight into the experiences of a limited group of participants and may not be representative of the experiences of the remaining participants from the initial treatment study. It is possible that the sample was biased, as access to contact information might be related to having a better-ordered life situation or having experienced the interventions in a more positive/negative way.

The studies presented here were conducted using a retrospective design as the interviews took place several years after the participants had finished participating in treatment. The experiences shared are therefore based on memories rather than on hard facts and verifiable statements. Memories can be blurred, events might get mixed up, and, as time passes, experiences might be reinterpreted in other ways than when they occurred. Conversely, the time

elapsed might also be a methodological strength: increased maturity and capacity for reflection may have enabled the participants to articulate their thoughts and experiences in more nuanced ways. As several participants had moved away from their family of origin, some may have felt freer to disclose information.

Ethical considerations

Children's and adolescent's participation in research puts additional demands on attempts to ensure a do-no-harm setting, even more so when the questions asked address sensitive areas such as experiences of family violence. Regardless of the respondent's age, verbalizing experiences and perceptions can be challenging (Källström, 2023). Eriksson and Näsman (2012) emphasized that involving children in research and conceiving of them as social actors do not exclude the possibility that they may need protection and support from adults. Ethical considerations were considered and discussed throughout the project, which was approved by the Regional Ethics Committee in Gothenburg (Dnr: 806-16).

All the potential participants received both verbal and written information about the aims of the study, the procedure, and the assessment. It was emphasized that participation was voluntary, and they were assured that they could decline to answer certain questions or terminate their participation at any time, with no questions asked. Participants were also informed that their decision to participate, or not to participate, would not affect their future contact with health care in any way. In both verbal and written information, it was stated that all the data collected would be anonymized and kept confidential. Depending on the participant's age, the information and the form of consent was age-appropriately adapted. For children under 18 years of age, written informed consent from the caregiver was obtained, parallel to asking for consent from the child.

Participants could choose to complete the interviews, which lasted from half an hour to two hours, either at home or at the CAMHS, and the distribution was more or less fifty-fifty. Both interviewers had extensive experience of working with children and adolescents within the CAMHS. As the topics in the interviews evoked feelings and reactions in the participants, the interviewers had no intention of adopting a distanced stance, and when deemed appropriate, the interviewers offered psychoeducation on trauma and PTSD. In some cases, the interviewer helped the participants handle signs of stress or trauma by coaching them in deep breathing and/or other regulating exercises. Furthermore, information on how and where to seek help was given to participants, and parents, when appropriate. After the interview, at least one participant

turned to the school nurse, asking her to contact the interviewer to discuss how she could best help the participant seek further treatment.

Taken together, as the wellbeing of the participants was always at the forefront of the research implementation, the importance of being heard and of being given agency was highlighted by the participants throughout the interviews. The results of these studies have, hopefully, given the participating children the opportunity to influence future treatment interventions for children with experiences of family violence, in line with the UN Convention on the Rights of the Child (1990).

Conclusions and clinical implications

The experiences of children affected by family violence are a crucial source of information in creating and implementing therapeutic interventions for them. Children are not passive recipients, but rather active agents – in their families, in the treatment setting, as well as in the broader community. The results indicated that participants who experienced a decline in symptoms during TF-CBT generally reported lower symptoms at the follow-up, supporting research suggesting that TF-CBT may be suitable in treating children traumatized by family violence. However, when treatment is ineffective, there is a risk of persistent trauma symptoms alongside the emergence of additional psychiatric issues, underscoring the importance of paying clinical attention to this group.

How children and adolescents experience treatment heavily depend on their own motivation and attitude. The children had their own agendas and the characteristics of the therapist played an important role in their motivation. To feel safe enough to face painful experiences, a trusting relationship with the therapist was essential. Sensing empathy, respect, curiosity, and patience from the therapist was fundamental to the process. Therapists, as well as organizations, need to put the importance of the therapeutic relationship into the equation when designing treatment, and not focus solely on protocols or empirically supported therapies.

