Child Psychiatric Patients Affected by Intimate Partner Violence and Child Abuse – Disclosure, Prevalence and Consequences

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Abstract

The overall aims of this thesis were (1) to document the prevalence of child abuse and exposure to intimate partner violence (IPV) among child and adolescent mental health care (CAM) patients, (2) to study the clinicians' attitudes towards asking routinely about IPV, (3) to compare psychiatric symptoms between patients with (a) experience of family violence (child abuse and/or exposure to IPV) (b) experience of violence outside the family and (c) patients with no such experiences, and (4) compare psychiatric symptoms between patients who had both witnessed IPV and been subjected to child abuse with those either subjected to child abuse or those who had witnessed IPV, but not both. An additional aim in study IV was to explore the importance of concordance/discordance between children's and parents' reports of occurrence of IPV. Data for the studies were collected among 9- to 17-year-old patients, their parents, and clinicians (psychologists, social workers and nurses) in an outpatient CAM unit.

Study I showed that routine questions identified many more IPV cases than expected from the known prevalence rate on the unit. Routine questions about IPV were difficult to implement, however.

In study II clinicians were interviewed about their difficulties in asking routine questions about IPV using a written questionnaire. Their responses showed that they were anxious about damaging their relationship with the parent, anxious about putting the mother in danger of recurrent IPV and self-critical about their performance in this area. The questionnaire facilitates gathering information through asking routine questions about IPV as a matter of routine, but its implementation requires management support and family intakes complemented by meetings in private.

In study III almost half of the consecutively enrolled patients reported exposure to family violence. Patients exposed to family violence in combination with exposure to violence outside the family had more general self-reported symptoms and more peer-problems and were more often assigned a PTSD diagnosis than those not exposed to violence either in or outside the family. Family violence was rated more negatively than exposure to violence outside the family. Patients affected by violence both in and outside the family rated the impact of violence more negatively than those affected by family violence only. The results indicate that experiences of violence outside the family are important to consider when assessing patients exposed to family violence.

In study IV 14% of the patients reported abuse only, 14% reported exposure to IPV only, and 22% reported both (were doubly exposed). Patients exposed to IPV only or to child abuse only did not differ on psychiatric symptoms or diagnoses, with each other, or with patients with no such violent experiences. The doubly exposed patients, in contrast, had more self-reported general problems and conduct symptoms and rated the impact of those events as more negative than patients who were exposed only to IPV or to child abuse and patients with no experiences of violence. Doubly exposed patients were also more often assigned a diagnosis of PTSD compared to those abused only or exposed to IPV only. The negative impact of the events post trauma was rated as more severe when children and parents agreed on IPV. Children who reported IPV when their parent did not were more often assigned a mood disorder diagnosis. The results are discussed and implications for clinicians in CAM are offered.

Sammanfattning (Swedish summary)

Barnmisshandel uppmärksammades på samhällsnivå på 1960-talet och våld mot kvinnor lyftes som en viktig samhällsfråga av kvinnorörelsen på 1970-talet i Sverige och andra västländer. Forskning kring våld mot kvinnor har etablerats i en feministisk tradition och har senare kompletterats med ett könsneutralt paradigm – familjevåldsforskning. En diskussion om karaktären av partnervåld pågår mellan forskare hemmahörande i olika paradigmen.

I Sverige är det sedan 1979 inte tillåtet att slå sina barn i uppfostrande syfte. Det görs ingen skillnad mellan barnmisshandel och aga, vilket görs i många andra länder.

Det finns ganska god överensstämmelse bland forskare om vad som bör rymmas i en definition av partnervåld, men många aspekter av våldet är ändå svårfångade. Det innebär att rapportering om förekomst av partnervåld kan variera, beroende på metodmässiga aspekter av studierna. Det samma kan sägas om studier av barnmisshandel. När barn och ungdomar tillfrågas i Sverige visar det sig att ca vart tionde barn har blivit slaget hemma en enstaka gång och vart tjugonde barn har varit med om detta ett flertal gångar. Att ha bevittnat våld mellan föräldrar rapporteras av barn och ungdomar i samma omfattning som förekomst av direkt våld. Omkring hälften av barn som bevittnat våld mellan föräldrar har också blivit slagna.

Varför våld uppstår mellan vuxna i ett parförhållande finns det flera teoretiska förklaringar på. Feministisk teori förklarar mäns våld mot kvinnor utifrån ett könsmaktsperspektiv, där män upprätthåller makt och kontroll i intima relationer, liksom i övriga delar av samhällslivet. I den mån kvinnors våld mot män förekommer, anses den som väsensskild från manligt utövat våld. Individinriktade teorier hänför våldsutövande till psykologiska störningar (t.ex. personlighetstörningar) och sociala problem (t.ex. alkoholmissbruk eller fattigdom) som orsaksförklaring. Inom anknytningsteori menar man att en bristfällig anknytning under barndomen kan komma att påverka framtida intima relationer, och kan vara en riskfaktor för våldsutövande eller våldsutsatthet. Det finns ingen gemensam teoribildning som omfattar både partnervåld och barnmisshandel, men många av orsaksförklaringarna till partnervåld gäller också för barnmisshandel. Inom forskning på barnmisshandel används ofta den ekologisk transaktionella modellen som understryker att många samverkande faktorer i barns liv är bestämmande för om barnmisshandel förekommer.

Studier visar att både barnmisshandel och bevittnande av våld mellan föräldrar kan leda till olika psykiska, beteendemässiga, kognitiva och sociala problem både på kort och lång sikt. Det finns fler studier om konsekvenser av barnmisshandel jämfört med studier på barn som bevittnat våld mellan sina föräldrar. För att förstå sambandet mellan barns våldsupplevelser

och de efterföljande problemen finns flera teorier; exempelvis anknytningsteori, utvecklingspsykopatologi, social inlärningsteori och traumateori.

Inom vuxensjukvården vet man att kvinnor tycker det är acceptabelt att bli tillfrågade om de varit utsatta för partnervåld. Man vet också att professionella har svårt att ställa frågor rutinmässigt om partnervåld. Studier om svårigheter att fråga om partnervåld och barnmisshandel inom barnsjukvård är mycket få. Socialstyrelsen rekommenderar att man inom barn-och ungdomspsykiatrin (BUP) rutinmässigt frågar om våldsutsatthet. Därför debatteras i Sverige för närvarande etik och säkerhet samt frågor om hur man på bästa sätt tar upp frågan i patientmötet.

En del barn som utsatts för barnmisshandel och som bevittnat våld mellan föräldrar blir patienter inom BUP. I Sverige har en enstaka rapport dokumenterat att patienter som bevittnat våld mot sin mamma är ca 25 %. Hur barnpsykiatriska patienters erfarenheter av våld är kopplade till psykiska symptom finns det inga studier av i Sverige – och få internationellt.

Det övergripande syftet med studierna var, inom BUPs öppenvård, att (1) undersöka förekomsten av barnmisshandel och våld mellan föräldrar (2) undersöka behandlares inställning till att fråga rutinmässigt om våld (3) jämföra psykiatriska symtom mellan patienter som upplever familjevåld (utsätts direkt och/eller bevittnar våld mellan föräldrar), upplever våld utanför familjen eller inte varit utsatta för våld och (4) jämföra psykiatriska symptom mellan patienter som både utsätts för direkt våld och bevittnar våld med patienter som enbart utsätts för en av dessa våldstyper. Samstämmigheten mellan barns och föräldrars rapportering om partnervåld och betydelsen för barnens symtom studerades. Studierna i avhandlingen bygger på data insamlade från patienter i åldern nio till 17 år och deras föräldrar samt från behandlare (psykologer, socionomer och sjuksköterskor).

Studie I, som var explorativ, visade att en femtedel av mammorna till patienterna inom BUP hade utsatts för våld av sin nuvarande eller före detta partner. Studien visade också att rutinmässig kartläggning av partnervåld var svår att införa.

I studie II intervjuades behandlarna om hur de upplevde att ställa rutinmässiga frågor om partnervåld till föräldrar på BUP-mottagningen. Studien visade att man var rädd för att förvärra våldssituationen eller att stöta bort föräldern genom att fråga om våld vid nybesöket. Behandlarna var också självkritiska och uttryckte obehag inför att våldet kom på tal. Det fanns dock positiva erfarenheter av hur rutinmässiga frågor underlättade att få fram information om våldssituationen vid nybesöken. Införande av rutinmässig kartläggning är en mödosam process som kräver riktat organisatoriskt stöd för att kunna genomföras med lyckat resultat. Både barn och föräldrar måste få frågorna om våld i enrum. Fördelarna med

rutinmässig kartläggning var att det gav en tydlig information om våldsutsatthet och att behandlarna inte missade att fråga om våld.

I studie III fick 305 patienter svara skriftligt på om de upplevt familjevåld (utsatts direkt och/eller bevittnat våld mellan föräldrar). Nästan hälften av patienterna bekräftade detta. Patienternas svar visade att de som upplevt familjevåld i kombination med våld utanför familjen hade fler självrapporterade symtom generellt och fler kamratproblem jämfört med patienter som inte varit med om våld vare sig i eller utanför familjen. Patienter utsatta för våld både i och utanför familjen fick också oftare diagnosen posttraumatiskt stressyndrom (PTSD) jämfört med patienter som inte utsatts för våld. Patienter som upplevt våld både i och utanför familjen skattade upplevelserna av våld mest negativt, därefter kom de som enbart upplevt familjevåld och därpå de som endast upplevt våld utanför familjen.

I studie IV adderades fler patienter till det urval som ingick i studie III och totalt 578 patienter ingick därmed i studie IV. Patienter utsatta för direkt våld jämfördes med de som bevittnat våld mellan föräldrar och de som utsatts för både och (dubbelt utsatta). Patienter som hade utsatts direkt var 14 % och lika stor andel (14 %) hade bevittnat våld mellan föräldrar, medan 22 % var dubbelt utsatta. De dubbelt utsatta patienterna hade fler självskattade symtom generellt och fler beteendeproblem jämfört med patienter som utsatts för endast en typ av våld. De dubbelt utsatta patienterna hade också oftare PTSD-diagnos och skattade våldsupplevelserna mera negativt än de patienter som enbart utsatts direkt eller enbart bevittnat våld mellan föräldrar. Barn som bevittnat våld mellan föräldrar skiljde sig inte på symtomnivå från de som utsatts direkt för våld. Patienter som utsatts för endast en våldstyp skilde sig inte heller från övriga patienters (de som vare sig var utsatta för direkt våld eller bevittnat). När hänsyn togs till andra faktorer (t.ex. kön, ålder när man utsattes, frekvens av våldshändelserna och våld utanför familjen), visade sig antalet våldshändelser barnet utsatts för ha betydelse för den negativa inverkan. Dubbel utsatthet var den faktor som hade starkast samband med att barnet fått diagnosen PTSD. Samstämmigheten mellan barns och föräldrars rapportering om förekomst av partnervåld var god. Bland barn som var överens med föräldern om att partnervåld hade förekommit, var påverkan av våldsupplevelserna mera negativ. Där barn rapporterade partnervåld, men ej föräldern, hade barnen oftare en förstämnings-diagnos.

Utsatthet för direkt våld respektive bevittnat våld mellan föräldrar var minst 5 gånger högre än i normalbefolkningen. Om den höga förekomsten av våld gäller explicit på mottagningar i socioekonomiskt svaga områden får framtida studier utvisa. En norsk studie har visat lika hög förekomst av våld bland patienter på BUP-mottagningar i ett blandat socioekonomiskt område. Det finns därför starka skäl att uppmärksamma våldsutsatta

patienter inom BUP genom att rutinmässigt fråga om våld. Om våldsutsatthet är obekant för behandlaren finns risk för felaktig diagnossättning. Om patienter har en historia av våld eller utsätts för våld aktuellt kan behandling bli resultatlös och i värsta fall skada barns uppfattning om samhällets vilja att skydda och stödja dem. Upptäckt av våldsutsatthet kräver att personalen utbildas och får stöd i processen att föra in frågor om våldsutsatthet i nybesöket. Frågor om våld måste tas upp i enrum med såväl barn som föräldrar, vilket kan skilja sig från den vanliga formen av nybesök – familjesamtal. Även förekomst av våld utanför familjen är viktigt att uppmärksamma. Det omedelbara omhändertagandet av de patienter som bekräftar våldsutsatthet är viktigt att behandlare kan hantera. Att erbjuda adekvat behandling måste också vara en del av ett fullgott omhändertagande av barn- och ungdomspsykiatriska patienter med erfarenheter av våld i sin familj.

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This thesis was made possible by Queen Silvia Children's Hospital in Gothenburg, Sweden. I feel privileged, as one of only a few from an outpatient unit at our clinic, to have the opportunity to do clinical research in child and adolescent psychiatry.

The data for the studies were collected by my colleagues from the Child and Adolescent Psychiatric Outpatient Unit in Gamlestaden, Gothenburg. As the studies in this thesis were part of a treatment study, children and parents spent a considerable amount of time answering questions. Informants in the studies were mainly children, adolescents, and parents attending the clinic. I would like to express my gratitude to the therapist colleagues who interviewed the patients, the secretaries who did all of the necessary paperwork, and the families who contributed their experiences. Both researching and intervening in family violence are difficult matters to handle. From my contact with the children and parents, I know that most of them appreciated their contact with the therapists and were glad to contribute to the research project.

Two people were essential to making the studies reported here possible and carried me through the project. One of them laid out the master plan; the other made it possible to conduct the research in an ordinary clinic.

My supervisor, Professor Anders Broberg, supported me all through this project. Our budgeted two-hour supervision meetings during my years as a PhD student were not enough, I can assure you, and Anders was very generous with extra time. Anders' background as a clinical psychologist and psychotherapist makes him excellent for doing clinical research and particularly qualified to supervise such research projects. His energy seems endless, and his patience and supportive approach contributed greatly to my ability to research and write this thesis.

Marie Hellsten, on-site manager where the studies took place, is also a psychotherapist. Without her skills and advice about how to handle difficult processes in the work groups, we would never have made it. To help a group of psychologists and social workers engage co-operatively in a research project is a challenge. Marie made it work by directing her employees to follow their inclinations to do what they were best suited to. She also managed all the operational structures in order to take care of her employees during the process.

I would like also to thank the psychologist Christer Telléus. He, together with Marie, created the structures at the site necessary for doing the clinical research that led to this thesis.

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Two networks have been of great importance during my time as a PhD student. The Network on Violence and Gender in Gothenburg initiated by Dr. Viveka Enander has been a pleasure to take part in. An important academic context has been the Nordic Network for Abused Children organized by Professor Maria Eriksson from Mälardalens högskola.

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It is now my responsibility as a researcher, as it will be eventually for clinicians, to interpret the results of these studies. The new knowledge should be transformed into high quality health care, promoting a better life for the children attending child and adolescent mental health care clinics.

Publications

This dissertation is based on the following four articles, referred to in the text by their Roman numerals, which describe a related series of studies:

I. Hedtjärn, G. I., Hultmann, O., Broberg, A. G. (2009). One out of five mothers of children in psychiatric care has experienced domestic violence. *Läkartidningen*, 106 (48), 3242-3247 [Originally published in Swedish: Var femte mamma till barn i BUP-vård hade utsatts för våld: Mörkertalet kan vara stort, visar explorativ pilotstudie].

II. Hultmann, O., Möller, J., Ormhaug, S. M. & Broberg, A. G. (2014) Asking Routinely About Intimate Partner Violence in a Child and Adolescent Psychiatric Clinic: A Qualitative Study. *Journal of Family Violence*. 29, 67-78. doi: 10.1007/s10896-013-9554-5

III. Hultmann, O. & Broberg, A. G. (2015) Family Violence and Other Potentially Traumatic Interpersonal Events Among 9- to 17-Year-Old Children Attending an Outpatient Psychiatric Clinic. E-pub ahead of print in *Journal of Interpersonal Violence*. doi: 10.1177/0886260515584335

IV. Hultmann, O., Axberg, U., & Broberg, A. G. (submitted) Child Psychiatric Patients Who Have Been Subjected to Child Abuse or Witnessed Intimate Partner Violence – Prevalence and Consequences.

Content

Preface

> The more details one comes to know about the events in a child's life, and about what he has been told, what he has overheard, and what he has observed but is not supposed to know, the more clearly can his ideas about the world and what may happen in the future be seen as perfectly reasonably constructions (Bowlby, 1979, p. 23).

During data collection for the studies in this thesis, clinicians asked hundreds of patients about their experiences of violence. After the intake procedures at the clinic, some of the children were asked how they felt about answering questions about violence. One adolescent said it was "annoying, but still ok. So you can stop the violence." Another said, "Good. It feels like all my problems come from these experiences." In my 25 years as a clinical psychologist in child and adolescent mental health care (CAM), I have found the connection made in the clinical world between children's negative life experiences (violence) and psychiatric symptoms to be quite weak. Although well-known as a public health problem, family violence has not been approached in a systematic way in CAM.

In 2005, the Department of Psychology, Gothenburg University, Sweden sent a request to our CAM unit. A need for specialized treatment had emerged during a research project examining support groups for children exposed to family violence. Some children who attended the groups did not improve and needed interventions for their psychiatric symptoms after finishing their group sessions. Fortunately, at the CAM unit we had familiarized ourselves in the 1990s with trauma work and how to help trauma victims. Our work with refugees (Norblad, 2014) and the survivors of a discotheque fire in Gothenburg (Broberg, Dyregrov, & Lilled, 2005) had made us familiar with traumas that originate outside the family. Traumas from within the family were, however, still a more or less uncharted territory for us. Therefore, we asked a psychology student to carry out focus group interviews with the clinicians regarding the current status of our work, particularly with regard to children affected by family violence (Onsjö & Broberg, 2007). The interviews made it clear that we lacked the necessary methods to detect such violence and most of our interventions were brief crisis interventions, rarely more comprehensive or focused psychotherapeutic interventions. The interviews also showed that we had no idea how many of our patients were affected by family violence, and we did not know how precisely to define the phenomenon.

