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No child is an island – The life situation before and during treatment for children exposed to family violence

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Abstract
Compelling evidence indicates that child maltreatment is a risk factor for developing serious psychopathology. Trauma-focused treatment has been found to be effective, but not all children benefit from it. Interventions that consider multiple aspects of treatment that could improve the efficacy need to be developed. The present study explored how children exposed to family violence described their life situation before and during their contact with the child and adolescent mental health service. Thirteen children and adolescents were interviewed and we analysed the material using thematic analysis. Several of the participants reported continued violence, conflict and insecurity at home, in school and in other contexts. These results indicate how important it is never to assume that because children exposed to family violence are in treatment, they are safe in their homes. Interventions should therefore include continuous assessment of ongoing victimization and safety planning, considering children, not as isolated units, but in the context of complex life situations in which their well-being is affected by their parents, siblings and friends.

Keywords
child, family violence, polyvictimization, children's experiences, treatment, mental health services

Introduction

The evidence for child maltreatment as a serious risk factor for the development of psychopathology is compelling (Felitti and Anda, 2010; Weinstein et al., 2000), and

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studies increasingly show its effects on brain development (Teicher et al., 2016). Family violence is a form of child maltreatment defined as exposure to adult intimate partner violence (IPV) and/or child abuse (CA; Hultmann et al., 2020). Since different studies use different terms and definitions which may imply the same forms of abuse (e.g. Maneta et al. (2017) refer to CA as parent-child aggression), we will use terms from the studies referred to.

In the last few decades, interventions such as trauma-focused cognitive behavioural therapy (TF-CBT) have proven effective in treating children exposed to violence (Dorsey et al., 2017). However, not all children benefit from such treatment. In treatment planning and research to develop and design interventions, it is important to both evaluate the efficacy and effectiveness of an intervention and to consider the multiple aspects of the child's context (Weisz, 2015). The aim of the present study was therefor to explore how children exposed to family violence describe their life situations before and during their contact with the child and adolescent mental health services (CAMHS).

Children worldwide experience maltreatment and violence in their families, which increases their risk of developing serious mental illness (Felitti et al., 1998; Finkelhor et al., 2015; Kloppen et al., 2015). Depending on the location and the formulation of questions, studies indicate approximate prevalence rates of IPV in children ranging from about 8% (Afifi et al., 2014) to 24% (Radford et al., 2011). It is also well known that children exposed to IPV are at greater risk of exposure to other forms of childhood maltreatment (Cohen et al., 2006; Hamby et al., 2010), and the overlap between exposure to IPV and CA is large (Hultmann, et al., 2020). Children with experiences of CA and exposure to other violence are at increased risk of experiencing additional trauma throughout their lives (Cook et al., 2005). Hultmann et al. (2020) suggest that exposure to domestic violence may be a precursor to subsequent exposure to violence outside the family. Finkelhor et al. (2011) describe this increased risk of exposure to multiple traumas as polyvictimization, which is a risk factor for both the development of mental health problems and child mortality (Felitti et al., 1998; Gilbert et al., 2009).

A child exposed to violence and neglect is at risk of developing a brain adapted to constant vigilance and feelings of stress which can impair multiple brain structures and functions and alter the reactivity of their stress response systems (Anda et al., 2006; Perry, 2009). They are also at increased risk of several psychiatric diagnoses such as post-traumatic stress disorder (PTSD), attention-deficit/hyperactivity disorder (ADHD), and anxiety, depression and dissociative disorders (Briscoe-Smith and Hinshaw, 2006; Endo et al., 2006; Stern et al., 1995; Webster, 2001; Weinstein et al., 2000). Many children in contact with the CAMHS are therefor likely to have experienced trauma, and one study showed that as many as 50% had experiences of IPV and/or CA (Hultmann and Broberg, 2016). Dorsey et al. (2017) found that empirically supported therapies (ESTs) were effective for trauma-related difficulties in children; however, Weisz et al. (2019), who showed that many children do not recover after EST, recommend that therapists personalize such interventions to the individual child. Kazdin (2017) highlighted the importance of multiple treatment models to meet the need for such personalized interventions.