Parallel to having their own agency, children exist within a context where their well-being is influenced by the actions and well-being of family members and friends. Challenging circumstances can make it difficult for children to understand the treatment focus and feel committed. This complexity suggests a need not only to assess psychiatric symptoms in the child, but also to include environmental factors. Family relations, current and previous school situations, romantic relationships, and abuse of themselves or other family members seem to be fundamental to the well-being of the child. Ongoing contact with a violent parent appears to hinder the development of a coherent trauma narrative and the processing of cognitive

distortions. Treatment should address the difficulty children face in understanding and integrating the implications of a parent's unwillingness to acknowledge violence.

Children with experiences of family violence are often likely to continue living in unsafe circumstances, sometimes enduring violence at home during treatment without the therapist's knowledge. This fact highlights the importance of therapists and other professionals not assuming that children are automatically safe once the violence has been disclosed. Addressing safety issues and consistently offering children a trusted space in which to disclose ongoing exposure to violence or abuse, along with developing safety plans, should be standard parts of the process.

Finally, treatments for children affected by family violence need to consider the various factors influencing the child's overall well-being. Although communication between parent and child may initially improve during treatment, it can deteriorate over time. Encouraging children to seek support from alternative sources, such as peer support groups, may help prevent feelings of isolation and loneliness. Interventions that focus solely on one aspect – such as family violence, parental training, the child's psychiatric symptoms, or their school situation – risk overlooking the complex interactions between these factors. Treating a child without considering their broader social context could result in ineffective interventions, potentially increasing feelings of deviance or reinforcing the child's perception of being the problem.

Future research

The present findings highlight the complexity of the life situations of children subjected to family violence. The way these children experience manualized treatments is an area that requires further investigation, as research is divided on whether such treatments primarily increase effectiveness or risk overlooking the child's individual needs. Effective methods to prevent ongoing insecurity and violence, once family violence has been recognized by the CAMHS and/or social services, should be explored. It is also important to improve our understanding of children who do not benefit from treatment and of how interventions can be tailored to meet their needs. Further studies are necessary to expand our knowledge of how the complexity of the child's life and family situation can be recognized by various organizations, and of whether extended collaboration between institutions can enhance children's safety and prevent mental health problems. Regarding the long-term effects of trauma-focused treatment, follow-up studies are scarce, representing a key area for future research.

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Appendix 1

Children subjected to family violence: a retrospective study of life situation and trauma-focused treatment

Interview guide

In an initial conversation, anonymity, voluntariness, and time frames are addressed by the interviewer. The interviewer explains that the purpose of the interview is to give children and young people an opportunity to express their own opinions on how they have experienced interventions from the Child and Adolescent Mental Health Service (CAMHS)/social services/schools/the legal system, etc.

What do you remember about how/why you came to the CAMHS? What was it like to get there, and what were your expectations beforehand?

How did you experience answering questions about violence/other traumas? Good/bad? What would you have liked to be different?

What did you think about the interventions you received at the clinic? What do you remember? What was good/bad, what would you have liked to change?

Do you think you had a say in how the work was done? Did anyone explain to you why the work was organized the way it was?

Apart from getting older, is there any difference in your life and how you feel now compared with then? If so, in what way? (where you live, how you are doing at school, who you socialize with, how you think about yourself/your parents, etc.)

What are your current thoughts about the violence you experienced? Do you talk to your siblings/parents/friends/anyone else about it?

Has the violence stopped? If so, when? Do you have contact with the perpetrator(s)? Who has decided that it should be so? Have you been subjected to other violence/frightening events?

Have you had contact with the police/other contact with the judicial system? How did you experience it? At trial – what was the outcome? Has anyone explained to you what happened/the decisions that were made?

Do you have/have you had any contact with social services? How did you experience it? Have you been listened to? Has anyone explained to you what happened/the decisions that were made?

Did anyone at the school(s) you attended know how you were feeling, what you experienced? Have you received any support/help from the school? How have you experienced your time at school, is there anything you would like to change?

Have you received other help/support based on the violence you experienced? How have you experienced it?

What help would you have liked you and your family to have received? In what ways would it have been helpful, what would have been different?

If it were up to you, how would society help children subjected to violence and their families? Do you have any advice for those working in health care/police/social services, etc.?

What do you think would be important for children subjected to violence to know?