A review of charts showed very few cases with disclosed intimate partner violence (IPV). After consultations with the Department of Psychology, the head of our unit agreed to initiate

the first data collection by routinely asking mothers at the intake interview if they had been subjected to IPV. This required changes in the clinicians' intake routines, which were not easily made. Focusing on violence also imposed an emotional burden on the clinicians, and the children's and parents' safety became an urgent issue. As new treatment methods were introduced, professionals' involvement in helping children affected by violence increased.

After 10 years of intense work with children exposed to family violence, much has changed at the unit. Family intakes are now complemented by private interviews with both the parents and the children. When routine questions indicate exposure to violence a thorough risk and safety assessment is conducted (Broberg et al., 2015). Patients are offered trauma treatment such as trauma-focused cognitive behavioral therapy (TF-CBT).

The thesis opens with an exposition of definitions and the prevalence of child abuse and IPV, followed by an overview of relevant theories on the etiology of perpetration and victimization in child abuse and IPV and on symptoms in subjected and exposed children. The consequences of child abuse and exposure to IPV are then described and finally the ethical and practical problems associated with disclosure of abuse and IPV are reviewed.

The thesis contains four articles reflecting the development of the CAM unit's work with children and parents exposed to violence. Article I presents exploratory data about the prevalence of IPV against mothers attending CAM with their children. Article II is a qualitative analysis based on interviews with clinicians about their reasons for not using a written IPV questionnaire with the parents. Article III compares background, psychiatric symptoms, and diagnoses between reports from patients exposed to family violence (child abuse and/or IPV), to violence outside the family, and to no violence. Article IV presents the specific and combined effects of child abuse and exposure to IPV.

Introduction

A brief history of family violence research

Public awareness about child abuse and family violence was raised in the late part of the 20th century. The United Nations (UN) has declared violence against women a global public health problem, and The World Health Organization (WHO) has declared child abuse a subject of crucial interest for public health. In Sweden, the government recently passed a gender equality policy with the specific goal of abolishing men's violence against women (SOU, 2015:55). Government action is a crucial step in fighting child abuse and family violence; however, each nation's dedication and practice to this cause varies. A short modern history of the academic disciplines focusing on family violence follows.

Violence against women. Women's movement protests against the structural problems of the suppression of women in general and of violence against women in particular first brought family violence into public awareness. In the early 1970s, women in the USA started "consciousness-raising" groups to discuss relevant life issues (McCue, 2008). On the other side of the Atlantic, in Great Britain, women organized a march for free milk for school children, which eventually led to the establishment of the first women's shelter, The Battered Wives' Centre, in Chiswick. Since then, the women's movement to end wife-beating spread to many other countries, and women's shelters often became a part of government-funded programs. The academic discipline of feminism developed out of the initial work of the women's movement.

Feminism, as both a social movement and a research paradigm, evolved in three waves (George & Stith, 2014). The first wave arose in the 1850s when middle- and upper-class women fought for the abolition of slavery and for voting rights for women. The second wave dates back to the middle of the 20th century when women advocated for civil rights and the end of violence against women. During the second wave in the 1970s, the feminist movement brought the issue of violence against women into the public eye (Walsh, Spangaro, & Soldatic, 2015). The third wave of feminist theories that emerged in the 21st century expanded on the theory of power and control with an intersectional perspective (George & Stith, 2014). In this theoretical framework, the singular explanation of patriarchy is stretched to include race (minority status), nationality, class, sexual orientation, and other markers of identity (social positions) to explain IPV (George & Stith, 2014).

Feminist researchers assert that the context in which violence is perpetrated must be taken into account; the intentions and consequences of violent behavior must be measured as well as the violent acts. This is the *structural* paradigm.

The individualistic perspective. This perspective is often called the *family violence* perspective, and this term will be used here. The family violence perspective emerged in the 1980s (Straus, 2011). Family violence scholars use the same standards to measure male and female perpetrated violence. They do so on the basis of violent actions per se and pursue a perspective of gender symmetry (Winstok, 2011). Contrary to feminist scholars, family violence scholars hold the view that IPV is symmetrical, i.e. that gender is not the primary significant factor in predicting IPV. Family violence is studied from a paradigm of conflict between partners. The causes of violence remain in the individuals perpetrating it. Violent acts are studied as behavioral units, without regard for the contexts in which they are perpetrated.

As a compromise between these two distinct perspectives, scholars have suggested that different types of family violence exist. One suggestion is that one must differentiate between severe violence and ordinary violence. Men are considered more likely to be perpetrators of severe violence, and "ordinary" violence is thought to be perpetrated more symmetrically (Johnson, 2006). Kelly and Johnson suggest four patterns:

1. *Coercive controlling violence* includes intimidation, emotional abuse, isolation, minimizing, denying and blaming, use of children, asserting male privilege, economic abuse, and coercion and threats. Coercive controlling violence is often found in settings such as courts, women's shelters, and hospitals, and is primarily perpetrated by men.
2. *Violent resistance* includes self-defense, usually by women defending themselves against violent attacks by men.
3. *Situational couple violence* occurs between partners with poor anger management who engage in mutual minor forms of violence.
4. *Separation-instigated violence* can be perpetrated by either partner in the separation process, most often the partner who is being left (Kelly & Johnson, 2008).

According to a review article, the dimensions of coercive controlling violence (also called intimate terrorism) and situational couple violence have empirical support in several studies (Langhinrichsen-Rohling, 2010). A review article of gender differences in partner violence in clinical samples found that men conduct more serious violence towards women (e.g., threatening the woman's life and inhibiting her autonomy) than vice versa (Hamberger &

Larsen, 2015). Studies show that woman-perpetrated physical violence against a partner usually occurs in response to the man's violence. They also show that women are more fearful than men and more often injured.

Child abuse. As in the case of violence against women, it was a women-driven social movement that brought child abuse onto the public agenda back in the late 19th century (Myers, 2010). Jane Adams was a central figure in the settlement movement working for child protection. Pediatricians began focusing on child abuse in the 1960s; however, a radiologist, John Caffey, wrote a scientific article about the issue as early as 1946. Henry Kempe and colleagues later drew attention to abused children with their article "The Battered-Child Syndrome" in 1962 (Myers, 2010). Due in part to Kempe's work, the reporting of suspected child abuse in the USA dramatically increased from 60,000 reports in 1974 to three million reports in 2000. Public interest in the topic of sexually abused children also increased in the 1970s, particularly after V. De Francis' study in 1969 about 250 sexually abused children and the subsequent emotional damage they suffered (Myers, 2010).

In Sweden in the 1960s, pediatricians, social workers and child advocates (lawyers), and the Swedish National Board of Health and Welfare (NBHW) also started to recognize violence against children as a problem (Janson, Jernbro, & Långberg, 2011). Since 1998 it has been illegal to affront women, children, and other close relatives (Brottsbalken, 1962). If offensive acts are repeated in order to affront another's integrity and harm their self-confidence, perpetrators may be convicted.

Corporal punishment. Parenting practices, child rearing, and care-giving differ between countries (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). A survey in Brazil, Chile, Egypt, India, the Philippines, and the USA showed that spanking ranged from 15% in highly educated groups to 76% in lowly educated groups (Runyan et al., 2010). In Sweden, authoritarian parenting (parenting by fear) has by and large been abolished and a similar trend holds in the other Nordic countries (Janson et al., 2011). The Parental Code [Föräldrabalken] was passed in Sweden's parliament in 1979, and since 1982 it has been a crime to abuse or punish a child by corporal means (Brottsbalken, 1962). Corporal punishment is still legal in most countries around the world, but none of the Nordic countries (Sweden, Norway, Denmark, Iceland, and Finland) permit it (Rädda Barnen, 2015).

Parents with immigrant backgrounds in Sweden have a more positive attitude toward corporal punishment than Swedish-born parents (Janson et al., 2011), and children of Swedish-born parents report that their parents use harsh parenting practices (locking the child in or out or threatening beatings) less often than in reports of children with parents born

outside Sweden. In particular, boys born abroad are at high risk of corporal punishment. Other social factors that worsen these harsh parenting practices in immigrant families are lower education, higher unemployment, and a lower standard of housing (Janson et al., 2011).

Definitions and core concepts in the realm of child abuse and IPV

Political and cultural context and common use of the concepts of child abuse and IPV shape our understanding of the phenomena. Clear definitions of terms are crucial to building consistent concepts for studying and communicating about child abuse and IPV. Which actions should be considered child abuse or IPV, and which should not? In this thesis, child abuse is seen as a specific type of harmful acts by caregivers that can be differentiated from other types of harm to children. This concept of child abuse encompasses the several sub-categories described below. Violence between intimate partners can also include a few or many types of actions. The specific dimensions of a child-centered perspective on IPV will also be described.

IPV

In this thesis, the term IPV is restricted to violence between intimate partners but incorporates several perspectives. It includes violence perpetrated by and against both women and men, while also recognizing gender-based power- and control-driven violence against women. Different terms and concepts are used within the field of violence between intimate partners, and some of them will be described here.

Because *violence against women* is an influential perspective in research and government-initiated actions, it is important to mention the UN's official definition of the term as:

> … any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Article 1; United Nations, 1993).

This definition of violence against women includes actions in public life including female genital mutilation, rape, non-spousal exploitation, prostitution, and violence condoned by the state (United Nations, 1993).

In Sweden, government-initiated actions regarding partner violence are dominated by the idea of male perpetrators against women. In 2007 an action plan against men's violence against women, violence in the name of honor, and violence in same-sex marriages was presented to the Swedish Government (Svenska regeringen, 2007).

The academic literature uses different concepts about violence against women, such as *wife abuse*, *woman abuse*, and *woman battering*, and in these terms the gender of the person abused is spelled out. One of the first terms used by the feminist movement in the 1980s was *domestic violence* (Enander, 2008). This term is gender-neutral and may also include also violence against children (Walsh et al., 2015) parents, elders, and siblings (Robinsson, 2014). It is no longer used by feminist researchers because of its gender neutrality and because it refers to a place rather than a person (Enander, 2008). IPV is a term widely used by such bodies as WHO to discuss violent acts between intimate partners (World Health Organization, 2013). The term *family violence* is used with the same implications as domestic violence. All three concepts include violence perpetrated by either partner and the concepts are gender-neutral. The term *family violence scholars* is used to denote researchers who study IPV as a mutual phenomenon in contrast to feminist researchers who study *violence against women* (Winstok, 2011).

According to the U.S. Centers for Disease Control and Prevention (CDC), IPV "includes physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" (Breiding, Basile, Smith, Black, & Mahendra, 2015, p. 11).

In Sweden, the concept of *violence in close relationships* [våld i nära relationer] is widely used (Nationellt centrum för kvinnofrid, 2015) and includes, along with child abuse and IPV, violence between siblings, close family members, and other relatives.

Psychological abuse[1]. The terms *psychological abuse* and *emotional abuse* are used interchangeably in the academic literature. Psychological abuse is a pattern of aggressive acts, verbal or non-verbal, intended to harm another person mentally or emotionally and/or to exert control over that person (Breiding et al., 2015). Feminist researchers have long highlighted this psychological component of IPV as a tactic used by men to exert power and control over women (Enander, 2008). Psychological abuse generates fear and anxiety, removes social support, impoverishes, and undermines self-esteem (Jewkes, 2010). Defining and measuring psychological abuse is a serious challenge for researchers. Because it mostly co-occurs with physical or sexual violence and can take many different forms, it is often overlooked (Jewkes).

[1] In the latest CDC terminology the concept *psychological aggression* replaces the concept psychological abuse from earlier version of these CDC recommendations. Psychological abuse is defined as a pattern of psychologically aggressive acts that result in a negative impact upon the victim.

Children and IPV. When the partners are parents, the child's perspective on IPV must be taken into consideration. Children can be in the position of *witnessing violence*, but often they will be more than just witnesses when they overhear, taking part in, or watch the aftermath of IPV. An alternative concept proposed, but not widely used, is *participating witness* (Hydén, 1995). Some researchers use the concept e*xperiencing violence*, which is quite similar to *exposed to violence*. Yet another suggested term is *children forced to live with IPV*, which stresses children's lack of free will to avoid the violence (Goddard & Bedi, 2010).

Children can be involved in IPV in many ways: being eyewitnesses to or overhearing violent acts, being victimized themselves during an incident, intervening in the violent situation, taking part in perpetration, or being exposed prenatally (Holden, 2003). Children can also see the effects (e.g. bruises, damaged property). Violence between parents can be physical or emotional and the perpetrator's personality can range from normal to severely disordered. Victims can be frightened and upset or in control of their reactions. Perpetrator and victim characteristics and reactions influence the child's perception of threat.

Child abuse

The definition of child abuse includes both acts and threats of physical violence, sexual violence, and psychological violence (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). "Physical abuse is defined as the intentional use of physical force against a child that results in, or has the potential to result in physical injury" (Leeb et al., 2008, p. 14). Child sexual abuse is "[a]ny completed or attempted (non-completed) *sexual act, sexual contact* with, or exploitation (i.e. *noncontact* sexual interaction) of a child by a caregiver" (Leeb et al., 2008, p. 14). Psychological abuse is "[i]ntentional caregiver behaviour (i.e., act of commission) that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another's needs" (Leeb et al., 2008, pp. 14-16).

The overarching term for child abuse and neglect is *child maltreatment*. Child abuse, and hence, studies of child abuse will often occur in the context of neglect. Child abuse is defined as *acts of commission* and child neglect as *acts of omissions*. Neglect consists of two subcategories: *failure to provide* for the child's physical, emotional, medical, and educational needs, and *failure to supervise* to ensure the child's safety within and beyond the home (Leeb et al., 2008). According to this definition, it is neglect if the parent fails to protect the child from exposure to IPV. But if no alternatives to protect the child are available, it is not considered neglectful behavior. Generally, the definition of child maltreatment used in Sweden is on par with the definition suggested by Leeb and colleagues (SOU, 2001:72).

Definitions in CAM

In Diagnostic and Statistical Manual of Mental Disorders (DSM-5) physical, sexual, and psychological abuse are listed as V-codes for child maltreatment as well as for spouse/partner violence, that may be focus of clinical attention or which could otherwise affect the patient's diagnosis, course, prognosis, or treatment (American Psychiatric Association, 2013). Operational definitions of actions qualifying as child abuse are listed. Each category of abuse has a conceptual definition, and examples of a threshold for distinguishing suboptimal care-giving from abuse are presented. V-codes are listed for physical, psychological, and sexual spouse/partner violence as well, constructed in the same way as the child maltreatment codes. The impact of IPV is mentioned as part of the definition, but is not operationally defined.

Definition of double exposure

When both abuse and IPV are present in the same family, it is known as *co-occurrence*. Other terms used are *intersection*, or *double exposure.* According to WHO researchers, these concepts are not rigorously defined in the academic literature and, thus, need clarification (Guedes & Mikton, 2013). Child abuse and IPV may occur at varying times, and one type of violence may be a risk factor for the other. Furthermore, one or both parents may perform child abuse and/or IPV. These two types of violence can occur in the same family in a variety of ways, as proposed by Appel and Holden: (1) a single perpetrator of child abuse and IPV, (2) the victim of IPV abuses the child, (3) both victim and perpetrator of IPV abuse the child, (4) mutual IPV and abuse of the child by one or by both parents, and (5) both parents and child engage in violent acts against each other (Appel & Holden, 1998).

The term *exposure* is used consistently in this thesis; therefore, *double exposure* will also be used to refer to the occurrence of both child abuse and exposure to IPV.

Studies of child abuse and IPV may not be conducted in line with the clear-cut definitions presented above. Measurement dimensions (e.g. past-year vs. lifetime, whether emotional and sexual abuse is included, whether both victimization and perpetration are included, and whether children themselves or one or both parents are informants) will vary between studies. Measuring the magnitude of child abuse and IPV is relevant for both researchers and policy makers. Prevalence figures inform society about, for example, whether and how to initiate preventive measures and evaluate interventions.

Aggression

Aggression developed through evolution and is an innate trait in humans. In dangerous situations, aggressive behavior increases chances of survival. All though the survival function

may explain violence in the family in some cases, aggression also has other functions and purposes.

Aggression is “any form of behavior that is intended to injure someone physically or psychologically” (Berkowitz, 1993, p. 3). The goal of aggression can be to influence another person’s behavior (*coercion*) or to impress other people by showing strength, competence, and courage. The goal can also be to exert power and dominance. Aggression can be emotionally driven by the pleasure of hurting other people or used rationally to achieve something such as money, territory, or safety (*instrumental aggression*). All of these types of aggressive behavior can be either consciously controlled or more driven by impulsive. A concept related to aggression is the feeling of *anger*, which does not imply action and does not have a specific goal to injure. *Hostility* is an attitude of ill-will and *aggressiveness* is the persistent readiness to become aggressive (Berkowitz, 1993). *Violence* is aggressive behavior, and clearly also rule-breaking behavior. Thus all violent acts can be considered aggressive, but not all aggression is violence. Violence will by definition cause harm.

Prevalence of child abuse and IPV

Rates of IPV are calculated as either past-year prevalence or lifetime prevalence. It is common to include physical, psychological, and sexual violence in the definition. Rates of child abuse are mostly calculated as lifetime prevalence. Studies usually either count rates of maltreatment (including physical, psychological, and sexual abuse, as well as neglect) or of physical abuse only.