Weisz et al. (2015), who point out that most adolescents referred to CAMHS have comorbidities, argue that research aimed to improve clinical practice tends to focus on single disorders or problem domains at the risk of ignoring other problems that may affect children's well-being and treatment outcomes. Manualized ESTs, however, often lack instructions on how to manage the complexity of coexisting problems in patients with comorbidities (Ng and Weisz, 2015). Others suggest that efforts to create ESTs and standardized protocols come at the expense of more personalized interventions (Persons, 1991, 2013).

Researchers have criticized studies on treatment efficacy for their primary focus on quantifiable treatment results over children's experiences of those treatments (Dittmann and Jensen, 2014; Persson et al., 2017; Stafford et al., 2016). A core principle of the United Nations Convention on the Rights of the Child (United Nations, 1989) is the right of children to participate in and express their views on all matters and decisions that affect them. By definition, this should also be recognised in research concerning them. Some studies on children's own experiences highlight the importance of therapists accepting, listening to and treating them as individuals (Hartzell et al., 2009; Persson et al., 2017). Others show that children are more likely to engage in and commit to treatment if they feel their individual needs are met and validated (Donnellan et al., 2013; Harper et al., 2014). However, very few studies have examined children's experiences of trauma-focused treatment (Neelakantan et al., 2019), and none have specifically focused on children's experiences of treatment after exposure to family violence (Statens beredning för medicinsk och social utvärdering, 2018).

Considering the serious negative effects of exposure to childhood violence and trauma and the fact that multiple traumas increase the risk of mental health and behavioural problems, it is important to develop efficient treatment methods. Evaluations of treatment interventions could be improved by measuring not only symptoms, but also how the child's general life situation may affect the outcome. Increased knowledge of how children exposed to IPV and/or CA describe their experiences is important for improving treatment interventions for this vulnerable group (Felitti et al., 1998).

The overall aim of this study was to explore how children exposed to family violence, including IPV and/or CA, describe their life situations before and during their contact with the CAMHS. The study had a qualitative approach focussing on participants' experiences of family, school and friends as well as their experiences of social services and the legal system.

Method

The present study analysed interviews with children and young adults who had experienced family violence. All participants had taken part in a study 4–5 years earlier comparing the effectiveness of TF-CBT against enhanced treatment as usual (Hultmann et al., unpublished).

Participants

Data consisted of interviews with 13 people aged 12–25 years (M = 20.2; 11 girls/young women and 2 young men). All participants were former patients at a CAMHS in a socioeconomically challenged area in one of the larger cities in the south of Sweden. The participants had taken part in a randomized controlled trial (RCT) of treatment for experiences of family violence in 2012–2015 (Hultmann et al., unpublished).

At the time of the interview most participants lived with their mother ($n = 5$) or father ($n = 4$). One alternated living with each of her parents, one lived with a partner, one with her grandmother and one in a former foster family. Most were students (2 enrolled and 5 having completed elementary school; 1 enrolled and 1 having completed high school; and 3 enrolled in municipal adult education) and one was working.

Previous assessment forms, current interviews and record reviews showed that 12 participants had experienced physical violence, 9 had experienced psychological violence and 7 had experienced sexual violence; 5 had experienced adults abusing drugs/alcohol, 7 had witnessed violence in the family and 6 had attempted suicide at least once.

In the first study, all participants were interviewed using the Schedule for Affective Disorders and Schizophrenia for School-Age Children–Present and Lifetime Version (Kiddie-SADS-PL; Jarbin et al., 2017) prior to treatment. All were assessed as having trauma-related symptoms; 8 of 13 met the diagnostic criteria for PTSD, 2 were also diagnosed with depression and/or anxiety and 1 with ADHD and oppositional defiant disorder. Four participants did not meet the criteria for any psychiatric diagnosis.

Procedure

We obtained contact information for 40 of the 93 children who had participated in the former RCT, 13 of whom agreed to participate and 13 declined. We were unable to reach the remaining 14 participants after the initial phone call.

We contacted all participants by telephone and informed them about the aim and procedure of the study. Those who agreed to participate received written information via email and a telephone call to confirm their willingness to participate, ask if they had any questions and book an appointment for the interview. After the interviews, all participants received two movie tickets as compensation for their participation.

