



# Implementing and evaluating the CPC-CBT intervention in a Swedish context

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# Introduction

Sweden was the first country in the world, in 1979, to ban all forms of corporal punishment of children. The UN Convention on the Rights of the Child (CRC) was ratified in 1990. In spite of that, experiences of corporal punishment are reported by among 14 % of children in ninth grade in Sweden<sup>1</sup>. The prevalence rate has been constant since the millennium<sup>2</sup>. Child physical abuse is a worldwide public health problem<sup>3</sup>. Around the world 25-50 % of all children have experienced physical abuse<sup>4</sup>. It is estimated that over one billion children experience some form of violence (physical, emotional, sexual, bullying or witnessing violence) yearly<sup>5</sup>. Similar numbers are presented by UNICEF (2014) who estimates that one billion children are victims of recurrent corporal punishment, indicating that six out of ten children worldwide are victims of physical abuse.

Exposure to child physical abuse can have long-term implications<sup>6</sup> and abuse is correlated with impaired health outcome<sup>7</sup>. Children depend on their parents and when the violence occurs within the family the child is particularly vulnerable<sup>8</sup>. Being abused by a caretaker, compared to experiencing potentially traumatizing events outside the family, increases the risk for both experiencing additional traumas as well as developing more severe trauma symptoms<sup>9</sup>. It is more likely that the abuse begins earlier in the child's life, which increases the risk for longer duration<sup>10</sup>. Furthermore, children often depend on adults to report abuse to child welfare service and/or the police<sup>11</sup>. Considering all this, when abused by a care taker, the child may lack a protective shield.



## To support children and families

Children who have experienced parental physical violence often continue to reside with their parent, even after being reported to the child welfare<sup>12</sup>. The families have rarely been offered any interventions aiming to reduce the violence<sup>13</sup> and children are likely to re-enter the child welfare system because of multiple reports<sup>14</sup>.

There has been a lack of valid treatment programs presented in Sweden and internationally, targeting children who are victims of physical abuse and their abusive parents. One of few presented treatment programs targeting child physical abuse is CPC-CBT<sup>15</sup>. The program is included in SAMHSA's National Registry of Evidence Based Practices and Programs (NREPP) (US Department of Health & Human Services).

In an update of evidence based treatment models presented by Dorsey and colleagues (2017) treatment programs were classified as a well-established, probably efficacious, possibly efficacious, or as experimental treatment. CPC-CBT was classified as probably efficacious treatment.

When abuse is identified and reported to the child welfare service it is of significant importance that child welfare can offer interventions aiming to prevent further abuse as well as to increase the child's wellbeing. With no available treatment program for those clients and in the absence of initiatives from national authorities, a group of social workers raised the issue that an intervention focusing on physical abuse was needed. The group identified CPC-CBT as a potential program and started in 2006 to prepare for an implementation in Sweden, as a bottom-up project<sup>16</sup>. Initially four teams were trained by Dr M Runyon, the program constructor, and promising results among families after treatment completion were identified in a pilot study<sup>17</sup>. Trained therapists advocated the treatment program, and this had a positive effect on colleagues who became interested in offering the CPC-CBT treatment to families. A more extensive implementation project started and, so far, more than hundred additional therapists have been trained to deliver treatment and more than thousand families have completed treatment. The Children's Welfare Foundation (Stiftelsen Allmänna Barnhuset) took the administrative responsibility as well as the main financial responsibility during the different stages of implementation.

12. Lindell & Svedin, 2006 13. Heimer, Näsman & Palme, 2017 14. Heimer et al., 2017; Lindell & Svedin, 2006  
15. Combined Parent Child Cognitive Behavioral Therapy for Families at risk for child physical abuse, Runyon et al., 2004  
16. Kjellgren, Nilsson & Thulin, 2017 17. Kjellgren, Svedin & Nilsson, 2013

## Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)

Combined Parent-Child Cognitive Behavioral Therapy is developed by Runyon and colleagues at CARES Institute (Child Abuse Research Education and Service)<sup>18</sup>. The intervention aims to address the violence both as a parental strategy and its consequences for the child. The aim of the treatment is to help parents end their use of corporal punishment and increase more positive parental strategies, while at the same time helping children recover from their experiences. The intervention addresses the whole family, including the violent parent<sup>19</sup>.