IPV

Worldwide each year 133 to 275 million children witness violence between their parents (Pinheiro, 2006). United Nations Children's Fund estimates from their global databases that almost half of adolescent girls worldwide think it is acceptable for a man to punish his wife physically under certain circumstances (United Nations Children´s Fund, 2014). The prevalence of IPV in the general population is lower in Nordic countries than in other high-income countries in Europe and North America (Gilbert et al., 2009).

Swedish studies in adults. In a Swedish study of the general population, men and women reported similar rates (8%) of past-year victimization by psychological, physical, or sexual violence. However, if lifetime prevalence was calculated, women reported higher levels of victimization than men for both psychological violence (24%/14%), physical violence (14%/7%) and sexual violence (9%/3%) (Nybergh, Taft, Enander, & Krantz, 2013). Being single, poor access to social support, and having grown up in a home with violence were

associated with exposure to violence. A report from the Swedish National Council for Crime Prevention estimated the prevalence of violence in close relationships, including systematic assaults and humiliations, restriction (of the partner's right to freedom), threats, harassment, and physical and sexual abuse (Frenzel, 2014). This national survey showed similar past-year prevalence of male and female victimization (7%) and a higher lifetime prevalence for women (26%) than for men (17%). Lifetime prevalence for violence was higher for women than for men, they were more often subjected to recurrent physical violence, the effects on them tended to be more serious, and they were more likely to be injured. Single mothers were most likely to be affected by violence in close relationships.

Swedish studies in children. In Sweden, the estimated lifetime prevalence of exposure to IPV is 10% for a single exposure and 5% for repeated exposure (SOU, 2001:72) in the general population. When asked directly, 13% of adolescents reported a single exposure to IPV and 4% reported multiple exposures (Annerbäck, Wingren, Svedin, & Gustafsson, 2010). How the IPV question was phrased was not reported. In a Swedish classroom study on teenagers, 12% reported that they had witnessed one family member being beaten or wounded by another (Nilsson, Gustafsson, & Svedin, 2012). The pupils completed the Lifetime Incidence of Traumatic Events (LITE) questionnaire. IPV was screened in by the item "parents (or grown-ups) broke things or hurt each other." In another Swedish study among 15- to 16-year-olds, 6% of adolescents reported exposure to IPV a single time and 2% reported multiple times (Janson et al., 2011). How the IPV question was phrased was not reported.

CAM studies. The prevalence of IPV in general CAM populations has been documented in only a few studies. In Spain, a past-year exposure rate of 20% was reported (Olaya, Ezpeleta, de la Osa, Granero, & Doménech, 2010). Other studies that did not restrict prevalence to a specific time frame included USA: 20% (Ford, Gagnon, Connor, & Pearson, 2011a), Finland: 25% (family violence) (Ryynänen, Alen, Koivumaa-Honkanen, Joskitt, & Ebeling, 2015), and Norway: 39% (Ormhaug, Jensen, Hukkelberg, Holt, & Egeland, 2012). Prevalence of IPV was reported to be 43% and 47% among CAM patients with behavioral problems in other studies in the USA (McDonald, Jouriles, Norwood, Shinn, & Ezell, 2000; Stewart, deBlois, Meardon, & Cummings, 1980).

Child abuse

Prevalence of child abuse differs between countries, largely due to economic and cultural differences. Prevalence of severe physical child abuse in high-income countries is estimated to be 4% to 16% in the past year and 5% to 35% over the lifetime (Gilbert et al., 2009). In the

Baltic countries and Russia, child abuse is even more frequent. In Sweden, less than 10 children die as consequence of abuse each year (Socialstyrelsen, 2011). In other Scandinavian countries and Southern Europe, the prevalence of death for children who die from child maltreatment is low, while in other countries (e.g., the USA and central and eastern Europe) the numbers are much higher (Gilbert et al., 2009).

A recent study of physical abuse in the USA for children aged 0- to 9-years-old (parent reports) and youth aged 10 to 17 (self-reports) indicated a 9% lifetime prevalence. Multiple incidents (more than 11 times) were reported by 45% of the informants (Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014a). The overall response rate was low and the study may have scored the prevalence rates too low according to the authors. In Sweden, 15-year-olds' self-reported prevalence of a single incident of physical abuse was 14% and for repeated incidents it was 3% (Janson et al., 2011). In another Swedish study, 16% of adolescents reported physical violence from parents and 7% reported repeated incidents (Annerbäck, Sahlqvist, Svedin, Wingren, & Gustafsson, 2012).

Very few studies on prevalence of child abuse in CAM have been conducted. In a study of boys with hyperactivity and conduct disorders, with parents as informants, the prevalence of physical abuse was 32% (Stewart, deBlois, & Cummings, 1980). In a study in Norway the reported prevalence of abuse for children and adolescents aged 10 to 18 years was 39% (Ormhaug et al., 2012). In the third study, CAM patients 7 to 9 years old with conduct problems were physically abused an average of 10 to 14 times a year (Jouriles, Mehta, McDonald, & Francis, 1997).

Prevalence of double exposure

Double exposure (to both child abuse and IPV) has been estimated at 30% to 60% in the general population according to two meta-studies (Appel & Holden, 1998; Edleson, 1999). In Sweden, more than half of adolescents in the general population who reported having witnessed IPV also reported that they had been hit themselves by one or both of their parents (Annerbäck et al., 2010; Jernbro, Tindberg, Lucas, & Janson, 2015). The presence of IPV puts children at 10 times the general risk of suffering physical abuse in their families (Janson et al., 2011). A review article reported that double exposure is lower in the general population than in high-risk and clinical samples (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008). In a Swedish national survey with mothers subjected to IPV who were receiving support from social services or CAM, the male abuser had also abused the child in 63% of the cases (Broberg et al., 2011). Another Swedish study of children living in a women's shelter with

their mother showed that 62% of the children had been abused physically or emotionally by their father or stepfather (Almqvist & Broberg, 2004). Of the 41 children who had been abused, 11 reported severe and repeated abuse.

Etiology of perpetration and victimization to child abuse and IPV

Violence is multi-determined by a variety of factors inherent in the adult perpetrators and victims and in their social situation. Currently, there are no theoretical models describing the common ground between child abuse and IPV, but many etiological factors for child abuse are also those of IPV. When analyzing the determinants of IPV it is important to remember the model of gender-based power- and control-driven violence, although, the possible cultural and political structures behind this kind of violence will not be addressed here. Feminist, individual, and interpersonal theories are, however, all of interest and will be described.

When violence-affected children receive interventions in CAM, the roles of the parents must always be taken into consideration. Therapeutic interventions, including parental participation, presume that violence against the child has ended. Explanations of the causes and dynamics of child abuse and IPV are relevant for clinicians aiming to introduce helpful interventions.

IPV

Feminist theory

According to the feminist paradigm introduced by Pence and Paymar, men perpetrate violence against women in order to exercise power and control over them (1993). Structural factors prevent women from gaining equality and participation in social, economic, and political systems. These structures are reproduced in the family where the man is in charge, and boys and girls learn to reproduce gender roles. Understanding violence against women using a *structural theory* denies that violence can be reduced to the effects of the man's individual psychological disturbance (Walby, 1990). The theory rejects the idea that men who batter are deviant in terms of psychopathology. Instead, all men are held to be capable of beating their intimate partner if their position of power is threatened (Walby, 1990). In this view, therefore, violent relationships are not radically different from "normal" intimate relationships. If a man does not have clear economic and educational superiority over his wife, he is more likely to use physical violence against her (Walby, 1990).

Physical violence is the ultimate expression of maintaining power. But violence exists on a continuum and includes many degrading tactics that are not usually defined as violence in research or by people in general. According to feminist theory, violence against women is

quite common and includes a variety of psychological violations to control the woman. Sexism and "harmless" affronts to the woman's integrity are noted as part of the continuum of violence or sexualized violence. Other feminist researchers focus on different tactics of emotional abuse (Enander, 2008). If these mechanisms of control are effective, physical violence may not be necessary in the eyes of the controller.

IPV is basically an asymmetrical phenomenon. In the feminist paradigm, male perpetrated violence must be understood as a phenomenon separate from violence perpetrated by women against men. Although woman perpetrated violence may occur, it does so in the context of male perpetrated violence, i.e. as a defensive violence sometimes enacted in a state of fear.

Interpersonal theories

Attachment needs are innate and serve to create a child's emotional bonds to its caregivers. Infants learn to use caregivers as secure bases from which to explore the world and as safe havens to return to when the attachment system is activated by a real or perceived threat. "The basic goals of an attachment bond are to obtain security and comfort through the emotional availability and responsiveness of an attachment figure" (Schneider & Brimhall, 2014, p. 368). The attachment relationships between children and parents are thus asymmetric; the child is attached to and dependent on the parent. Romantic relationships in adulthood can also develop into attachment relationships. To function well, however, they should be reciprocal— both partners perceive the other as one who will offer protection and support in times of pressure or stress.

According to Bowlby, experiences of close relationships during childhood influence adult relationships through the developing child's internal working models of self and others (Henderson, Bartholomew, Trinke, & Kwong, 2005). Children will generalize their experiences of protection, comfort, etc, with their caregivers to their expectations other people in close relationships.

A child who has experienced a *secure* attachment relationship will feel worthy of love and will believe that others will respond in a supportive and appropriate way. As an adult, such a person will generally have a low level of attachment anxiety and approach others in a trustful manner. Henderson et al. (2005) incorporated the concepts of self and others into a model to explain adult attachment. The self-dimension ranges from self-confidence to anxiety and on others dimension ranges from avoiding intimacy to seeking others (Allison, Bartholomew, Mayseless, & Dutton, 2008). Individuals with secure attachment tend to have a high, but not

conceited, feeling of self-worth, and a correspondingly high regard of others as potential sources of comfort when needed.

Attachment theory offers an explanation of how IPV can be transmitted from one generation to the next through the internal working models of attachment that each partner in an adult relationship brings with them. It is the interaction between these internal working models that will determine possible IPV, if the attachment needs of one individual are rejected by the partner. Attachment insecurity in both partners can make either one, or both, become violent against the other. The interaction of both partners' attachment styles will determine whether aggression will occur (Bartholomew & Allison, 2006).

The most unlikely partners to conduct IPV are those with secure attachment, who feel worthy of being loved (low on the anxiety dimension) and perceive others as supportive (low on the avoidance dimension) (Bartholomew & Allison, 2006). Low self-esteem (high anxiety) and an excessive need of approval of others (low avoidance) will lead to hypersensitivity to cues of being left out or rejected. Such an attachment style is called *pre-occupied* or hyperactivating (of the attachment system). For people with this attachment style, feeling rejected leads to anger. If the partner does not offer comfort or support in such times of stress, but instead tries to avoid contact, that anger may turn into aggression. IPV can thus be regarded as a kind of protest behavior, also seen in children whose attachment needs are not met. Perceived threats of abandonment, separation, or rejection are the main triggers of IPV.
If one partner is low on anxiety, downplays the importance of intimate relationships, and at the same time has a high or even inflated self-esteem, the attachment orientation is denoted *dismissive* or *deactivating* (of the attachment system). When this person's partner demands closeness or is "overly" needy the person with a dismissive attachment style will perceive this as a threat, and may use physical force in self–defense (from intimacy). Adults with this attachment style tend to use IPV to maintain distance their partner in times of stress and conflict (Allison et al., 2008).

The fourth attachment orientation is *fearful* and is seen a person who ranks high on both the anxious and avoidance dimensions and avoids intimacy due to fear of rejection (Henderson et al., 2005).

Particularly high-risk dyads are those in which one partner is dependent on and seeks intimacy (preoccupied) and the other is dismissive and avoids intimacy.

Both avoidant and anxious attachment behaviors will result in intimate relationships with less rather than more secure attachment over time (Oka, Sandberg, Bradford, & Brown, 2014). Strategies such as stonewalling and withdrawal in the dismissive attachment style or

criticism and blaming in the preoccupied attachment style will make the person's partner reluctant to comfort or give support. Adults with preoccupied or fearful attachment styles are more likely both to perpetrate and to be recipients of IPV (Schneider & Brimhall, 2014). The dismissive attachment style has also been linked to men's perpetration of IPV (Babcock, Jacobson, Gottman, & Yerington, 2000). Some insecurely attached adults, however, will not be more prone to engage in IPV, probably because they are totally disengaged in times of stress or conflict (Babcock et al., 2000).

Individual focused models

Individual models locate the origins of IPV in the perpetrator's or victim's psychopathology. The most relevant (DSM-5) types of psychopathology are Personality Disorders, Trauma and Stressor-Related Disorders, Disruptive, Impulse Control and Conduct Disorders, Substance-Related and Addictive Disorders, and Depressive Disorders (American Psychiatric Association, 2013). These can be related to the perpetration of IPV or may develop as a consequence of the partner's victimization.

Approximately 15% of adults in the USA suffer from at least one personality disorder[2]. Some of these disorders (e.g. antisocial personality disorder) are more frequent among males (American Psychiatric Association, 2013). Higher rates of personality disorders have been found among men in IPV treatment than in the general population (Dutton, Saunders, Starzomski, & Bartholomew, 1994). In a Norwegian study of men voluntarily in treatment, 20% fulfilled the criteria for a diagnosis of an antisocial personality disorder (Askeland & Heir, 2014). A review article also found that perpetration of IPV is more prevalent among males with personality disorders, especially borderline personality disorder, than in the general population (Ali & Naylor, 2013).

Posttraumatic stress disorder. People with a diagnosis of PTSD may show symptoms similar to symptoms of personality disorders: deviations in cognitions, affectivity, interpersonal functioning, and impulse control (the core criteria in personality disorders) (American Psychiatric Association, 2013). However, unlike personality disorders, PTSD symptoms are stress-related and associated with one or several previously experienced life-threatening traumatic events. Although the symptoms and subsequent violent behavior associated with these two diagnoses can be quite similar, the mechanisms inducing them are different.

[2] A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (American Psychiatric Association, 2013, p. 645).

PTSD is associated with perpetration of IPV, especially by men and when the trauma is severe (Taft, Watkins, Stafford, Street, & Monson, 2011). One epidemiologic study found that the risk of perpetrating IPV was higher for men with PTSD, even when controlling for depression and substance abuse (Hahn, Aldarondo, Silverman, McCormick, & Koenen, 2015). Among females, IPV contributes to, rather than is caused by, the development of PTSD (and other psychiatric disorders, e.g. depression and drug abuse) as shown in a longitudinal study (Ehrensaft , Moffitt , & Caspi 2006).

Other psychiatric problems. Problems with emotional and behavioral regulation are listed in DSM-5 under the headline "Disruptive, impulse-control, and conduct disorders" (American Psychiatric Association, 2013, p. 461). These syndromes are not personality disorders, thus they are possibly easier to change, through psychotherapy, for example. Several longitudinal prospective studies have shown that conduct disorders or early behavior problems predict perpetration of IPV (Ehrensaft et al., 2003). Depression and anxiety disorders have also been found among men voluntarily admitted to treatment for IPV perpetration (Askeland & Heir, 2014).

Temperament. Individuals without a psychiatric diagnosis, but who score high on the temperament trait of negative emotionality, are also at risk for engaging in IPV (Moffitt, Robins, & Caspi, 2001)[3]. A prospective study among young adults found that perpetrators of general crime had lower self-control than perpetrators of IPV. Negative emotionality (e.g. poor coping, suspiciousness) was present in both groups (Moffitt, Krueger, Caspi, & Fagan, 2000). Interestingly, all findings applied to both men and women.

Studies have been conducted on perpetrators of IPV who have a hostile attitude or strong feelings of anger (Ali & Naylor, 2013). These persistent attitudes and feelings seem to be a contributing factor to the perpetration of IPV, but findings are inconsistent and the concepts need to be more precisely defined.

Alcohol abuse. Alcohol abuse is associated with IPV according to a meta-study by Foran and O´Leary (2008). In studies of male alcoholics the prevalence of partner violence is 50% to 60% compared to 12% in the general population. In studies on aggressive perpetrators, alcohol use was as high as 72% versus 24% in community samples.

Among prisoners incarcerated for murder, manslaughter, or assaults, common social characteristics were found regardless of whether the crimes were aimed at their partner or at someone else. They were alike on the dimensions of drinking at the time of the incident,

[3] Negative emotionality shares some criteria with the DSM-5 diagnosis of Oppositional Defiant Disorder

having alcohol problems, having a criminal record, having been abused by non-partners, and having been abused as a child (Felson & Lane, 2010).

In a study of males in a treatment program for IPV perpetrators, 40% of the sample fulfilled the criteria for an alcohol or substance abuse disorder (Askeland & Heir, 2014). In a Swedish national survey of 219 IPV-affected mothers, a third reported their partner abused alcohol and a fifth reported that their partner was a "problem drinker". The sample was drawn from women's shelters, CAM, and social services (Broberg et al., 2011).

For victims, use or misuse of alcohol is mainly a consequence, rather than a cause, of IPV according to several studies (Foran & O'Leary, 2008). The causal links between IPV and alcohol/drug abuse still need to be clarified (Ali & Naylor, 2013). The studies on psychiatric disorders and alcohol/drug abuse in relation to IPV perpetration and victimization referred to above, apart from that by Broberg et al., do not include CAM samples. A variety of more or less serious psychiatric disorders than those found in the studies reported above would probably be present in parents attending CAM. Alcohol and drug abuse may also be present in different levels in both perpetrators and victims in CAM.