Interview

The interview guide was semi-structured with interview questions designed according to Brinkmann and Kvale (2018). It included 13 questions, which were followed up when answers needed clarification or further exploration. The interviews took one to 2 h each. The first author (MO) conducted 10 interviews and a clinical psychologist specialized in treating children conducted 3 either in the participants' homes or at the CAMHS.

Following the interview guide, we asked participants to describe their lives before, during and after their care at CAMHS and to focus on how their lives had changed. Questions also concerned their experiences of social services and how they thought society should support children and families exposed to violence. They were also asked

about their experiences of the care they had received and how they felt about being questioned about the violence, but in line with the current aim, we did not analyse those answers for this study.

All interviews were audio recorded and transcribed. The interviewers aimed for an attitude of openness to encourage the children to speak freely about what they considered important in their life situation.

Analysis

We analysed the data using an inductive thematic approach intended to capture the participants' experiences and perspectives following the six phases of analysis described by Braun and Clarke (2006).

The first author read and re-read all interviews, noting initial thoughts and reflections and coding parts relevant to the study's aim (participants' life situation before and during their contact with CAMS). In a parallel process, the second author coded every third interview to ensure the first author's preconceptions of the group did not influence the analysis. Both authors then compared and discussed their initial codes to find those most suitable to the content, which they then listed and structured into potential themes. All three authors collaborated in reviewing the potential themes multiple times to define and name the final themes. Finally, we identified three themes and seven sub-themes and selected quotations to illustrate their essences. The quotations have been translated from Swedish and are presented with fictitious names.

Ethics and reflexivity

All participants received both verbal and written information about the procedure and aims of the study that emphasized the voluntary nature of their participation and the confidentiality of the data collected. Before the interviews, we reassured the participants, both verbally and in writing, of their anonymity and their right to decline or end participation at any time without questions or effect on their future contact with the psychiatric health care. The study began after approval from the regional ethical review board in the designated research area (Dnr: 806-16).

Because the interviews focused on sensitive topics, no attempts to appear neutral were made; rather, there was a strive to create a friendly atmosphere to help participants feel secure. Although it could be challenging to stay focused on the interview guide, the interviewers' experiences as therapists created a readiness to deal with participants' reactions and to give them advice about where and how to request treatment for trauma-related problems.

It is important to emphasize that the first author, who conducted most of the interviews, was also a therapist in the prior treatment study. This thorough pre-understanding may have been an advantage, but it could also have allowed preconceived notions to affect the objectivity. To counteract this risk, we constantly engaged in self-reflection, parallel coding, close supervision and discussions among all authors.

Results

The analysis of the interviews produced three main themes and seven sub-themes, which will be presented with illustrative quotes to reflect the relevant content.

Home and family

This theme emerged from the participants' narratives about the continued vulnerability they experienced during treatment. Descriptions of conflicts and feeling unsafe at home predominated and many described having been preoccupied with parents who had let them down and betrayed them in various ways.

Continued conflicts and distress. Most participants lived with one of their parents, some with each parent alternately, and a few with their grandparents or in foster care. Many described feeling loved and supported by the parent they lived with, but also having continued conflicts with one or both parents and/or the parents' partner. Although most reported no physical violence during treatment, many described their relationship with one or both parents in terms of insecurity or fear: 'I've always been pretty careful and frightened of my mother' (Gerd).

Although none of the children's parents lived together at the time of the study, many participants had experienced their parents' relationship as tense. Several described stressful situations where parents had slandered each other or tried to turn the child against the other parent.

> Katrin: I'm not sure if I dreamed this or if it was for real, but Dad asked me who was my favourite and Mum also asked me who was my favourite.
>
> Interviewer: Yes, which of them was your favourite? /… /
>
> Katrin: Yes. I told my dad it was him, and I told my mom it was her. But really it was both.

Some participants chose not to have contact with one or both parents as the relationship continued to be violent and threatening. One participant described how she and her brother lived under constant fear as their mother regularly showed up uninvited at their home. For some, the home itself triggered memories of violence and provoked distress rather than being a place for recreation and rest. Other participants had been sexually abused by relatives or family members, which added to their mental pain and distress by making them feel unsafe in their homes.