The intervention is based on cognitive-behavioural theory, but it also rests on other theoretical foundations such as systemic theory, trauma theory, developmental theory, and motivational theory/interviewing. CPC-CBT includes different components proven effective in treatment with physically abused children and their parents. This includes for example positive reinforcement and behavioural contracting<sup>20</sup>. As in trauma-focused therapy, careful and gradual exposure to the trauma is a significant part<sup>19</sup>.

Social welfare service assesses whether CPC-CBT is an appropriate intervention, corresponding to the needs of the family, but also to evaluate the safety of the child. The child's safety is addressed throughout the intervention and parents sign a non-violence contract before treatment. Therapists inform both parents and children about their professional obligation of mandatory reporting.

Treatment can be offered to groups of families or to a single family. Both children and parents have separate therapists, but every session ends with a joint session. The joint sessions will expand as the treatment moves forward. The child and parent/s will meet a therapist individually or with a group of other children/parents.

CPC-CBT is an outpatient treatment typically lasting around 16 sessions, with weekly meetings. Specific themes are addressed each week according to a structured treatment manual<sup>19</sup>.

The treatment includes four phases; (1) Engagement and Psychoeducation, (2) Effective Coping Skills, (3) Family Safety, Planning and Continuation of skill building and (4) Abuse Clarification. Parenting skills are addressed throughout all phases.

18. Runyon et al., 2004 19. Runyon & Deblinger, 2014 20. Runyon et al., 2004

## Child treatment

During treatment, children are gradually exposed to abuse-related material to increase the child's comfort level in dealing with personal experiences of abuse. During the initial phase, Engagement and Psychoeducation, children will learn about violence and its possible consequences. This helps the child to better understand their own reactions, and to acknowledge them.

In phase two, the Effective Coping Skills phase, children will learn to identify, regulate, and appropriately express their emotions. They will learn productive coping strategies for dealing with feelings of stress and anxiety in order to reduce their anxiety. This also prepares them for being able to share part of their abusive experiences. It is an essential part of CPC-CBT to help the child both understand, but also to express their feelings. Some children have difficulties to recognize and regulate their feelings. Since the treatment is based on cognitive behavioural therapy the therapist aims to help the child understand the connection between the child's thoughts, feelings, and behaviour. Many children have cognitive distortions where they blame themselves for the abuse. They can perceive that the violence happened because of their behaviour. It is an important part of treatment to address those thoughts and beliefs and to ensure that the child learns that they were not responsible for the violence that occurred. This belief will also be clarified together with the parents, and parents can then take responsibility for being violent. Depending on the child's age and maturity different activities such as games, roleplays, and tools can be used as part of the therapy.

The child's safety is of first priority and it's integrated into every phase of the treatment. In the Family Safety Planning phase, the family members develop and implement a safety plan. This includes using skills learned to date in order to enhance the safety of all family members. The treatment begins with giving the child space and time to describe the specific occasion leading to the report to the child welfare service or to the police. This could be a very scary episode, which the child may need to repeatedly talk through. The therapist helps the child explain what the child has experienced and how the parent behaved. It is important to repeatedly confirm that the child did not do anything to deserve the abuse.

In the final phase of therapy, the Abuse Clarification phase, the child develops a trauma narrative. Before starting to form the narrative, the therapist makes sure that the child feels safe with the parents, and that the abuse is terminated. The therapist encourages and helps the child to talk about a specific experience of abuse. Different methods could be used in this process, such as drawing,

playing, using dolls or character cards. Some children need help from the therapist to finish the narratives. Finalizing the narratives can be emotional since it evokes painful memories, but children describe this to be one of the most significant parts of treatment and stress the importance of therapist being supportive in order to help the child finalize the narrative<sup>21</sup>. Some children need to be further reassured that the violence was not their fault during this process. The therapist asks the child if he or she has any questions concerning the abuse to ask the parents, and if the child want the parents' therapist to forward the questions. When the child feels ready their narrative will be shared with the parents. The parents will later respond to the narrative (see parents' treatment).