Three models are commonly used to explain the alcohol–IPV link. Alcohol can be a direct influence on violence because of aggravated aggression due to intoxication. This *proximal effects model* has been supported in studies. If partners are unhappy and live in dysfunctional relationships, alcohol misuse may again have an indirect association with partner violence. This *indirect effects model*, however, has been questioned in studies. The third model states that the association between alcohol and IPV is explained by other background factors such as personality disorders. This *spurious model* has found little support in studies (Foran & O'Leary, 2008).

Child abuse

The *ecological-transactional* model describes different systems involved in child maltreatment: the child, the family, the proximate social environment, and the overarching cultural and political context (Cicchetti & Valentino, 2006). Factors in these systems can either increase or decrease the risk for maltreatment. Enduring risk factors can include, for example, psychiatric disturbance in the parents, disability in the child, or poverty. A transient risk factor can be a short period of unemployment or a divorce. Protective factors can be intelligence or social capability in the child or caring people in the neighborhood. The interaction between the environment, the caregivers, and the child along with the balance between risk and protective factors will determine the outcome.

Low socioeconomic status has been acknowledged as a strong correlate to child abuse in many studies, and it specifically links to unemployment (Cicchetti & Valentino, 2006). Other factors related to child maltreatment are community violence and social isolation.

Parental characteristics. On the psychological level, parental depression and lack of impulse control are linked to child maltreatment (Cicchetti & Valentino, 2006). Parents with these traits are less satisfied with their children overall. They perceive negative intentions in their children. They talk less with them and have unrealistic expectations of them. Instead of talking and reasoning, they will use inappropriate discipline practices.

Very few studies have documented the associations between psychopathology in parents and child abuse. In a sample of 300 parents accused of physical abuse or neglect, undergoing psychological evaluations, 64 % had a personality disorder (Bogacki & Weiss, 2007). Another study compared parental psychopathology in parents (mothers or fathers) accused of physical abuse or neglect with a control group of parents not formally accused by the child protection services. No differences were seen between the two maltreating groups, but abusive and neglectful parents had more personality disorders, more alcohol abuse, lower income, and more social isolation than the control group (Fontaine & Nolin, 2012).

Family factors. Disruptive relationships, anger, and conflicts and dissatisfaction in marriage are some of the features of maltreating families. Family systems theory explains the disruptions in structure, processes, and communication. Hierarchies and subsystems (e.g. parents, siblings) may be malfunctioning and communication disrupted. A disorganized family structure is typical in maltreating families (Cicchetti & Valentino, 2006).

Child characteristics. Children with chronic diseases and disabilities are more often abused than children with no such diseases or disabilities (Janson et al., 2011; Sullivan & Knutson, 2000). This association may be dependent on stress in parents, increased demands of parenting, and deficiency of support for families with disabled children (Svensson, 2013). In a Swedish study the presence of chronic diseases/conditions, in particular for those not born in Sweden, were a risk factor for physical abuse (Svensson, Bornehag, & Janson, 2011).

Intergenerational transmission of child maltreatment. Studies consistently find that individuals maltreated in their childhood are more likely to maltreat their own children, but the rate of the transmission varies (Cicchetti & Valentino, 2006). This may be due to social learning and socializing or internalized models of how to be a parent drawn from care-giving experiences (attachment theory). Genetics, temperament, and personality are alternative explanations. Nowhere near will all of those maltreated in childhood maltreat their own children, and many protective factors are involved in this process.

Etiology of double exposure

A few studies have found risk factors on the individual, family, and environment levels in families with double exposure (Robinsson, 2014). These studies include samples from the general population, but also from families charged with child maltreatment or with substantiated reports from the criminal justice system. Male perpetrators of both child abuse and IPV more often use drugs (Beeman, Hagemeister, & Edleson, 2001; Dixon, Hamilton-Giachritsis, Browne, & Ostapuik, 2007; Hartley, 2002; Tajima, 2004) and more often have been convicted for non-domestic violent crimes (Dixon et al., 2007; Hartley, 2002; Slep & O'Leary, 2009) than men who engage in only one form of family violence. In families with double exposure, mental health problems are more common in both men and women than in families where only one form of violence occurs (Dixon et al., 2007; Hartley, 2002; Slep & O'Leary, 2009; Tajima, 2004), as are lower education and being a childhood victim of abuse (Lévesque, Clément, & Chamberland, 2007). Some studies found higher stress levels in both male and females in families with double exposure (Dixon et al., 2007; Tajima, 2004), but others did not (Coohey, 2004; Lévesque et al., 2007).

Studies of the etiology of double exposure are still at an early stage. Samples typically studied from the perspective of criminology may generate different results from those of the general population. Different levels of severity may also influence the results.

Consequences of child abuse and IPV on child development and psychopathology

Child abuse and exposure to IPV affects children in both high-income and low-income countries. Both short- and long-term consequences have been documented. Double exposure is not unusual and has more negative effects than either child abuse or IPV on its own. How can we understand the reactions of children growing up in a harmful environment? Theoretical models help both policy makers and clinicians to work toward prevention and intervention for these children. Several theories describe the interplay between the environment and the adaptive or maladaptive development of children living abusive relations.

Theoretical aspects

Developmental psychopathology.

Developmental psychopathology is a theoretical model that seeks to decipher a growing child's psychopathology in an ever-changing environment. This model focuses on "...the interplay between normal and abnormal development, continuity and discontinuity, risk and protective factors and processes, and influences both within and outside the individual..."

(Cicchetti & Tooth, 1995, p. 542). Psychopathology in children should be studied and compared with normal or adaptive behavior at a particular stage in the child's development. It is important to consider the influence the child's internal development and external factors have on each other. For example, if a parent who experienced IPV appealed for comfort and help from her teenage daughter, this would probably have a specific effect on the daughter's individuation process, a core developmental task at that age. The ability to develop an identity independent of parental needs will be difficult. If this developmental task is not solved, there is a risk for individual or relational problems in dating or mating in the future. At this stage in the child's specific developmental process, the actual exposure to intimate violence and the parent's capacity to handle the situation will determine the adaptive or maladaptive behaviors in the child. The paradigm of developmental psychopathology takes into account that the child, parent, and environment are constantly changing. A certain type of violence may result in distinct difficulties for the child at varying times and contexts in the developmental process. *Attachment theory* conceptualizes the consequences of abuse and IPV through the impact these experiences have on the child's attachment to caregivers, both abusive and victimized. *Social learning theory* stresses how children learn and imitate aggressive behavior. The perspective of *psychological trauma* suggests that a frightening experience can result in specific trauma symptoms, affecting emotions, behavior, and other attributes. An overview of these theories will be presented below.

Attachment theory

Attachment theory, developed by John Bowlby (Bowlby, 1988), will help us understand how exposure to violence affects relationships in a care-giving context. Children rely completely upon their parents or substitute caregivers in the first years of life and develop attachment bonds to their primary caretakers—most often, but not necessarily, their biological parents. Depending on the quality of care and history of the relationship between the caretaker and child, the child will develop a secure or an insecure attachment relationship. If the parent is attuned and responds appropriately to the child's needs for physical and psychological caretaking and inclination to exploration, a *secure attachment* relationship will develop. A secure attachment relationship will enable the child to use the parent as a secure base from which to explore the world and as a safe haven to return to when the child is worried, scared, or in need of support. In secure attachment relationships, it is safe for children to communicate their need for protection without being afraid of being abandoned, rejected, or ridiculed. The child is also safe to discover the outside world, because there is a safe haven to return to. On the other hand, if the caregiver repeatedly does not meet the child's attachment

needs, an *insecure attachment* may develop. When the child expresses fear, a normal parental reaction is to comfort. But in insecure attachment relationships, a parent may instead reject the child. Rejection can be open and conscious or more subtle and unconscious on the part of the parent. Children are especially vulnerable to disruptions in the attachment relationship during the first years of their life.

If the parent behaves in a frightening manner, for example in the case of abuse or IPV, the child is in a very difficult and paradoxical situation because the caregiver, who is supposed to be a source of comfort, may now be a source of danger (Kobak & Madsen, 2008). The impulse to seek proximity to the caregiver does not cease, even if the parent is frightening or frightened. Thus the child is caught in a struggle between two opposing forces: to approach the attachment figure while avoiding or even fleeing from the frightening parent. The child then loses both parents as a secure haven and has no way to meet its need for protection and is left in a state of *fright without solution* (Hesse & Main, 2006). This *disorganized attachment* was described by Main and Solomon in 1990 (Broberg, Risholm Mothander, Granqvist, & Ivarsson, 2008). This type of attachment can develop if a parent is abusive towards the child, but also if a parent is victimized and lives in fear (Kobak & Madsen, 2008). The child is at risk of developing disorganized attachment also if a victimized parent becomes depressed, dissociative, or neglectful towards the child. Disorganized attachment relations are predictive in particular of externalizing problems and to a lesser degree of internalizing problems according to two meta-studies (Fearon, Bakermans-Kranenburg, Van Ijzendoorn, Lapsley, & Roisman, 2010; Groh, Roisman, van Ijzendoorn, Bakermans-Kranenburg, & Fearon, 2012). Disorganized attachment is also related to aggressive behavior against peers later in childhood. Hostility towards partners in young adults is another consequence of disorganized attachment (Hesse & Main, 2006).

In middle childhood and adolescence children are less in need of proximity of the parents, and peers become more important. However, the child still needs to know that a parent is available for comfort and protection. Children continue to maintain and develop the attachment relationship to their parents during adolescence (Allen, 2008). In a stable environment, the attachment pattern also tends to show stability, while overwhelming events and radical changes in the environment can lead to change or discontinuity in the attachment pattern (Broberg et al., 2008). If the abuse or exposure to IPV begins in middle childhood or adolescence the attachment relationship may change from secure to insecure, but if early abuse or exposure to IPV stops later in childhood, the attachment relationship may change

(with or without psychotherapy) from insecure to secure. Secure attachment to at least one parent can buffer the risk of developing externalizing problems (Kochanska & Kim, 2013).

Social learning theory.

Abused children may themselves become aggressive, as documented in many studies (Gilbert et al., 2009). The central idea in *social learning theory* is that children (and adults) learn behaviors by observation and reproduce them via symbolic representations. The theory draws from both behaviorism and cognitive theory (Grusec, 1992). In this process, called modelling, children will imitate the behaviors of significant others if those behaviors are rewarding. Passer and Smith wrote that "people learn by observing the behavior of models and acquiring the belief that they can produce behaviors to influence events in their lives" (2007, p. 225). Violence watched or experienced at home may be imitated by the child when interacting with peers or other people. To gain advantages or toys, children may use aggression in an instrumental way. A child who is attacked may in turn use aggression instead of other tactics to calm the tense situation. In verbal conflicts, the child may use aggression in an early state of argumentation instead of solving the conflict with words.

Observational learning occurs in four steps: (1) the child attends to a behavior performed by an important person, e.g. a parent; (2) the child remembers the behavior; (3) the child imitates the behavior; and (4) the child is rewarded for the behavior. For example if the father hits the mother, this action can be reproduced, e.g. the child can hit a doll or a friend. The observed behavior will be reproduced with greater probability if there is an incentive linked to the behavior. If the father's violent acts generate certain advantages, the child may think that reproducing this behavior will generate similar advantages. When children judge that they can accomplish a goal, this will motivate them to exert a certain behavior. This process is called *self-efficacy*.

Trauma theory

PTSD. Studies have consistently shown associations between PTSD and physical and sexual abuse (Gilbert et al., 2009). Some studies have also shown an association between PTSD and exposure to IPV (Evans, Davies, & DiLillo, 2008). Taking the perspective of *psychological trauma*, it is the exposure to actual or threatened death or injury that causes damage in the child. Many events will qualify as potentially traumatic in a child who is abused and/or exposed to IPV. The severity of the violence, multiple exposure, the functioning of the non-abusive parent, and the child's subjective interpretation will also influence the risk for PTSD (Margolin & Vickerman, 2007). Children interpret threats according to their developmental

stage, and the interpretations of preschool children differ from those of older children and adults (American Psychiatric Association, 2013).

The PTSD diagnosis includes an external event under the definition's syndrome section. Domestic violence, sexual abuse, and physical abuse are all listed as possible events. The disorder can be long-lasting, especially if the stressor is interpersonal and intentional (e.g., torture, sexual violence) (American Psychiatric Association, 2013). Risk factors for developing PTSD are, among others, lower socioeconomic status, lower education, exposure to prior trauma, childhood adversity (e.g. economic deprivation, family dysfunction, parental separation, and death), minority status, and family psychiatric history.

Trauma theory. Recurrent memories from a traumatic event will trigger a stress response when a person is confronted with a reminder of the event. Increased arousal such as irritability and anger will occur. Such trauma symptoms from these two clusters have been explained as a dysregulation of the stress response or "allostatic overload" (Gunnar & Quevedo, 2007). Chronic stress in early childhood can make children hypersensitive to stress stimuli. Such easily elevated stress levels will negatively impact both the body and the brain.

The *dual representation theory* is based on memory research (Brewin, 2001). According to this theory traumatic memories are dysfunctionally stored in the amygdala and not directly accessible for language. The memories are only accessible via situational cues, and no inhibitory functions can influence the recall. The connection between traumatic memories and cortical structures in the brain are weak and thus out of conscious control.

Yet, another theory of trauma is the *cognitive model of PTSD* by Ehlers and Clark (Smith, Perrin, Yule, & Clark, 2010). When confronted with danger, children (and adults) will over-generalize the possibility of similar traumatic events reoccurring, which will result in anxiety or fear. Mistaken beliefs about the cause of the traumatic event can result in exaggerated guilt or responsibility for the events. These negative appraisals will extend to false interpretations of symptoms and the reactions of people in the proximity.

The concept of complex trauma was originally introduced by Judy Herman in the 1990s (Herman, 1992). Herman argued for the existence of a complex form of PTSD in survivors of prolonged, repeated traumas. In the field of childhood trauma, the terms type I and type II trauma were introduced by Leonore Terr to distinguish singular "out of the blue" trauma (type I) from the complex and repetitive traumas (type II) often connected with more serious symptoms (Terr, 1991). Additional trauma-specific symptoms after abuse, IPV, and other caregiver-induced traumas have been suggested (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). Those symptom clusters include problems with adequately controlling

and directing affects and behaviors: *dysregulation of affect, disturbance of attention and consciousness*, *distorted attributions*, and *interpersonal difficulties*.

When PTSD is assessed from the complex trauma perspective, children exposed to prolonged but non-life-threatening traumas may not fit into these post-traumatic stress symptom clusters and the assessment may fail to include them in the diagnosis (Courtois & Ford, 2008). PTSD will often present in combination with depression, anxiety, conduct disorder, aggression, and attention-deficit hyperactivity disorder (ADHD) in children who have been abused and exposed to IPV (Margolin & Vickerman, 2007).

Social adjustment

Studies of teenagers have shown associations between physical abuse and convictions of violent offenses, perpetration of IPV, and re-victimization (Cicchetti & Valentino, 2006). Prospective studies show that maltreated adolescents are at risk for alcohol problems and deficits in educational achievement (Gilbert et al., 2009). In adulthood especially, women are at risk for alcohol abuse linked to IPV victimization (Gilbert et al., 2009). Retrospective studies and systematic reviews also show that physical abuse is associated with delinquency (Gilbert et al., 2009).

Psychopathology

The consequences of child abuse and of exposure to IPV are to some extent similar, but studies of the two types of violence are often conducted separately. Often studies of one type of abuse do not control for the other. More studies have been conducted on the consequences of child abuse than of exposure to IPV. Relatively little is known about the consequences of exposure to IPV (Wood & Sommers, 2011). Studies of child maltreatment will be referred to when relevant, and when these studies specifically single out physical or sexual abuse, they will be highlighted. Some studies are retrospective, and thus possibly subject to recall bias in informants, selective inclusion of patients, and difficulties adjusting for social and individual confounding factors (Cicchetti & Valentino, 2006; Gilbert et al., 2009). Prospective studies do not have these caveats, and when such study designs are referred to, they will be pointed out. Few studies have compared the effects of double exposure with exposure to just one type of violence.

IPV

The consequences for children exposed to IPV are highly diverse. Four meta-analyses (including from 37 to 118 studies conducted from 1978 to 2006) have found small to moderate associations between IPV exposure and children's behavioral and emotional

problems (Chan & Yeung, 2009; Evans et al., 2008; Kitzman, Gaylord, Holt, & Kenny, 2003; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). In one meta-analysis PTSD was associated with exposure to IPV, but only six studies were included in the analysis (Evans et al., 2008). Children exposed to IPV more often attend both somatic health care (Olofsson, Lindqvist, Gådin, Bråbäck, & Danielsson, 2011) and psychiatric health care (Rivara et al., 2007). The IQ of children exposed to high levels of IPV have been shown to be lower than those of non-exposed (Koenen, Moffitt, Caspi, Taylor, & Purcell, 2003).

Child abuse

A review article reported that child maltreatment is related to educational under achievement, delinquency, and poorer physical and mental health (Gilbert et al., 2009). Long-term consequences of child maltreatment have been found in adulthood, and strong relations to behavior problems in children and adolescents and PTSD have been found in prospective studies (Gilbert et al., 2009). Depression, attempted suicide, and alcohol problems have been moderately related to child abuse in prospective studies, but strongly related in retrospective studies (Gilbert et al., 2009). Social factors, particularly low parental education and poverty (unemployment), but also community violence and social isolation, influence the association between child maltreatment and mental health (Cicchetti & Valentino, 2006). A pediatric study also related symptoms, signs, and diseases (injuries, sexually transmitted infections, bruises, burns, skeletal injuries, abdominal traumas, and head traumas) to child maltreatment including sexual abuse and physical abuse (Denton, Newton, & Vandeven, 2011). Parents were also occasionally found to apply for medical help for diseases that they had themselves inflicted on their children while suffering Munchausen by proxy syndrome. Prospective studies have shown strong associations between child maltreatment and obesity (Gilbert et al., 2009).