## Parents' treatment

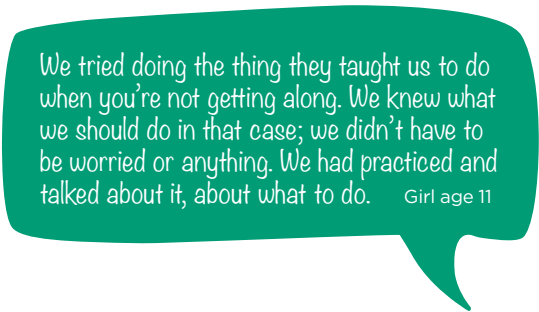
Some parents have their own history of being victims of physical abuse. During the Engagement and Psychoeducation phase, they can discuss and process their own personal experiences of abuse. This could lead to an increased empathy for the experiences of their children and a better understanding on how their parenting style is perceived. During the phase parents get support to examine how children can be affected by growing up in a violent environment. They receive psychoeducation and learn about child development and needs of children as well as possible consequences of child abuse. It is a critical part of treatment to educate parents on alternative non-violent parenting strategies. Parents will learn how to be an active listener in order to improve the communication with the child. This will also prepare them for listening to their child's narrative during the Abuse Clarification phase.

It is also important that parents learn to express more appreciation, to confirm and praise their child. Likewise, parents are taught different strategies for dealing with feelings of anger. In the Effective Coping Skills phase, they learn how to understand and express their feelings differently. It is common that parents need help to regulate their emotions and anger management is an important part of treatment. Like the child, parents will also learn how thoughts, feelings and behaviour are interacting. Parents will receive their children's narratives about the abuse. During the Abuse Clarification phase, parents will prepare a responding letter. In their abuse clarification, they will take responsibility for their abusive behaviour and ease the child from blame. They will express what they learnt in treatment and how they think they can parent their child in a more positive way from now on. Parents can respond to any fears, misconceptions, or concerns the child might have expressed in the child's narrative. The Abuse Clarification phase can be a very emotional phase. Parents will prepare

by reading the child's narrative together with their therapist, and receive help formulating their response. Therapists make sure that both child and parent are prepared before they share their narratives. When being interviewed about the treatment, children describe hearing their parent's letters as very emotional. It could be the first time they hear their parents express their feelings. Hearing the parent's describe how they felt and feel, take responsibility for the violence, and admit acting wrong gives a new image of the parent<sup>21</sup>.

### JOINT SESSIONS

Every treatment session ends with a joint session. In this part of treatment children and parents will communicate what they have learnt. Parents can practice achieved parenting strategies, and both parents and children can demonstrate a more positive way towards each other, such as confirming each other and giving (and receiving) praise. In the third phase children and parents will create a security plan together. This helps the family to know how to act if any member in the family feels afraid that a future stressful situation could escalate into abuse. The plan states what everyone should do, and how to act to minimize the risk for an abusive behaviour. This could also be practiced in the joint sessions. As one girl who completed treatment describes:



*We tried doing the thing they taught us to do when you're not getting along. We knew what we should do in that case; we didn't have to be worried or anything. We had practiced and talked about it, about what to do.* Girl age 11

21. Thulin, Kjellgren & Nilsson, submitted



In an interview study, children described the treatment as child-centred. They highlighted the structure of the treatment, with time solely with the therapist, as well as joint sessions together with the parents<sup>21</sup>. The violence in the family is pronounced and a cohesive part that is addressed throughout treatment. By working with different behavioural patterns within the family, the dynamics in the family can change. The treatment sessions become a shared project for all family members, and as the treatment progress the individuals can experience the changes. Even if the violence is the pronounced cause for treatment, the family members are invited to formulate their problem. Likewise, they take part in exploring what works in their family and how they want to affect their life together. By participating in treatment, and talking openly with each other in the joint sessions, they experience a new way of being against each other. Parents' and children can describe perceiving each other in a new way after completing treatment. Children can describe their parents' as more caring, open, and social<sup>21</sup>:

They gave us a lot of advice so we could listen much better. It's really better to listen than to fight and stuff. [...] For example, that they [the parents] had to play with us more often and such. Because before they would sit and they didn't do that; they didn't play with us that much. And they ask us what we want or something much more instead of us asking them.