A prospective study of the long-term effects of physical maltreatment before the age of five, even after controlling for family and child characteristics, showed associations with many symptoms in adolescence including (among others) aggression, anxiety/depression, PTSD, and social problems and social withdrawal, (Lansford et al., 2002). Another long-term (20 years) prospective study of abused and neglected children found an increased risk for developing PTSD as long as 20 years after the events (Widom, 1999). Around a quarter to a third of maltreated children suffer from major depression in their late 20s, with no clear evidence for a specific effect of any particular type of maltreatment (Gilbert et al., 2009). For many of these adults depression will start in childhood or adolescence. Physical abuse is also linked to suicide attempts in people in their late 20s.

Emotional maltreatment. The consequences of emotional maltreatment have not been studied to the same extent as physical and sexual abuse, but they do seem to be serious (Egeland, 2009). In particular, emotional maltreatment inflicted in the early years seems to have especially deleterious effects (Manly, Kim, Rogosch, & Cicchetti, 2001).

Sexual abuse. Sexual abuse is related to a number of psychiatric disorders. Depression in adulthood and sexualized behavior in childhood seem to be the most common outcomes of child sexual abuse according to one review (Putnam, 2003). Suicide attempts are associated with sexual abuse according to another review (Gilbert et al., 2009). Prospective studies consistently show associations between child sexual abuse and PTSD (Gilbert et al., 2009).

CAM studies. Youngsters can exhibit a unique form of co-morbidity, with an increased risk for misuse of alcohol and drugs, suicide attempts, eating disorders, criminality, school problems, and dating violence (Margolin & Vickerman, 2007). These young people may then show up as patients in CAM.

One study in CAM found a higher risk of PTSD, dysthymia, and self-harming behavior among patients aged 8 to 17 years who had been exposed to IPV than in patients with no such experiences (Olaya et al., 2010). Control for concurrent child abuse was not performed. Children aged 4 to 7 years who had been referred for oppositional and non-compliant behaviour had marginally more externalizing and internalizing symptoms than patients not exposed to IPV (McDonald et al., 2000). At least one incident of physical IPV in the past year was counted as exposure and child abuse was controlled for. The results hold true whether the father or the mother perpetrated the IPV. Boys 5- to 15-years-old living in families with physical IPV (bruised or hurt more than once or seriously hurt at least once) received a conduct disorder diagnosis more often than similarly aged boys not exposed to IPV (Stewart & deBlois, 1981). Child abuse was not controlled for. In a Norwegian study of children and adolescents aged 10 to 18 years, post-traumatic stress reactions above clinical levels were reached by 70% of patients exposed to IPV and 80% of patients sexually abused in their family (Ormhaug et al., 2012). Control for concurrent child abuse was not performed. A study of children receiving community based interventions found that child abuse was associated with post traumatic symptoms, however neglect and other potentially traumatic experiences were not (Telman et al., 2015).

Unique and cumulative effects of child abuse, IPV, and other traumatic events

Unique effects. Studies on the specific effects of IPV relative to the effects of child abuse are few and the evidence is mixed. Many studies of exposure to IPV do not control for child

abuse, therefore it is difficult to say whether one or the other has more or different effects (Herrenkohl et al., 2008).

In the three meta-analyses on studies of abuse or exposure to IPV no specific effects for either type of abuse were found (Chan & Yeung, 2009; Kitzman et al., 2003; Wolfe et al., 2003). In a prospective study, witnessing IPV was an important predictor for delinquency in youth, but child abuse was not (Herrera & McCloskey, 2001). In a study among parents, their own childhood exposure to IPV predicted subsequent perpetration of child abuse (Cunningham, 2003). Some of the parents had also been hit during childhood, but these experiences did not increase their risk for perpetrating child abuse. One prospective study that controlled for exposure to IPV found unique effects of child maltreatment on conduct disorder (McCabe, Hough, Yeh, Lucchini, & Hazen, 2005) and another study also found associations between child abuse and conduct problems (Maughan & Cicchetti, 2002). A longitudinal study showed that child maltreatment was more related to crime and violence during young adulthood than was exposure to IPV (Park, Smith, & Ireland, 2012). Participants in this study also had a higher risk for committing crimes and perpetrating severe IPV in adulthood. In a Swedish cross sectional study children with experiences of physical abuse alone or in combination with IPV reported more psychosomatic problems than non-abused children (Jernbro, Svensson, Tindberg, & Janson, 2012). Children exposed to IPV alone did not report more psychosomatic problems than non-abused children.

Double exposure. Several studies show that exposure to both child abuse and IPV worsens children's symptoms (Herrenkohl et al., 2008). A mega-analysis showed that children who suffered child abuse and exposure to IPV were found to have more internalizing problems (Sternberg, Baradaran, Abbott, Lamb, & Guterman, 2006), and in a meta-analysis the doubly exposed children had more emotional and behavioral problems (Wolfe et al., 2003) than children who had been abused or exposed to IPV, but not both. Compared with abuse only or exposure to IPV only, double exposure was associated with increased adolescent delinquency and depression (Moylan et al., 2010). A study from a child welfare sample documented that combined experiences of abuse and witnessing IPV, compared with just one of these experiences, are associated with more adolescent antisocial problems (Sousa et al., 2011).

Community violence. Violence experienced outside the family is described in research literature as community violence (Fowler, Tompsett, Braciszewski, Jacques-Tiura, & Baltes, 2009). Maltreated children are at increased risk for community violence, but studies of community violence are often conducted separately from those of family violence. According to a meta-analysis, community violence has its strongest effects on PTSD and externalizing

problems (Fowler et al., 2009). In a prospective study on adolescents, the independent effects of community violence, maltreatment, and exposure to IPV were compared (McCabe et al., 2005). Community violence and maltreatment predicted conduct disorder, but exposure to IPV did not. In a study of adolescents and young adults, experiences of community violence in addition to experiences of childhood maltreatment exacerbated both externalizing problems and PTSD (Cecil, Viding, Barker, Guiney, & McCrory, 2014).

Multiple exposure. Frameworks under the umbrella of trauma theory have evolved, and in addition to child abuse and IPV they encompass community violence and household dysfunctions such as parental psychiatric illness and alcohol abuse. Different concepts are used to understand the nature of the traumatic events and the reactions: adverse childhood experiences (ACE), complex trauma, and poly-victimization. These frameworks are holistic in their approaches, and the interpersonal aspects of the traumatic events are core features in these studies. Commonalities between the frameworks can be found, but the studies differ with regard to study populations and operational definitions. Vincent Felitti and colleagues study adult populations who retrospectively recall childhood traumas and household dysfunctions. In addition to childhood maltreatment and exposure to IPV, adverse experiences include parental alcohol or drug abuse, psychiatric disturbance, incarceration of a parent, and childhood out-of-home placement. Studies have shown that somatic and psychiatric symptoms increase with the number of ACEs (Felitti et al., 1998). Poly-victimization is studied by Finkelhor and colleagues using the Juvenile Victimization Questionnaire. This contains questions about conventional crime, child maltreatment, peer and sibling victimization, sexual victimization and witnessing, and indirect victimization (Finkelhor, Hamby, Ormrod, & Turner, 2005). A study of poly-victimized children and adolescents aged 2-to 17-years-old showed a strong association with trauma symptoms (Finkelhor, Ormrod, & Turner, 2007).

Besel van der Kolk and colleagues study the complex trauma reactions after interpersonal traumas in the caregiving relationship (D'Andrea et al., 2012). These reactions are: dysregulation of affect, disturbance of attention and consciousness, distorted attributions, and interpersonal difficulties. A study in Sweden showed that poly-victimization is not unusual here, either (Nilsson et al., 2012). Cumulative exposure to traumatic events was found to be associated with trauma symptoms.

CAM studies. Studies in clinical populations have found that exposure to multiple traumas is associated with PTSD (Ford, Wasser, & Connor, 2011b) and co-morbidity (Cloitre et al., 2009). In a Dutch clinic, in addition to exposure to IPV, other ACEs had an impact on

children's trauma symptoms as reported by their parents (Lamers-Winkelman, Willemen, & Visser, 2012). A study of five-year-old children showed that the more types of incidents (assault, maltreatment, sexual abuse, and witnessing IPV) experienced the more negative symptoms (Hickman et al., 2013). A study in CAM found that poly-victimization partly explained post-traumatic symptoms among children exposed to IPV, child abuse, and other potentially traumatic experiences (Telman et al., 2015).

Moderating factors

Dose-response

When looking at one type of violence at a time, the amplitude can be measured on different dimensions. The amount of violence can be measured with reference to duration – *chronicity* and how many times the violent acts occur – *frequency*. The *severity* of violent acts is another dimension to measure. Yet, the *type* can be measured in terms of verbal, physical or sexual acts. The degree of involvement in the violence (by calling for help, inventing or fleeing) or proximity to the violent acts (e.g. saw it on a close distance, saw the effects afterwards, was injured) are other possible dimensions to measure. Childhood studies of these dimensions are few.

Among children of mothers who were victims of IPV and police-reported, the effects of type, severity, and duration were studied (Kernic et al., 2003). Mother-reported duration of IPV was associated with externalizing and externalizing problems, but not type or severity.

In a clinical sample of 5-year-old children the life time frequency of child abuse, exposure to IPV and other types of victimization was measured through parental reports. (Hickman et al., 2013). The frequency of all violence exposure was not associated with negative symptoms. An exception was frequency of sexual abusive acts which was related to more trauma symptoms.

In a clinical sample of 2- to 12-year-old patients exposed to IPV, those exposed to more *types* of IPV had more internalizing and externalizing symptoms according to teacher reports (Lamers-Winkelman et al., 2012). The duration of exposure to IPV was not associated with more symptoms. Because most children were exposed to long-lasting IPV, associations between duration and symptoms may have been missed. Also, sexual abuse was associated with a risk of parental reported trauma symptoms 6 times higher than in those not exposed to sexual abuse.

Duration, frequency and type seem to be important aspects when studying the association with childhood symptoms. Especially sexual abuse and trauma symptoms can be of importance in relation to dose – response effects.

Parental functioning

Recent studies show that the reactions of both preschool and school-aged children to IPV against their mothers are moderated by maternal psychological functioning and parenting behavior while studies of fathers parenting are very few (Hungerford, Wait, Fritz, & Clements, 2012). Better maternal functioning is associated with fewer child problems. PTSD and other psychological symptoms in parents can influence the parental capacity. Parental stress was a significant moderator for post-traumatic symptoms in a clinical sample of patients exposed to IPV, child abuse and other potentially traumatic experiences (Telman et al., 2015).

Child factors

Children's cognitive functioning in terms of how they perceive threat, if they blame themselves for the IPV and coping efficacy influence the impact of violent experiences. However, if these capabilities are innate or shaped by parenting is not clear (Hungerford, Ogle, & Clements, 2010). Intellectual resources and social competency also are traits that could buffer the experiences of IPV and abuse (Cicchetti & Valentino, 2006).

Gender.

Generally, girls react to life stressors with more internalizing symptoms and boys with more externalizing symptoms (Merikangas et al., 2010). Two meta-analyses showed no gender differences with regard to the effects of exposure to IPV (Kitzman et al., 2003; Wolfe et al., 2003). A more recent meta-analysis and one mega-analysis, however, showed that boys had more behavioral problems than girls after exposure to IPV (Evans et al., 2008; Sternberg et al., 2006). Among children exposed to IPV aged 6- to 11-years-old, boys were more likely to engage in hitting and fighting than girls when personally rejected in simulated conflict situations (Ballif-Spanvill, Clayton, & Hendrix, 2007). In addition to the meta-analyses, a more recent review concluded that boys are more likely than girls to engage in increased aggression after exposure to IPV (Wood & Sommers, 2011). Some studies show that aggression is expressed differently by boys and girls. Aggression in adolescent girls is more often exerted towards a partner, while boys tend to aim their aggression towards same-sex peers. One study showed that boys were more likely to engage in physical aggression against a same-sex friend while girls reported expressing more aggression toward an opposite-sex dating partner (McCloskey & Lichter, 2003). Among teenagers exposed to IPV with severe

behavior problems, girls reported being more aggressive toward their dating partner and boys more aggressive towards friends (Moretti, Obsuth, Odgers, & Reebye, 2006). Moretti's study also showed that a diagnosis of PTSD was assigned two times more often in girls than in boys. A longitudinal study of teenagers showed that after physical child abuse, girls were more often arrested for violent offenses than boys (Herrera & McCloskey, 2001). Nearly all referrals of girls were for domestic violence and of boys for community crimes. A study in CAM found more post-traumatic symptoms in girls among children exposed to IPV, child abuse and other potentially traumatic experiences (Telman et al., 2015).

Age

In studies of children exposed to IPV some have shown moderating effects of age and others have not. None of the meta-analyses of IPV have shown any age effects (Chan & Yeung, 2009; Evans et al., 2008; Kitzman et al., 2003; Wolfe et al., 2003). A mega-analysis showed that the risk for externalizing behavioral problems were greater for younger children (4 to 7) than for older children (7 to 14) (Sternberg et al., 2006). The influence of different types of maltreatment at different developmental stages influence is a complex topic and studies of these details have not been studied extensively (Gilbert et al., 2009). The earlier maltreatment begins, the more damaging it is, but it is unclear whether physical abuse, psychological abuse, or neglect is the most damaging. A study in CAM found more post-traumatic symptoms in younger children among children exposed to IPV, child abuse and other potentially traumatic experiences (Telman et al., 2015).

Disclosure of child abuse and IPV

Child abuse and IPV can come to a clinician's awareness in many ways. Asking children and parents about violence when symptoms seem to indicate is one option. When clinicians routinely ask about violence, however, they must consider how such questions will be perceived by the children and their parents, who in the family is best to ask, and when and how to ask routine questions. These practical and ethical questions need to be addressed. A debate currently exists within both the academic sphere and the field of health care (Becker-Blease & Freyd, 2006; McClinton Appollis, Lund, de Vries, & Mathews, 2015). Routine inquiry about IPV in health care has been studied by asking women patients and health care providers for their opinions. The key issue in this research is what advantages and disadvantages women and health care providers perceive in bringing up the issue of violence in a health care setting if no indications are present. Does it harm the relationship between caregiver and patient? Or does it offer the opportunity of bringing IPV to the surface and thus

into conversation? Will disclosure put the woman at risk for further or increased IPV from her partner?

Children's perceptions of answering question on sensitive matters have been studied when they participated in research and young adults´ thought and feelings about abuse, including disclosure, during childhood has been studied in Sweden (Jernbro, Eriksson, & Janson, 2010).

Ethical considerations

From an ethical perspective, it is crucial to consider whether a medical practice could violate the autonomy or integrity of the patient. Disclosure of violence could jeopardize the safety of the woman, because it could trigger aggressiveness in the partner if he were to become aware of the disclosure. Routine questions about abuse and/or IPV could also trigger traumatic memories and the questioning could be unnecessarily time-consuming for non-exposed patients. These considerations apply to both parents and children. The UN Convention on the Rights of the Child (article 12) says that children have a right to express their opinions in matters that concern them (United Nations, 1989). It may therefore be unethical not to ask them about abuse or exposure to IPV. Ethical consideration must also be given to how patients who disclose IPV are supported. Asking questions about IPV, but then taking no action to follow up or support the patient, can be unethical.

The vast majority of studies show that women are not bothered when asked about IPV in health care settings, and they will typically disclose if the inquiry is done in privacy and with empathy (Plichta, 2007). Even in pediatric care, mothers are willing to answer general questions about IPV (Dubowitz, Prescott, Feigelman, Lane, & Kim, 2008; Zink, 2000). Studies of men's attitudes to routine questions about IPV have rarely been conducted, but one study found that men's experiences of disclosing a history of exposure to violence to health care professionals are similar to those of female (Simmons, 2015). Four studies have looked into the ethics of asking children and adolescents about violence and abuse in research settings (McClinton Appollis et al., 2015). The young respondents reported that harm was relatively low, but those with a history of abuse reported relatively more harm. Another study among adolescents showed low levels of upset in telephone interviews about violence, sexual assault, and family maltreatment (Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014b).

Women, children, and adolescents all seem to tolerate questions about these sensitive issues. Performed with care, asking questions about violence seems to produce no major harm. Those who may be upset by the questions must, however, receive adequate care in the

clinical situation. Young adults, abused during childhood, stress the importance of receiving information about their rights and being helped to care and support when abuse is disclosed (Jernbro et al., 2010).

Obstacles facing clinicians when asking about IPV have been documented extensively in health care and they include the belief that it will do more harm than good, the lack of time at hand, the fear that patients will be offended, and the opinion that it is not within the professional role description (i.e. not a medical problem) or that IPV is simply not a problem among the professional's patients (Todahl & Walters, 2009).

Studies of obstacles to questioning patients about abuse and IPV in CAM have not yet been conducted.