Girl age 10

Dad is much calmer and tries to listen more and mum kind of is too. [...] He could be, like, very... 'I'm the one who decides' and would kind of raise his voice quickly, only to, you know, stop it now. But now he's calmer and he tries to explain things more calmly.

Girl age 14

## Method

### PARTICIPANTS

A larger effect study is ongoing to evaluate whether the CPC-CBT intervention could reduce parent's use of corporal punishment and provide better outcome concerning psychological well-being in a Swedish context. Parental well-being is measured by reported depressive symptoms and child well-being is measured by presence of trauma symptoms (reports from parents as children). Data is obtained before treatment starts, after completing treatment (approximately four months after treatment started) and with a follow-up data collection six months after completing treatment. In this report the scores and potential changes for a subsample of 34 children and their parents ( $N = 45$ ) (a total of 28 families) on self-reports collected by pre- and post-treatment (before treatment started and by the completion of treatment) are presented. The results have previously been published within a book chapter<sup>22</sup>.

Table 1. Demographic Characteristics of the sample

Characteristics	Children	Parents
<b>Gender (%)</b>		
Female	14 (42)	23 (50)
Male	19 (58)	22 (50) <sup>a</sup>
<b>Age M (SD)</b>	9.5 (2.2)	39 (6.7)

<sup>a</sup> 46 % were biological fathers and four % were step-fathers.

It was most common that the child lived with both parents (61 %) and 14 % altered living with one of two separated parents. Eight children (18 %) lived with one parent and a step parent and three children (7 %) lived with a single mother. It was most common that both parents joined treatment (72 %). Most parents were married, 57 % stated that they were married to the child's other biological parent and 17 % were married to one other than the child's biological parent. The families lived in private villas or a townhouse (37 %) rented apartment (34 %) or lived in a private apartment (29 %).

A vast majority of the parents had fulltime employment (68 %). Twelve percent was out of work and seven percent worked part time. Five percent of the parents owned a company and one were out of work due to sickness. Two parents were housewives.

21. Thulin, Kjellgren & Nilsson, submitted

22. Thulin & Kjellgren, 2017

Nine of the parents (17 %) stated that they were born in a country outside Sweden. They were aged 2-25 years when arriving in Sweden ( $M = 14.6$ ,  $SD = 7.5$ ). Most commonly they immigrated from a country outside Europe (83 %).

### PARENTS EXPERIENCES OF ABUSE IN CHILDHOOD

It was quite common that parents had experiences of being physically abused by parents during their own childhood. About half of the parents (57 %) stated that they at some time were hit by their mother before the age of 12, and 51 % stated that they were hit by their father in the same timeframe. Between the ages of 13 to 18 years of age 24 % were at some time hit by their mother and 31 % were hit by their fathers.

### PROCEDURE

Children and parents responded on self-assessment scales and took part in a minor interview individually. No parents were present when children completed their scales. The data collection took place at the units where the family had received treatment.

The result has been statistically analysed using SPSS version 23. Mean values has been compared using paired t-test to measure change at an individual level. Effect size is calculated and presented using Cohen's  $d$ . Effect size is used to estimate the degree of change. The cut-off points of Cohen's  $d$  used in the analyses are  $\geq .80$  (indicating large effect),  $\geq .50$  (moderate effect) and  $\geq .20$  (small effect).