In Sweden the concept of screening has been central in the discussion of how to solicit disclosure child abuse and IPV in health care and social services (Juth & Munthe, 2012). Screening was defined by the American Commission on Chronic Illness in 1957 as "the presumptive identification of unrecognized disease or defect by the application of tests, examinations and other procedures, which can be applied rapidly" (Hall & Elliman, 2003, p. 135). Among other requirements, a strict definition of the disease and access to preventive medicine or treatment must be in place before starting a screening program (Hall & Elliman, 2003). Moreover, the benefits of asking everyone must outweigh of the harm or disturbance screening might cause in some patients by causing unnecessary worry. To draw a parallel, we can turn to the example of screening women universally for breast cancer, which would without question cause worry in a part of the population screened, because the disease may be present but unknown to the individual. If many women could be identified in an early stage, and those affected could benefit from preventive interventions, the discomfort or worry may be regarded as a necessary cost. Two reviews have recently analyzed whether or not screening about IPV in health care should be recommended to health care professionals (Nelson, Bougatsos, & Blazina, 2012; Taft et al., 2013). Currently, the positive effects in terms of benefits for women have not been substantially documented, and therefore universal IPV screening in health care is not recommended in these reviews. Standardized questionnaires are fairly accurate, though, and disclosure rates increase when they are used. Women may benefit from the screening and adverse effects are minimal (Nelson et al., 2012). However, asking routinely about abuse and IPV in a selected population (CAM) is different from screening in the general population. In the case of possible child abuse and/or IPV, the patient is already aware of the violence (the *condition*) when asked. Bringing up IPV in the conversation may cause worry, but not in the same way as when the issue is an unknown and possibly serious

disease. Questions about child abuse and IPV are thus better regarded as a natural part of history-taking during the patient's exam in the context of the presented psychiatric symptoms. The rigorous requirements attached to a screening program thus do not apply to routine questions about child abuse and IPV in CAM.

Since 2014 the Swedish NBHW has recommended that clinicians in CAM, but also those in prenatal care and adult psychiatry, ask routinely about IPV (Socialstyrelsen, 2014a). The benefits of routine inquiry are considered to outweigh possible disadvantages, and advice is given about how to maximize the beneficial effects. Professionals in social service working with children are also recommended to consider routine questions about child abuse and IPV.
In addition to the guidelines recommending routine inquiries in CAM, the Swedish NBHW has also passed regulations for health care and social service about how to handle child abuse and IPV (Socialstyrelsen, 2014b). These prescribe that it is mandatory for the boards of both social service and health care providers to create routines to effectively and safely take care of those affected by abuse and IPV.

Informant

Multiple informants. When studying the reliability of questionnaires, one must analyze the degree of agreement between parents and their children to discern the probability of accuracy. The few studies conducted about agreement (concordance) between child and parental reports on IPV show low to moderate agreement. Good agreement corresponds to a kappa value > .6, which corresponds roughly to agreement in 80% of cases. In a study with children aged 5 to 13 years and parents from domestic violence shelters and a community center both completed a questionnaire about IPV (Hungerford et al., 2010). Parents and their children reached agreement in 67% of cases about occurrence (20%) and non-occurrence (47%). In another study, children aged 6 to 13 years and their parents, agreement reached 66% about father to mother violence, and 64% about mother to father violence (Kolko, Kazdin, & Day, 1996). In a study of immigrant mothers and their 6- to 12-year-old children, a very low agreement was found about whether or not violence had occurred against the mother (McCloskey, Fernández-Esquer, Southwick, & Locke, 1995). In one study, children and parents had particularly low agreement when children were asked if they had seen grown-ups hit each other and parents were asked if the child had witnessed this. The correlation between the informants was low, but significant (r =.124) (Litrownik, Newton, Hunter, English, & Everson, 2003). In another study with 8- to 11-year-old children and their parents from the general population, 66%

agreed on occurrence or non-occurrence of husband aggression (O'Brien, John, Margolin, & Erel, 1994).

Child-parent concordance regarding IPV has, to my knowledge, not been studied in CAM.

Methods for disclosure

It is important to consider the variety of ways in which a health care professional can inquire about IPV in a comfortable and effective way. In order to effectively perform routine inquiries about child abuse and IPV in CAM, every patient should be asked as quickly as possible so as not to take up to too much time, particularly if the questions do not apply to the patient's situation. The instrument should preferably identify too many cases (false positives) than too few (false negatives). Asking about IPV has been tested verbally, in writing, on a computerized form, and through response to a recorded voice over headphones. One study found that women preferred self-completed approaches (written or computer-based questionnaires) to being asked face-to-face (MacMillan et al., 2006). According to a meta-study, no studies have found a preference among women for face-to-face interview questions. Furthermore, computer-assisted questions lead to a higher detection rate of IPV prevalence (Hussain et al., 2015). The benefits of routinely asking about IPV include the opportunity for clinicians to increase their expertise and comfort with these issues (Todahl & Walters, 2009). In addition, families will not feel singled out because of their particular circumstances or symptoms if the questions are clearly routine and asked of everyone at intake. Routine questions will offer clinicians an opportunity to discuss IPV whether or not a parent is personally affected.

Studies on children's preferences for being asked about abuse or exposure to IPV have, to my knowledge, not been conducted. Young adults, abused during childhood, stress the importance of talking to children seriously and listen to them, when abuse is uncovered (Jernbro et al., 2010). Improved medical and psychiatric care services are asked for by participants in this study.

In addition to the best instrument, environmental and relational factors are important for collecting correct responses. A parent may choose not to disclose her IPV victimization because of personal feelings or circumstances associated with the encounter with the professional. Willingness to disclose is dependent on whether or not the woman feels that privacy during the disclosure is guaranteed (McCauley, Yurk, Jenckes, & Ford, 1998). It also depends on whether or not the woman feels certain that the health care provider has some knowledge about partner abuse, shows care and interest, and is not in a hurry (Hathaway,

Willis, & Zimmer, 2002). In one study, 58% of women said they would disclose abuse during a healthcare encounter. On the other hand, 28% responded with "maybe," and 14% said "no" because the professional was uninformed, did not care, or rushed (Kramer, Lorenzon, & Mueller, 2004).

There are many written standardized questionnaires used in health care settings. The most studied written standardized questionnaires are Hurt, Insult, Threaten and Scream, the Woman Abuse Screening Tool, the Abuse and Assessment Screen, and the Partner Violence Screen (PVS) (Rabin, Jennings, Campbell, & Bair-Merritt, 2009). None of these standardized questionnaires have excellent psychometric properties. A problem with validity testing is that no gold standard for measuring IPV currently exists. It is crucial that the standardized questionnaires do not fail to identify IPV victims. The instrument must be sensitive to the phenomenon it claims to identify. Also, victims identified by the questionnaire, when asked in-depth questions, should be true positives (real victims). If the questionnaire succeeds in identifying those individuals who really are victims, it is said to have a good specificity. Sensitivity and specificity are measured as the percentage of correctly identified individuals. Test–retest reliability (the ability of the instrument to consistently identify IPV when informants are asked a second time) has not been studied for these questionnaires.

The PVS has been validated in several studies and has an advantage over other validated questionnaires in that it takes less than a minute for parents to complete (Feldhaus et al., 1997). The PVS was developed for emergency departments (Feldhaus et al., 1997) and contains just one multi-part question about physical violence: (1) "Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? If so, by whom? A person in a current relationship, a person from a previous relationship, or someone else?" The questionnaire also includes two questions about safety: (2) "Do you feel safe in your current relationship?" and (3) "Is there a partner from a previous relationship who is making you feel unsafe now?" Any one answer of *yes* to question (1) (with an indication that the violence was by a person in a current or previous relationship,) *no* to question (2), or yes to question (3) meets the criteria for IPV exposure. The first question is the most important, and answers to the other two questions do not affect prevalence rates substantially (Feldhaus et al., 1997). The questionnaire does not screen specifically for sexual or emotional abuse. Occurrence of IPV more than a year ago, potentially important in a CAM context, is not included in the questionnaire.

The questionnaire has been rated "good" by the U.S. Preventive Service Task Force (Nelson et al., 2012). The sensitivity of these studies has been found to range from 49% to

71% and specificity from 80% to 94% (Feldhaus et al., 1997; MacMillan et al., 2006). Other studies have found that the PVS identifies victims at a higher rate than other questionnaires A study of PVS in two emergency departments found good sensitivity (ranging from 74% to 90%) and specificity (ranging from 88% to 96%) (Halpern, Perciaccante, Hayes, Susarla, & Dodson, 2005). One study on PVS that included only men found it had lower sensitivity compared with the psychological scale of violence on the CTS (35%), but a somewhat higher sensitivity compared with the CTS physical scale (46%) (Mills, Avegno, & Haydel, 2006). This result may reflect the primary focus of the PVS on measuring physical violence. The ability to predict future IPV was also tested in a study, and it showed a good predictive validity (Houry et al., 2004).

Direct inquiry of children and adolescents about abuse and exposure to IPV is preferable. Only one questionnaire has been tested for reliability in Sweden—the LITE questionnaire (Greenwald & Rubin, 1999). It contains items about child abuse and exposure to IPV and has been used with children as young as 8 years old. The instrument's reliability has been tested and found satisfactory with children 13- to 16-years-old (Nilsson, Svedin, & Gustafsson, 2010). Interpersonal items on the LITE scale have been shown to be related to scores on the clinical scales on the Trauma Symptom Checklist for Children (Briere, 1996). The questionnaire contains eight additional questions about non-interpersonal potentially traumatic events and seven questions about interpersonal events (Nilsson et al., 2010). The questions address such events as loss of a primary family member or relative, car accident, or being in a fire or a natural catastrophe (hurricane, tornado, flood or mud slide). It takes 10 to 20 minutes to fill in. One item ("have seen parents hitting each other or destroying furniture") captures exposure to IPV and three items capture child abuse ("being whipped, beaten or otherwise hurt," "being tied up or locked up," and "being subjected to sexual abuse") but do not specify whether these events occurred inside or outside the family.

Summary

History. From the 1970s studies of IPV have been rooted in the gender–based perspective on violence against women. This perspective focuses on men's violence through the lenses of gender and power. The family violence perspective or individualistic perspective emanating in the 1980s seeks the causes of violence in the individuals perpetrating it. These scholars therefore focus on behavioral, rather than structural, aspects of violence and measure violence perpetrated by women by the same standards as that by men. Violence against women, though an important problem that includes human trafficking, prostitution, female gender mutilation,

and other systemic abuse of women exceeds the more narrow perspective of family violence. Male–perpetrated power and control violence seem to dominate in clinical populations.

Definitions. Child abuse is defined as harmful physical, psychological, or sexual acts conducted against a child by a caregiver. Psychological abuse is especially difficult to assess in cases both of child abuse and of IPV. Child abuse consists of acts of commission, which are different from (also harmful) acts of omission that constitute neglect. The overarching term for abuse and neglect is child maltreatment, and studies of child abuse are often conducted from a child maltreatment perspective. IPV is defined as harmful physical, psychological, or sexual acts or stalking by a current or former intimate partner.

In prevalence studies children and adolescents are usually asked about life-time prevalence, while adults are usually asked about past–year prevalence. Studies of child abuse and IPV vary in terms of which types of violence they include: physical, psychological, sexual or some combination. Different dimensions of violence are measured; chronicity measures how long the violent acts have been occurring, frequency measures how often, and severity describes whether the acts could be considered mild, moderate, or severe.

Double exposure. The term double exposure refers to co-occurrence of child abuse and exposure to IPV, and it is not rigorously defined. Child abuse can be exerted at different times from IPV by the same perpetrator, and it can be perpetrated by the victim of IPV, or by both parents.

Prevalence of child abuse and IPV. The past-year prevalence of IPV in Sweden is around 7% and is reported equally by men and women. Around one in four women report a life-time prevalence of IPV, which is higher than that in men, and women are more often subjected to repeated and more severe violence. In Sweden more than 10% of adolescents report exposure to IPV a single time and around 5% report multiple times. Around 15% of adolescents report being physically abused a single time and around 5% multiple times. Double exposure is common. In the few studies conducted in CAM the prevalence of IPV among patients range from 20% to 50% depending on the sample studied. Internationally, very few studies have looked into the prevalence of child abuse in CAM, but they show that approximately a third of patients are affected.

Etiology of perpetration. Feminist theory holds the view that violence against women is a structural phenomenon and male–perpetrated violence is the problem that must be addressed. Gaining or maintaining power and control is the drive behind this gender-based violence. Intimate terrorism or coercive controlling violence is a typically male dominant type of violence. Attachment theory explains how a child's attachment pattern will transcend into

intimate relationships in adulthood. If learned as a child that *I am not worthy of love* and that others will not respond supportive in times of danger, violence in love relationship will be more probable. Certain combinations of attachment styles in intimate partnerships are more risky for IPV to evolve. The individualistic perspective explains child abuse and IPV through different types of psychopathology (e.g. PTSD and personality disorder), alcohol abuse, and temperament. Social risk factors for perpetrating child abuse have been consistently identified and a few studies have documented psychopathology among parents who abuse their children. Chronic diseases and disabilities in children are risk factors for being abused. Childhood abuse predicts abusive behavior in close relationships in adulthood, so called intergenerational effects. Explanations for co-occurrence of child abuse and IPV are scarce. A few studies have found more risk factors in families with both forms of violence than in those with only one form of violence.

Consequences. In general, both internalizing and externalizing symptoms have been found to be a consequence of abuse and exposure to IPV. More research has been conducted on child abuse than on children's exposure to IPV and a strong link has been found between abuse and behavioral problems. Socio-economic factors have been linked to both child abuse and exposure to IPV, and effects of double exposure have been found. The possible unique effects of either child abuse or exposure to IPV are sparse and mixed. Among CAM patients, more elevated symptoms have been found in patients exposed to IPV than in non-exposed patients, and conduct disorder and PTSD were found more often among abused and exposed patients. A common methodological problem in these studies is that those that measure exposure to IPV do not control for child abuse and those that measure child abuse do not control for exposure to IPV.

Disclosure of child abuse and IPV. Health care providers and clinicians must consider ethical issues when asking routinely about child abuse and IPV. How to deal with the role of children in family violence and how to respond when patients or parents confirm child abuse or IPV are important ethical issues. Which family members to ask about child abuse and IPV and how to evaluate the conflicting answers complicate the introduction of routine inquiries in CAM. A written inquiry is an option for asking about child abuse and IPV. Most studies show that women tolerate routine questions about IPV, and a few studies have shown that children do not mind being asked sensitive research questions about violence and sexual abuse. The WHO defined concept of a *screening* activity, does not apply to the suggested routine inquiries about violence in CAM.

Moderating factors. No clear pattern of the importance of gender in child abuse and exposure to IPV has been found. Maltreatment at a younger age is more damaging, but it is unclear specifically what kind of abuse or neglect is most damaging. The consequences of child abuse and exposure to IPV can be moderated through the various dimensions of chronicity, frequency, severity, and types of violence (verbal, psychological, or physical). A dose-response relationship tends to exist between the moderators and the consequences. Parental functioning can influence children's symptoms, as can individual child-related factors such as cognition and social competence.

Maltreated children are at increased risk for violence in the community, and such additional exposure can increase externalizing symptoms and PTSD. Exposure to other types of victimization and family dysfunctions can also exacerbate symptoms. According to the poly-victimization hypothesis the more different types of traumas children experience, the greater their risk for clinical symptoms. A few studies undertaken in CAM have shown that poly-victimization is associated with more behavioral symptoms and PTSD than exposure to only one type of victimization.

Concluding remarks. We know that around one in ten of teenagers in Sweden are abused in their family at least once, and the same prevalence is reported for exposure to IPV. Approximately one in twenty report being abused or exposed to IPV multiple times. The overlap between child abuse and exposure to IPV exceeds 50%. A few international studies indicate that exposure to IPV among CAM patients is higher than in the general population. Data on how many patients in Swedish CAM are affected by abuse and IPV are meager, but the prevalence may be substantial. Knowledge is being developed about the problems associated with disclosing IPV in adult health care, and the Swedish NBHW request CAM professionals to routinely bring up the issues of child abuse and IPV with patients and parents. The specific ethical, practical, and safety problems of routinely addressing child abuse and IPV through interviews or questionnaires in CAM need to be further investigated.

Among children in the general population, abuse is associated with psychological and behavioral problems, and some studies show those problems are associated with exposure to IPV as well. Exposure to violence in the family in combination with violence outside the family (so called poly-victimization) can exacerbate symptoms. A few international studies suggest that adolescent patients in psychiatric care who have been exposed to violence in and outside their families constitute an important subgroup because they show more serious symptoms. However, more research is needed into whether those associations between violent experiences and symptoms holds true for patients in CAM in Sweden, and whether these

violent experiences result in different or worse symptoms than those found in patients not exposed to violence.

It is not clear whether child abuse and exposure to IPV are associated with different symptoms, or whether one type of violence is more harmful than the other. A few studies have shown that double exposure (child abuse and exposure to IPV) is associated with more symptoms than only one type of violence, but more research is necessary into both of these questions.

In sum, more studies are needed of the prevalence, both internationally and in Sweden, of child abuse and exposure to IPV in young people in psychiatric care, and these may be aided by routine inquiries at intake. But we first need to know what kind of problems CAM clinicians experience when asking routinely about child abuse and IPV; what kind of psychological and behavioral problems are associated with violence in and outside the family for CAM patients, and do violence-affected patients differ from other CAM patients? These questions will be addressed in the studies in this thesis.

The current studies

Aims of the thesis

There are very few studies of the prevalence and consequences of child abuse and exposure to intimate partner violence (IPV) among child and adolescent mental health care (CAM) patients. Attitudes in clinicians when implementing routine questions in CAM about child abuse and IPV have not previously been investigated.

The overall aims of this thesis were (1) to document the prevalence of child abuse and exposure to IPV among the patients, (2) to study the clinicians' attitudes towards asking routinely about IPV, (3) to compare psychiatric symptoms between patients with (a) experience of family violence (child abuse and/or exposure to IPV) (b) experience of violence outside the family and (c) patients with no such experiences, and (4) compare psychiatric symptoms between patients who had both witnessed IPV and been subjected to child abuse with those either subjected to child abuse or those who had witnessed IPV, but not both.

Study I

Aims

The aims of this exploratory study were to (a) document the prevalence of mothers of patients in CAM exposed to IPV, (b) compare possible links between background variables and IPV exposure with links to non-IPV cases, and (c) identify problems clinicians might have with conducting routine inquiries about IPV.

Methods

For one year clinicians verbally asked patients' mothers whether or not they had been subjected to IPV. Clinicians were psychologists, social workers and nurses. Child psychiatrists were not included in the study, because they did not conduct intake interviews. Control cases (charts in which no maternal reports of IPV had been made) were selected randomly among other patients. The two groups were compared with regard to the child's age, sex, number of siblings, custody, residence, referring person/agency, reason for seeking care, mother's level of education, incidence of legal proceedings/disputes, migration, and any incidence of physical violence towards the child from the partner of the mother. Clinicians were asked about any possible obstacles they faced in asking routinely about IPV.

Results

The proportion of IPV against the mother found in the patients' charts before conducting the routine questions was 6%. Of the 438 mothers eligible for inclusion in the study, 308 were asked about the occurrence of IPV and 66 (21%) reported that they had been subject to IPV. There were no differences between the study group and the control group regarding the child's age, sex, the mothers' age, level of education, or whether or not she had been born in Sweden. The mothers in the study group had sole custody more often and more inter-parental legal disputes than those in the control group. Compared with those in the control group, children in the study group lived more often only with their mother, were more often subjected to violence by the mother's partner, were less often referred to CAM by their schools, and were more often referred for "relational problems."

In 130 eligible cases (30%) the question about IPV was not asked. These cases did not differ with respect to the child's sex or place of residence from those in which the question was asked. The question about IPV was, however, asked more often when the child was younger or the mother sought care of her own volition and less often when the case was referred from the school. The question was also asked more often when the reason for referral was "relational problems."

When asked why they had not asked routinely about IPV, clinicians responded that they felt the subject was "taboo." They did not want to be seen to accusing the family, especially the mother, and felt it was unethical to ask such a sensitive question of families that were already extremely socially disadvantaged and vulnerable. Non-response varied between clinicians, and those with knowledge about and experience with IPV problems were more inclined to ask.

Discussion

The known proportion of IPV cases among mothers in the clinic before the study began was 6%. When asked routinely, 21% of mothers confirmed that they had been exposed to IPV. Because a third of the eligible mothers were not asked about IPV and a third of the mothers confirming IPV were not included in the study, the found prevalence must be interpreted with care. The true prevalence is estimated to be between 15% and 30% of the mothers. Because of the found prevalence and possible links between exposure to IPV and psychiatric symptoms in children, it is advisable to ask routinely about IPV in CAM.

When the reason for referral is relational problems, it may indicate a need to be particularly observant about the child's possible experience of family violence. Fewer IPV cases were referred from schools than from elsewhere and these were more often missed in the routine

inquiry, which explain why a low prevalence was found in this group. Schools may miss referring these cases to CAM, or may alternatively refer them to social services. Mothers reporting IPV more often lived alone and had sole custody of the child, which indicates that it is likely easier to talk about violence no longer living with the perpetrator. Because of social problems and a high incapacity rate in the catchment area, the prevalence found cannot be generalized to other CAM clinics, but further studies of prevalence are recommended.

The missed opportunities to ask about IPV were 30%. Education and more awareness of IPV among clinicians are necessary in order to implement routine questioning about IPV. Routine questions about IPV may be more reliably performed using standardized, written questionnaires.

Limitations were that IPV was not rigorously defined, affirmative answers on IPV questions were not checked against other informants or sources, and fathers were not asked about IPV.

Study II

Aims

The aim of this study was to explore clinicians' experiences of routinely asking about IPV in CAM, especially in those cases in which clinicians did not in fact ask the questions.

Methods

Clinicians who had recently started to conduct written inquiries about IPV at intake interviews with parents took part in a semi-structured interview about their experiences with this routine. Clinicians were psychologists, social workers, and nurses. Child psychiatrists were not interviewed because they did not conduct intake interviews. Thematic analysis was used to interpret the data. A total of 153 extracts were coded from interviews with 14 clinicians.

Results

The written questionnaire was used by clinicians in 75% of intake interviews during the first year of testing this procedure. Three main themes describing the use of the questionnaire were found in the interviews: (a) *Constraint*. This theme includes negative opinions about asking routinely about family violence, marked by anxiety that use of the questionnaire could put the parent at risk for more violence or could damage the relationship with the parent and concern that other things were in more urgent need of discussion; (b) *Uncertainty*. Clinicians expressed a positive attitude to the idea of asking routinely about IPV, but also voiced self-criticism and described problems with the context or the preconditions; (c) *Utility*. Clinicians

expressed their appreciation of the regularity of the questionnaire and the ordered way it allowed them to ask sensitive questions.

Discussion

The fear of escalating violence might be an unnecessary worry, because no such clinical observations have been noticed and few mothers reported ongoing violence. Still, safety issues are very important to attend to when asking about IPV. Worries about damaging the relationship with the patient may be more due to the clinician's conceptions than to patient–related factors. Introducing routine questions about IPV is a long process, but overall, the written inquiries worked well in the intake situation. In some cases it is inappropriate to ask about IPV, but these cases should not be more than 5% to 10% of intake interviews, when a parent or foster parent is present to answer the questionnaire. Family intake must be complemented with private meetings in which the issue of IPV is brought up. The practical and emotional difficulties perceived by clinicians must be met by the health care provider with both monitoring and support. The positive experiences reported by clinicians about the routine inquiry were linked to their (a) knowledge about the prevalence of IPV among patients, (b) frequent discussions and consultations with the researchers, and (c) access to treatment options. Some cases of past-year IPV probably remain undisclosed for reasons that warrant further research. Two of the authors were colleagues of the participating clinicians. This might have influenced the clinician's responses and is a limitation of the study.

Studies III & IV

The two studies used the same methods to obtain data about patients' exposure to violence. In Study III patients exposed to family violence (abused and/or exposed to IPV) and/or exposed to violence outside the family were compared with patients not exposed to any kind of violence in or outside the family. Study IV used an expanded sample of those in study III. The expanded sample in study IV made comparisons regarding psychiatric symptoms between doubly exposed patients and patients who were either abused or exposed to IPV, but not both.

Aims

Study III

The aim of the study was to relate 9- to 17-year-old CAM patients' self-reported experiences of violence exposure to their current psychiatric symptoms, and to compare patients exposed to violence (a) in the family, (b) outside the family, or (c) both, with patients who reported no such exposure.

Study IV

The aims of the study were to:

(1) examine the concordance/discordance between children's and parents' reports of occurrence of IPV;

(2) compare self-reported psychiatric symptoms, impact of experienced violence, and clinician–assigned diagnoses between CAM patients who had (a) both witnessed IPV and been subjected to child abuse or (b) been subjected to either child abuse or witnessing IPV, but not both;

(3) explore the importance of concordance/discordance between children's and parents' reports of occurrence of IPV on (a) self-reported psychiatric symptoms, (b) perceived long-term impact of IPV and/or CA, (c) psychiatric diagnoses according to DSM-IV, and

(4) explore the relative impact of background factors and exposure to violence, both within and outside the family, on psychiatric symptoms and diagnoses.

Methods

Study III

The study population consisted of 305 9- to 17-year–old patients consecutively enrolled over 18 months in CAM in a Swedish city. Background information was obtained about reason for and origin of referral, habitation, custody, and migration. Patients' self-reported exposure to family violence and violence outside the family was obtained through the Lifetime Incidence of Traumatic Events (LITE) questionnaire. Psychiatric symptoms and functional impairment were measured using the self-reported Strength and Difficulty Questionnaire (SDQ) self-report. The subscales of emotion, conduct, hyperactivity, and peer problems and the total problems scale were used. The impact of the traumatic events were measured through self-report on the LITE questionnaire. Diagnosis and global assessment of function were obtained from charts.

Study IV

The expanded sample consisted of 578 patients. Background variables and dependent variables obtained were similar to those in Study III. Rates of child abuse and rates of exposure to IPV were obtained. Other factors analyzed in relation to child abuse and exposure to IPV were age of first experience, frequency of violent acts, and impact. In the initial analyses of background variables, even patients not abused or exposed to IPV (N = 287) were included. The full dataset were also used to analyze whether children abused only or exposed to IPV only or both differed from patients not exposed to any of these types of violence with regard to self-reported symptoms and assigned diagnoses. Parental reports on IPV were

obtained parallel to children's reports. The chi-square test was used to analyze the importance of concordance/discordance on IPV reports between children and parents for diagnosis. Independent *t*-tests were used to test differences between SDQ total scale and conduct problems scale and LITE post-impact scores in comparison with concordance/discordance. In the rest of the analyses, however, only patients abused or exposed to IPV were included in the statistical analyses (n = 291). SDQ total scale, SDQ conduct scale, SDQ impairment scale, and LITE impact post-trauma were tested in hierarchical linear regression models. Predictors were entered in the following order: gender, age, age of first experience of abuse or exposure to IPV, frequency of IPV, frequency of abuse, double exposure and violence outside the family. A binary hierarchical logistic regression was conducted to predict PTSD diagnosis using the same independent variables as in the hierarchical regression analysis.

Results

Study III

Forty eight percent of the patients reported exposure to family violence, either in combination with violence outside the family (27%) or solely within the family (21%) (Figure 1). Nineteen percent of the patients reported violence outside the family, but not family violence. Patients exposed to violence both within and outside their families cohabited less often with both parents, lived more often in residential care, institutions, foster homes, etc., and more often had parents with single custody than patients who had not been exposed to violence within or outside the family. Patients exposed to family violence only were more often born abroad than those in the no-violence group. There were more girls among those exposed to family violence than among those exposed to violence outside the family.

Patients exposed to violence both within and outside the family rated the impact post-trauma as more negative than those exposed to violence in the family only, who rated the impact post-trauma more negative than those exposed only outside the family.

Patients exposed to violence both within and outside the family differed significantly from those exposed to violence neither in nor outside the family; they reported more symptoms on the SDQ total problems scale and the peer problems scale, had marginally more conduct problems, and were more often diagnosed with PTSD.

Study IV

Fourteen percent of the patients reported abuse only, 14% exposure to IPV only, and 22% both (double exposure; Figure 2); 33% of parents reported IPV. No differences in psychiatric

symptoms or diagnoses were found between those exposed to IPV only, abused only, and neither abused nor exposed to IPV.

Doubly exposed patients were more often referred from social services and less often from schools, were more often living with a single parent under single parent custody, and were more often exposed to violence outside the family compared with patients neither abused nor exposed to IPV. Children born abroad were abused more often than children born in Sweden.

The concordance between parents' and patients' reports of occurrence or non-occurrence of IPV was as high as 77% (Cohen's kappa: .69). In 12% of cases patients reported IPV while the parent did not, and in 11% parents reported IPV when the child did not. The negative impact of the events post trauma was rated as more severe when children and parents agreed on IPV than when children reported IPV but the parent did not. Children who reported IPV when their parent did not were more often assigned a mood disorder diagnosis.

Comparisons between the three groups of exposed patients leaving out the non-exposed.

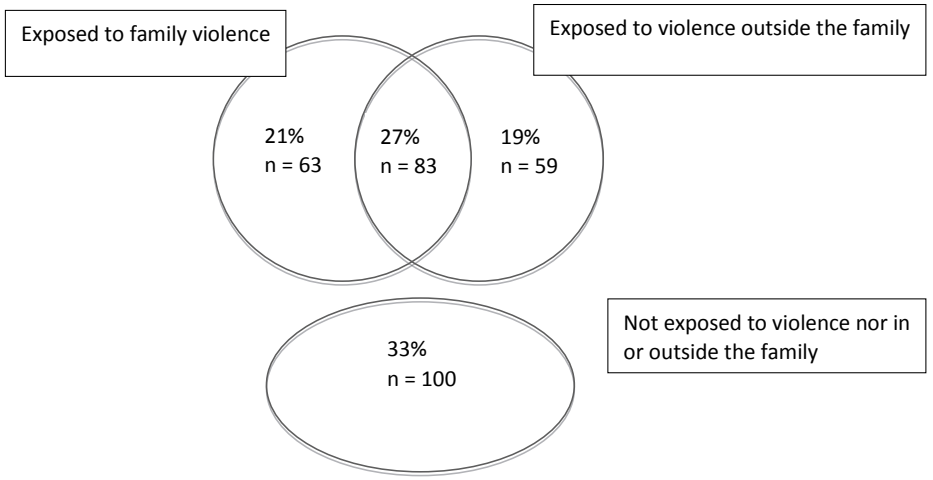
The doubly exposed patients reported more psychiatric symptoms on the total SDQ scale and the conduct scale, rated the impact of the events as more severe both peri-trauma and post-trauma, and the decrease of impact from peri- to post-trauma was lower compared with patients who were abused only or exposed to IPV only. The doubly exposed patients were also more often assigned a PTSD diagnosis and were more often exposed to violence outside the family.

The hierarchical regression analyses of self-reported symptoms on the SDQ total scale, score on the conduct scale, and post-trauma impact showed significant associations. The model for the SDQ impairment scale turned out not to be significant. Older age predicted higher ratings on SDQ total problem scale. No single predictor contributed significantly to the final model of SDQ conduct scale. More frequent acts child abuse and frequency of witnessing IPV, were significant predictors of the severity of post-trauma impact.

The logistic regression model showed that double exposure was a significant predictor of PTSD.

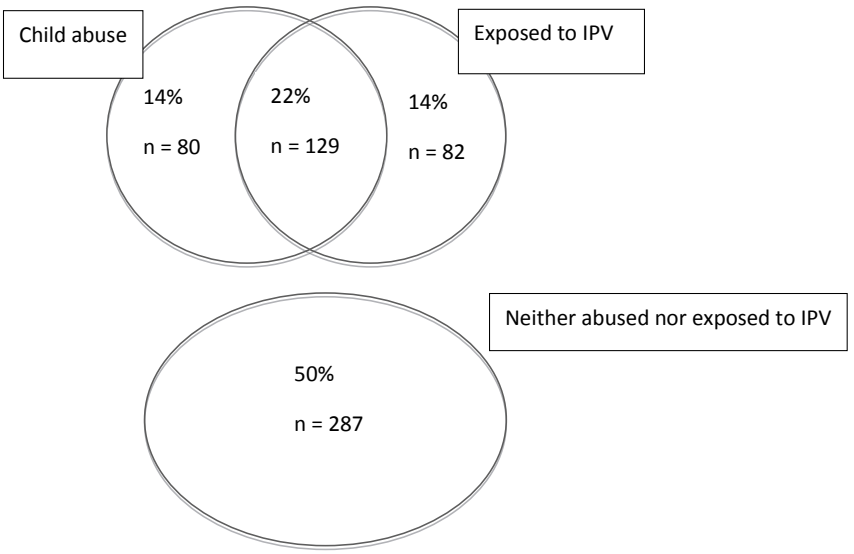
- Figure 1.

Study III. Exposure to family violence, violence outside the family or no exposure.
N = 305



- Figure 2.

Study IV. Comparisons of patients abused only, exposed to IPV only, and both abused and exposed to IPV (doubly exposed) with those not exposed to either. N = 578



Discussion

Study III

The proportion of patients exposed to family violence (with or without exposure to violence outside the family) was 48%. No Swedish study on prevalence of family violence in CAM populations has been conducted. A chart review study in Finland among CAM patients showed the prevalence of family violence to be 25%.

Living with both parents is associated with less exposure to the combination of violence in and outside the family, indicating that the two-parent family may be a protective factor. An alternative interpretation, however, is that patients in two-parent families may find it difficult to disclose family violence. The association between exposure to violence both within and outside the family and single custody may be due in part to previous disputes over the child in this group.

The cultural acceptance of corporal punishment among refugees may explain the over-representation of family violence among children born abroad. The elevated stress and socio-economic disadvantage among this group may also contribute. Boys tend to be more at risk of exposure to violence outside the family than girls. Patients exposed to violence both in and outside the family rated the violence more negatively post-trauma than patients exposed to violence outside the family only. This finding is in line with an ecological transactional framework—proximal factors have more impact on child development. The dose-response relationship found between exposure to violence and self-reported impact, self-reported psychiatric symptoms, and PTSD is in line with other studies in CAM. Violence exposure outside the family is a contributing factor to psychiatric symptoms in patients also exposed to family violence. Age of onset of family violence was 2.5 years earlier than first experience of violence outside the family, indicating that interventions targeting family violence could possibly reduce exposure to violence outside the family.

Study IV

The prevalence of a third of patients abused and a third of patients exposed to IPV is at least five times higher than reported by adolescents in the general population in Sweden. Double exposure was common among the patients. The prevalence of both child abuse and exposure to IPV found in this study was similar to that found in a Norwegian study in CAM. Other studies that found lower and higher levels of child abuse and IPV used different methodologies to that in the present study and the Norwegian study. Time frame, informant, and type of abuse also differed in these studies.

Child protection is a major obligation of the social services, which could explain why many doubly exposed children were referred from this source, while very few were referred from schools. Doubly exposed children may be referred or reported in schools to social services instead of to CAM. An alternative interpretation is that this group remains unidentified. Double exposure was associated with not living with both parents or not having parents with joint custody compared to patients not abused nor exposed to IPV. The probable explanation is that the family separated because of the family violence. Alternatively, child abuse and IPV in families living together may be more difficult to disclose.