## Self-assessment scales

### PARENTAL FORMS

Parents responded on five self-assessment scales at pre-treatment and four at post-treatment respectively. Beck Depression Inventory (BDI) aims to measure the parents own symptoms of depression<sup>23</sup>. The Alabama Parenting Questionnaire (APQ-P) aims to measure five broad parental strategies; Parental Involvement, Positive Parenting, Poor Monitoring/Supervision, Inconsistent Discipline and Corporal Punishment<sup>24</sup>. The three sub-scales Positive Parenting, Inconsistent Discipline and Corporal Punishment are used within this report. The Trauma Symptom Checklist for Young Children (TSCYC) reports trauma symptoms for the child. The scale includes the subscales of Anxiety, Depression, Anger, PTSD (PTSD includes the three subscales intrusion, avoidance, and arousal), Dissociation and Sexual Concern<sup>25</sup>. The scores on subscale Sexual Concern

is not reported in this study due to its irrelevance for many of the participating children (children being too young). Child and Childrearing (Barn och barnuppfostran) is completed to provide information about socio-demographics and how parents think about childrearing. The questionnaire was translated into Swedish by Staffan Janson and colleagues (2011) and originates from the Parent Child Conflict Tactics Scale<sup>26</sup>. In addition, Linköping Youth Life Experience Scale (LYLES) was used at pre-treatment to measure children's experiences of three kinds of potentially traumatic experiences; non-personal, interpersonal, and adverse childhood circumstances<sup>27</sup>.

### CHILD FORMS

Children responded on three scales. As for parents they completed the Alabama Parenting Questionnaire (APQ-C), the Trauma Symptom Checklist for Children (TSCC) and Linköping Youth Experiences (LYLES-Y). The forms are present in both a parental version (where parents in TSCYC and LYLES report how they perceive their child/the child's experiences) and a child version.

### ETHICAL CONSIDERATIONS

The study has been approved by the Regional Ethical Review Board of Linköping, Sweden (Dnr 2008/206-08).

Children and parents received both oral and written information about the study, its purpose and how it should be conducted. They were informed that their participation was voluntary and that they at any time could withdraw their consent. Since the topic could be perceived as sensitive, and some children could think they revealed a family secret, it was considered important that the parent gave their consent for participation in front of their children. Children however completed their self-assessment scales and interviews without parents being present. The families had been informed about the confidentiality in their responses, with the exception of mandatory reporting concerning suspicions of renewed child physical abuse.

In the meetings with the children, the interviewer/researcher was observant of any sign of inconvenience for the child. The meetings were conducted in the settings where the child had received treatment and professional staff was available. However, no child expressed a wish to talk to former therapists after the interview.

23. Beck, Steer & Brown, 1996 24. Frick et al., 1999

25. Briere et al., 2001 26. Straus, Hamby, Finkelhor, Moore & Runyan, 1998 27. Nilsson, Gustafsson, Larsson & Svedin, 2010



## Result

### PARENTAL REPORTS

#### Trauma Symptoms

Parents reported a significant decrease in all measured trauma symptoms for their children from pre- to post-treatment (see table 1). According to parental reports, the children had less introvert behavioural problems, such as anxiety, depression, post-traumatic stress symptoms and dissociation after completing treatment. Furthermore, parents reported less externalizing behaviour of children such as decreased anger.

Table 2. Parents reported differences in their children's psychological well-being before and after treatment,  $N = 36$

	Before treatment	After treatment			
Variable	<i>M</i> (SD)	<i>M</i> (SD)	<i>t</i>	<i>p</i>	<i>d</i>
Anxiety	12.89 (3.55)	11.31 (2.55)	3.75	.001	.52
Depression	13.15 (3.62)	11.24 (1.97)	3.56	.001	.71
Anger	14.37 (4.48)	12.20 (3.64)	3.67	.001	.54
PTS-intrusion	11.50 (2.83)	10.18 (1.66)	3.16	.003	.57
PTS-avoidance	11.12 (3.17)	10.18 (1.99)	2.06	.047	.35
PTS-arousal	13.56 (4.37)	12.38 (3.06)	2.39	.023	.32
Dissociation	12.94 (3.40)	11.29 (2.98)	3.27	.002	.50
Total trauma symptoms	120.46 (27.99)	106.43 (19.41)	3.65	.001	.61

### PARENTAL STRATEGIES

Parental reports indicate that parents became significantly more consistent in their child-rearing and hence more predictable for their children after completing treatment. This can be understood as that a sense of security arises when the child easier can understand parental rules and consequences. When parents become more consistent children can easier predict the upcoming reaction. The strongest significant result, and effect size, was obtained for the change in reported parental use of corporal punishment after taking part of treatment. The value 3.0 indicates no use of physical punishment and parental reports indicate that parents almost ended that form of discipline/punishment. Parental reports did not indicate any change in their positive parenting practice.