Of the violence affected patients those with double exposure were more likely to have PTSD and more self-reported symptoms than patients who were abused or exposed to IPV. This finding is in line with other studies in CAM. Agreement about IPV between children and parents was associated with greater post-trauma impact in the children. Other studies have found that child/parent agreement about the occurrence of IPV is related to higher levels of violence, which may explain the increased severity of post-trauma impact in those children.
Doubly exposed patients' rating of the negative impact both peri- and post-trauma as more negative than those abused or exposed to IPV can partly be explained as a result of the number of violent acts experienced. PTSD can be explained as a result of the cumulative effect of double exposure.

Diagnoses were analyzed by group, which may have restricted our ability to find associations between specific conduct disorders and violence exposure.

Being doubly exposed is an important factor in explaining PTSD, and exposure to many violent acts is an important factor in explaining the severity of post-trauma effects.

Summary of the four studies

The known proportion of maternal IPV victims in the clinicians' charts was 6% prior to the first study. Study I showed that routinely asking about IPV dramatically increases the known prevalence.

Study II, which had a qualitative approach, showed that implementing routine questions about IPV is affected by clinicians' perceived obstacles. Organizational support is necessary to make the process work.

In study III, of the sample of patients studied at the CAM unit, about half reported exposure to family violence (child abuse and/or exposure to IPV), a rate several times higher than in Swedish adolescents in the general population. Children experiencing violence outside the family in addition to violence in the family reported more psychiatric symptoms, and they

were more often assigned a diagnosis of PTSD than children not exposed to any kind of violence. Impact of events was more severe after family violence compared to the impact of events after the violent events outside the family.

In Study IV the prevalence of patients abused and of patients exposed to IPV was reported to be at least five times higher than among adolescents in the general population in Sweden. A high prevalence of child abuse and exposure to IPV has been documented in other studies of CAM patients. Doubly exposed patients had more psychiatric symptoms, were more severely impacted by the events, and were more often assigned a PTSD diagnosis compared with those either abused or exposed to IPV (but not both). Concordance between children's and parents' reports on IPV was high. Both agreement and disagreement were associated with the children's symptoms.

General discussion

The first aim of this thesis was to document the prevalence of child abuse and exposure to IPV among patients in CAM. The second aim was to investigate clinicians' attitudes when implementing routine written questions about IPV. The third aim was to investigate associations between psychiatric symptoms and family violence (child abuse and/or exposure to IPV) and/or violence outside the family and to compare those results with symptoms in patients with no such experiences. The fourth aim was to compare psychiatric symptoms in patients both abused and exposed to IPV with those of children reporting only abuse or only exposure to IPV. A related aim in study IV was to study the agreement between child and parent reports of IPV.

Prevalence of child abuse and exposure to IPV among CAM patients. In study IV 14% of the 578 patients reported abuse only, 14% exposure to IPV only, and 22% reported both (double exposure) (figure 2). The prevalence of both child abuse and IPV was thus 5 to 10 times higher than that found in self-reports from adolescents in the general Swedish population (Annerbäck et al., 2012; Janson et al., 2011). The prevalence of child abuse and IPV in CAM is similar to that found in a Norwegian study using similar methodology and measures (Ormhaug et al., 2012). In Sweden, as in other countries, the proportion of patients attending CAM clinics who have been exposed to IPV is substantial (Broberg et al., 2011; Ford et al., 2011a; McDonald et al., 2000; Olaya et al., 2010; Ryynänen et al., 2015; Stewart & deBlois, 1981).

Abused patients were as frequent as those exposed to IPV in the present study and a similar prevalence has been documented in another study in CAM (McDonald et al., 2000).

Whether the prevalence found in this disadvantaged sample of the population is representative of more mixed catchment areas remains to be studied. The Norwegian study by Ormhaug et al., however, was conducted in high- and mixed income catchment areas, indicating that the numbers are indeed representative for other areas as well (Holt, 2015).

Double exposure in CAM patients was not unusual (22%). Co-occurrence of child abuse and exposure to IPV in CAM has been documented in other CAM studies (Ford et al., 2011a; Ford et al., 2011b; Lamers-Winkelman et al., 2012; Telman et al., 2015).

About half of the patients reported violence outside the family, and about one in four had experienced violence both in and outside the family (figure 1). One study among CAM

patients have also found that subjection to different kinds of violence outside the family is common, as was the case in one study in this thesis (Ormhaug et al., 2012).

Asking questions routinely and the process of uncovering child abuse and IPV. Child abuse and IPV are conditions already known by patients or parents when attending the clinic, and routine questions help them to disclose or talk about these sensitive subjects. The Swedish NBHW recommends professionals in CAM ask routinely about child abuse and IPV, and the rigorous preconditions attached to screening programs are not part of these recommendations (Socialstyrelsen, 2014a). As shown in study II, clinicians' great concern about matters of safety and integrity may even be an obstacle to their raising the subject with patients and their parents. The anxiety about undermining trust in their relationship with the parents and endangering women is not, however, mirrored in studies of the attitudes of the women being asked. Instead, women are generally positive about being asked routine questions about IPV in health care and any adverse effects are minimal (Nelson et al., 2012). By showing concern and being informed, clinicians can minimize much of the possible discomfort parents may feel (Feder, Hutson, Ramsay, & Taket, 2006; Plichta, 2007). When identified, victims of child abuse and IPV must be protected from further violence and offered proper and adequate care as directed by the Swedish NBHW (Socialstyrelsen, 2014b). But health care professionals must act for the safety of family members exposed to violence regardless of whether the violence is uncovered as a response to routine questions or by any other way. Unfortunately, according to a recent national inspection in Sweden (Inspektionen för vård och omsorg, 2015), abused children and those exposed to IPV attending health care do not receive appropriate attention and assessment.

In clinics where family intake interviews are standard, they must be complemented with individual, private meetings. When confirmative answers are received, they must be followed up with probing questions to the parents, the child, or both, in privacy as instructed by the Swedish NBHW to ascertain whether mandatory reporting to the CPS is warranted (Socialstyrelsen, 2014b).

The results in these studies show that routine questions increase the identified cases of IPV in CAM. Increased rates of IPV cases through routine questions have also been documented in adult counseling (Stith, Barasch, Rosen, & Wilson, 1991; Todahl & Walters, 2009). Before introducing routine questions about IPV in study I, the known proportion was at a low 6% in clinicians' charts. In response to routine verbal questions, a fifth of mothers at CAM said they were affected by IPV; with the written inquiries used in studies III and IV, the prevalence rose to 33%. This increasing prevalence during the implementation process points to the

importance of asking routinely to uncover IPV. It takes time for a workgroup to implement routine questions, and support from the health care provider is needed. Over time, the IPV question was asked more consistently, increasing from 70% of mothers in study I to 86% of at least one parent in studies III and IV. Of the intake interviews during the data collection period for study III and IV, where a parent or legal guardian actually accompanied the child the questionnaire was used to a high degree (94%).

Because child abuse is associated with feelings of shame, many cases will not be disclosed spontaneously by children. Asking 9- to 17-year-old patients routinely about abuse and exposure to IPV worked well during studies III and IV and can be recommended. Studies of adolescents participating in research about child maltreatment show that harm from answering such questions is low (McClinton Appollis et al., 2015). Whether routine written questionnaires increase the number of identified abused patients is not known. More studies are needed on children's opinions of how health care professionals best uncover violence.

The information gained from routine questions about violence is highly relevant for the clinician assessing child psychiatric symptoms. Both child abuse and exposure to IPV are strongly linked to psychiatric symptoms (Cicchetti & Valentino, 2006; Gilbert et al., 2009). If violence exposure is part of the child's history, but not weighed into the assessment, the diagnosis assigned may be incorrect. The variety of stress-related trauma reactions can mistakenly be attributed to ADHD, bipolar disorder, depression, conduct disorder, oppositional defiant disorder, and other conditions. Even if the diagnosis is correctly assigned, the impact of violence may still play an important role in maintaining symptoms. If ongoing violence is not identified during assessment and treatment, interventions may be ineffective or may even worsen the situation for the child. Treating a child's behavioral problems is inappropriate if the child is being beaten after leaving the clinic. It will damage the child's trust in adults and violate their rights to protection and participation according to the UN Convention on the Rights of the Child (United Nations, 2009).

Knowledge about the impact of child abuse and exposure to IPV can inform the clinician and aid in the choice of appropriate treatment modalities. If past exposure to violence is not identified, clinicians will have difficulty understanding trauma reactions or family dynamics. Psychotherapy may not be beneficial and such patients will likely drop out of treatment over time. PTSD, which was related to child abuse and exposure to IPV in the studies in this thesis, should be treated with trauma-focused therapies (Silverman et al., 2008). TF-CBT is an option that has been found effective in CAM (Jensen et al., 2013). In Sweden, TF-CBT is being tested in a randomized controlled study (Broberg & Hultmann, 2011).

Consequences of child abuse and exposure to IPV in CAM patients. CAM patients abused only or exposed to IPV only did not differ in symptoms or diagnoses when compared with patients not abused or exposed to IPV. Exposure to a single type of family violence may signal that the violent act happened once only. This possibility is supported by the finding that doubly exposed patients were more often exposed to violent acts multiple times. The number of different *types* of violent events and the *frequency* of violent acts may interact and affect both the degree and type of symptoms. If so, the conclusion is that if patients have been exposed to any kind of family violence just once, it will not likely make their symptoms any more severe than those of patients not exposed to violence. Chronicity and severity of child abuse and IPV can also influence how children react. Furthermore, the degree of involvement in IPV can influence their reactions.

Abused patients did not show more symptoms than those exposed to IPV. Prospective studies in the general population, however, have found more behavioral symptoms in abused children than in those exposed to IPV (Maughan & Cicchetti, 2002; McCabe et al., 2005). In CAM no such comparisons have been made.

CAM studies that have shown high levels of symptoms for abused or IPV-exposed patients may have done so partly because of either double exposure or exposure to additional adverse childhood experiences (Ford et al., 2011a; Olaya et al., 2010; Ormhaug et al., 2012; Stewart & deBlois, 1981; Telman et al., 2015). Thus, when a child or a parent confirms abuse or IPV, an additional question should be asked: "Did any additional interpersonal violent or adverse event happen?" Exposure to several types of violence and multiple exposures will increase the probability that psychiatric symptoms are linked to experiences of violence.

Family violence in combination with violence outside the family was associated with more self-reported problems in general, more self-reported peer-problems, and more diagnoses of PTSD. The elevated levels of PTSD and behavioral symptoms found among these patients are in accord with studies on children who have been abused (Gilbert et al., 2009), exposed to IPV (Evans et al., 2008; Wolfe et al., 2003), or exposed to community violence (Fowler et al., 2009). Links between interpersonal violence, PTSD, and behavioral problems have also been found in CAM studies (Ford et al., 2011a; Ford et al., 2011b; Lamers-Winkelman et al., 2012; Ormhaug et al., 2012; Telman et al., 2015).

Double exposure and unique effects. The co-occurrence of child abuse and exposure to IPV was high (44%) and thus in accord with other studies in the general population, as well as in clinical and high risk samples (fig. 2) (Herrenkohl et al., 2008).

Double exposure was associated with more symptoms, more negative impact, and more PTSD diagnoses than child abuse or exposure to IPV only. Studies suggest that doubly exposed children are exposed to additional risks (Herrenkohl et al., 2008), and this may hold true for the sample studied in this thesis as well. Doubly exposed patients more often lived with a single parent or in a fostering or institutional setting. That single custody was more common in this group may indicate more disputes over custody and visitation. Doubly exposed patients were also more frequently exposed to violent acts outside the family. A few studies have shown serious risk factors in families where child abuse and IPV co-occur, such as substance abuse, a criminal lifestyle among fathers, and mental health problems in both parents (Robinsson, 2014). Such household dysfunctions were not studied in this thesis, but may be important aspects to consider in clinical assessments as well as in future studies.

Poly-victimization. The studies in this thesis investigated the influence of a few types of violent incidents outside the family: physical violence, sexual assault, and physical restriction (being tied up or locked in). Other studies of poly-victimization typically include other types of adverse experiences in the family (e.g. incarceration of a parent, parental substance abuse or psychiatric disorder) or outside the family (e.g. witnessing assaults or being robbed). One study in CAM found that 8% of patients had experienced an average of four types of maltreatment and adversity, and such poly-victimization was associated with PTSD (Ford et al., 2011b). Patients studied in this thesis may have been poly-victimized, i.e. affected by additional types of violence, adversity, or household dysfunctions. Some of the poly-victimized patients will probably become the perpetrators of violence as they grow up. This points to the importance of professional efforts to stop violence early in children's lives and offer appropriate support and treatment.

PTSD was more prevalent among patients exposed to family violence than those exposed to violence outside the family, and the impact of family violence was rated more negatively than the impact of exposure to violence outside the family. These findings are in line with the concepts of *proximity* and *distance* in the ecological transactional framework (Cicchetti & Valentino, 2006). The proximal events of family violence had a more negative impact than the more distal violent events experienced outside the family. Also family violence was experienced at a younger age than violence outside the family. Interventions in family violence may thus spare children from future violence outside the family. If not stopped, families and therapists will have a difficult time to alter the trajectory of adolescents who have also been poly-victimized.

Strengths and limitations

Children's and parents' reports about violence were obtained in real-life situations. When clinicians collected information from the patients, the primary intention was to understand children's psychiatric symptoms from the perspective of violence and then to offer interventions. The clinicians may thus have been concerned and asking the questions with compassion. The health care setting may have facilitated patients' and parents' ability and willingness to truthfully report violent experiences.

Patients' self-reports are a strength in the analysis of the associations between exposure to violence and symptoms because they provide first-hand information. Children may report violence exposure more truthfully than adults, presumably because they are not fully aware of the practical and relational consequences of disclosure. Self–reports of the post-trauma impact of violent events have high content validity because they reflect the personal meanings of the events.

The instruments used to obtain information about violence had been tested for reliability and validity. Agreement between parents and children about the central concept of IPV were high.

The definition of IPV in the LITE questionnaire was mainly restricted to physical violence. The reports from patients may thus reflect a fairly delineated concept of child abuse, which could be a shortcoming because psychological violence was not included in the concept.

Diagnoses were assigned by clinicians and obtained from charts. Clinically assigned diagnoses generally have lower validity and reliability than structured diagnostic interviews.

Diagnoses were categorized in groups and only the main diagnosis (DSM 4) was analyzed. The groups constructed subsequently left out some cases because they did not fit into our categories (n = 60). Some patients did not receive an F-diagnosis (n = 91) or received no diagnosis at all (n = 26). Nearly a third of patients were omitted from the analyses of diagnoses for these reasons.

About a third of patients did not answer the questions about abuse and exposure to IPV; this may have influenced prevalence rates and associations with dependent variables.

The studies were conducted in one CAM unit in a disadvantaged catchment area. Only future studies can show whether these results can be generalized to mixed socio-demographic areas, as shown in another study in Norway.

Reported peri-trauma reactions may have been influenced by recall bias in the patients. These reactions should ideally have been measured directly after the events occurred. But this measure was not crucial to our findings or conclusions.

Parents may have underreported IPV exposure, especially if it was ongoing, and especially if the child was still living with parents who co-habitated.

Clinical conclusions

- If questions about violence are not actively approached by clinicians, these issues may remain hidden. Being unaware of patients' historical violent experiences or ongoing experiences of violence may lead to wrong diagnoses or ineffective interventions.
- CAM providers must consider asking routinely about child abuse and IPV, as requested by the Swedish NBHW. Routine inquiry about IPV is a good way for clinicians to start this process. Identifying IPV may lead to uncovering child abuse given the large overlap between the two phenomena. A suggested option to minimize discomfort is the use of written questionnaires.
- Issues of ethics, privacy, integrity, and safety must be discussed among clinicians when routine questions are introduced. Both practical difficulties and the feelings evoked in clinicians when broaching the topic of violence must be discussed, especially at the start of implementing routine questions.
- Private meetings are imperative when discussing matters of family violence, both with parents and with children.
- It is important for clinicians to know about the dynamics of family violence in order to understand how to respond when families disclose violence. Structured in-depth questions should be asked to assess the types, duration, severity and frequency of violence. Structured risk assessments should be applied to assess whether patients and parents are safe during treatment.
- Violence exposure in different domains should be asked about, because poly-victimization is not unusual and is associated with various levels and types of psychiatric symptoms.
- Clinicians should master trauma treatment in order to ensure adequate interventions for their patients.

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Research papers

I. Hedtjärn, G. I., Hultmann, O., Broberg, A. G. (2009). One out of five mothers of children in psychiatric care has experienced domestic violence. Läkartidningen, 106 (48), 3242-3247 [Originally published in Swedish: Var femte mamma till barn i BUP-vård hade utsatts för våld: Mörkertalet kan vara stort, visar explorativ pilotstudie].

II. Hultmann, O., Möller, J., Ormhaug, S. M. & Broberg, A. G. (2014) Asking Routinely About Intimate Partner Violence in a Child and Adolescent Psychiatric Clinic: A Qualitative Study. Journal of Family Violence. 29, 67-78. doi: 10.1007/s10896-013-9554-5

III. Hultmann, O. & Broberg, A. G. (2015) Family Violence and Other Potentially Traumatic Interpersonal Events Among 9- to 17-Year-Old Children Attending an Outpatient Psychiatric Clinic. E-pub ahead of print in Journal of Interpersonal Violence. doi: 10.1177/0886260515584335

IV. Hultmann, O., Axberg, U., & Broberg, A. G. (submitted) Child Psychiatric Patients Who Have Been Subjected to Child Abuse or Witnessed Intimate Partner Violence—Prevalence and Consequences.