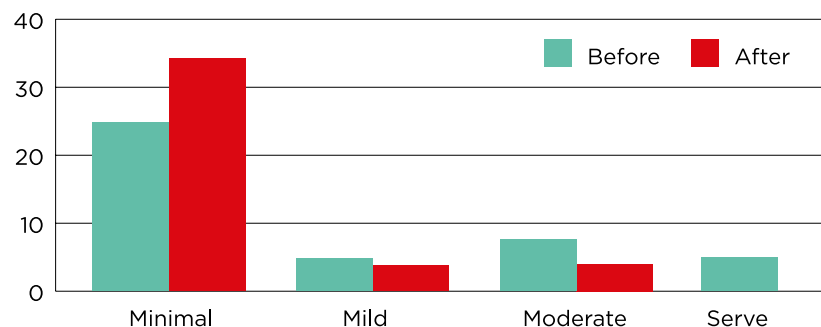
Table 3. Mean differences in parenting strategies after treatment (APQ-P), *N* = 41

	Before treatment	After treatment			
Variable	<i>M</i> (SD)	<i>M</i> (SD)	<i>t</i>	<i>p</i>	<i>d</i>
Positive parenting	24.37 (3.27)	24.20 (3.93)	.42	.680	.05
Inconsistent discipline	14.11 (3.45)	12.95 (2.94)	2.18	.036	.38
Corporal punishment	3.56 (1.27)	3.05 (0.32)	2.64	.012	.63

### Parents' Psychological well-being

Psychological well-being among parents was measured with Beck Depression Inventory<sup>28</sup>. The scale is a widely used self-assessment scale for measuring symptoms of depression in adults. Responses are summarized and categorized in four levels of depressive symptoms; minimal, mild, moderate, and severe<sup>28</sup>. The CPC-CBT treatment is not explicitly aiming at reducing parental depression, but the result indicates that components in treatment affect depressive symptoms among parents. After completing treatment, the mean depression score was significantly reduced, from *M* = 12.37 (*SD* = 13.28) to *M* = 6.14 (*SD* = 7.63) (*t* = 3.69, *p* = .001).

Table 4. Parental degree of depression before and after treatment, *N* = 35



28. BDI, Beck, Steer & Brown, 1996

## CHILDREN'S REPORTS

### Trauma Symptoms

Children's reports indicate a significant decrease in all measured trauma symptoms after completing treatment. After treatment children reported less anxiety, feelings of depression, anger, PTSD symptoms and dissociation, see table 3.

Table 5. Children's trauma symptoms before and after treatment (TSCC), *N* = 25

	Before treatment	After treatment			
Variable	<i>M</i> (SD)	<i>M</i> (SD)	<i>t</i>	<i>p</i>	<i>d</i>
Anxiety	5.84 (3.14)	4.0 (2.38)	2.85	.009	.64
Depression	4.72 (3.49)	2.68 (2.21)	2.81	.010	.69
Anger	5.88 (3.86)	3.72 (2.42)	3.02	.006	.69
PTSD	7.32 (4.58)	5.44 (2.89)	2.22	.036	.50
Dissociation	5.72 (3.18)	4.08 (1.96)	2.46	.022	.62
PTS-arousal	13.56 (4.37)	12.38 (3.06)	2.39	.023	.32
Dissociation	12.94 (3.40)	11.29 (2.98)	3.27	.002	.50
Total trauma symptoms	29.48 (13.82)	19.92 (8.97)	3.70	.001	.84

### CHILDREN'S EXPERIENCES OF PARENTAL STRATEGIES

Children reported how they perceived the parental strategies applied by their parents before and after treatment. As the parents, children reported a significant decrease in corporal punishment. There is however a noteworthy difference between parent's and children's responses. In comparison, children reported a higher prevalence of corporal punishment before treatment. The difference in responses highlights the importance to include children when various conditions in a family are investigated. The results are similar with the results of previous studies revealing that parent's tend to under-report the extent of physical abuse<sup>29</sup>. Even though children reported more positive parenting and a decrease in parental inconsistency after treatment, the results were not significant.

29. Kjellgren et al., 2013; Svensson, 2013; Litrownik et al., 2003

Table 6. Children's reports of parenting strategies, *N* = 33

	Before treatment	After treatment			
Variable	<i>M</i> (SD)	<i>M</i> (SD)	<i>t</i>	<i>p</i>	<i>d</i>
Positive parenting	22.28 (5.00)	23.69 (4.00)	1.79	.084	.31
Inconsistent discipline	14.28 (3.73)	12.86 (3.30)	1.74	.093	.40
Corporal punishment	4.25 (1.68)	3.09 (0.39)	3.68	.001	1.1

### POLY-TRAUMATISATION

The participating children had experienced several potentially traumatic events. The total number of experienced events range from 7 to 22 (*M* = 13.09, *SD* = 6.1). LYLES has three subscales; Non-Interpersonal events (18 item), Interpersonal events (13 item), and Adverse Childhood Experiences (10 item), a total of 41 item. Children reported a range of 2-12 Non-Interpersonal events (*M* = 7.22, *SD* = 3.0). They experienced 0-7 Interpersonal events (*M* = 3.47, *SD* = 2.0). Lastly, children reported between 0-5 Adverse Childhood Experiences (*M* = 2.1, *SD* = 1.8). The result supports previous research stating that physically abused children is an exposed group where the abuse is likely to co-exist with other potentially traumatic events.

## Discussion

### THE IMPORTANCE OF ACKNOWLEDGING THE VIOLENCE

In order to make a sustainable difference, social welfare service must address the “right” problem and offer interventions targeting that goal. Previous research indicates that parental violence is diminished in social welfare investigations<sup>30</sup>. The lack of a clear description of what causes the problems within the families, with the absence of statements from children, often lead to vague descriptions of the aims of interventions offered. The result is recurring reports to child welfare service, and children passing in and out of the system, without having their needs looked after<sup>31</sup>. One of the advantages in working with CPC-CBT, according to social welfare workers, is that the treatment sets the searchlight on the violence. From the first meeting, and following through the intervention, the parental violence and its consequences are discussed<sup>33</sup>.

The overall findings, when examining changes from pre- to post treatment among children and parents in Sweden, are promising similar to the U.S. results<sup>33</sup>. Children report significant reductions of trauma symptoms which indicates improved emotional health. It is of vital interest that societal interventions make a difference in those aspects. Furthermore, a main reason for trauma symptoms among the children, the violent parenting strategies, has come to an end, and in interviews both children and parents highlight the change in parental attitudes and strategies as well as improved engagement after treatment.

The major reduction of parental depressive symptoms seems to impact parents to be more available for their children. Children express in interviews that their parents spend more time with them and acknowledge them more and that the family climate has become closer and safer<sup>34</sup>. Likewise, parents can express how they see and value their children in a different way after completing treatment. Even if the change is not captured within the Positive Parenting subscale, it seems to be an important part of the family change after finishing treatment.

Children and parents report confidence in the treatment as well as in the strategies the families received on how to deal with conflicts and prevent violence in the future. Hopefully future follow-up studies can confirm that the new strategies applied in the family will last.

30. Heimer, Näsman & Palme, 2017 31. Heimer et al., 2017 32. Thulin, 2015 33. Runyon, Deblinger, & Schroeder, 2009; Runyon, Deblinger & Steer, 2010 34. Thulin, Kjellgren & Nilsson, submitted

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