> Beatrice: I was raped.
>
> Interviewer: You were raped while you were in contact with the CAHMS?
>
> Beatrice: Mhm, by a family member. Or an in-law.

Losses and feelings of betrayal. Many participants described their relationship with one or both parents in terms of disappointment and betrayal as they had experienced their parents vanishing, lying or trying to manipulate them. Even though sadness and confusion over losing the parent were predominant some described a parallel feeling of relief.

> I will always be disappointed with him. Always. But [sighs] I have realized that it is his choice. That he is the one who will suffer for it later in life. He will not get to know me. But yes, it's his choice. Before, I was angry, I was very angry, I was very sad. (Beatrice)

Others described having felt manipulated when they realized that the parent they lived with had prevented their contact with the other parent, sometimes lying and depicting the absent parent as violent and dangerous. For example Hilma discovered when social services placed her with her father that her mother had in fact been responsible for the violence she had blamed on Hilda's father. 'I think I've always just been manipulated all my childhood, believed in everything she's said.'

Participants commonly said their parents denied or minimized the violence, and some blamed the child, even to the point of sacrificing their parental relationship to remain with the perpetrator. For example Emmanuel expressed the disappointment and confusion he felt when his father decided to stay with his violent partner. 'Yes. First and foremost, I would never go back to the person who beat my child. It is, it is so obvious really that you do not stay with the person who beat your child'.

Some participants described fearing their parents would not believe them if they disclosed the violence or abuse they had experienced. Annelie, who had been sexually abused by a close relative whilst she was in treatment, said that she never told her parents about this because she feared that they already knew but would do nothing to protect her. 'He used to do it to her [Annelie's mother] … so that's why I [wondered], "Why did she let me go there?"'

Few participants said they had sought support from their parents to deal with the anxiety or confusion the violence and/or abuse had caused them. Many reported having been reluctant to talk to family members, as they feared their reactions would cause sadness or disappointment. Camilla explained that when she was sexually abused for the second time she blamed herself and did not want to cause her mother more worry by telling her that she had been abused again. 'I remember not telling my mother because I did not want to make her sad'.

Although many participants were hesitant to talk to family members about the experiences that burdened them, some described feeling supported, love and safe, knowing that someone would always care for them. 'I will always have someone in the family to talk to, and if there's anything [worrying me] I will always go to grandma first'. (Frida)

Concern for parents and siblings. Several participants described having been concerned about their family members throughout their upbringing, even when in treatment. Many had parents and/or siblings who suffered from recurrent mental health issues, serious illness or drug abuse. These children were frustrated by their inability to help the people they loved. Desirée, who later had found out that her father was abusing drugs, accepted

contact with the CAMHS partly in the hope that her father, who she perceived as depressed, would receive help as well.

> I asked him, 'Can't we go to CAMHS?' I thought that I could get help and he could get help as well, because I knew he was feeling bad, but I never knew why. (Desirée)

Some said they felt insecure because of a parent's tendency to form destructive romantic relationships or worried about the family's resultingly strained economic situation. Whilst some participants were able to confide in their siblings, sharing their thoughts and feelings, some also feared for their siblings' safety.

> I've always been the one to take the blows. I've always been the one to intervene and hide my brother. I have always hidden him in the room, locked the room, taken a shoehorn, gone out, and done what I had to do. (Hilma)

In a few cases, social services had separated the siblings. One participant, Annelie, was relieved when her sister was removed for protection from the sexual and physical violence in the family. She described having wished for social services to place her and the rest of her siblings in a foster family as well. 'I wished them to take us away from there and move us to some fucking orphanage or foster family or something'.

For Lova, it was painful to realize that she was protected and receiving treatment whilst her siblings remained with their violent mother and did not receive the same help.

> We have seen so many things that we never should have seen, but I've received much, much more help than he [big brother] has received, and yet I am still affected by stuff, and I do not even want to imagine how – how it affects him.

School and friendships

This theme concerns experiences related to school and friendships before and during the participants' care at CAMHS. With a few exceptions, the children described their school experiences as negative. Many had been bullied and felt let down by professionals who failed to protect them or to offer the support they needed. Friendships ranged from being sources of support to being liabilities as friends often had problems of their own.

Being bullied, feeling let down and not talking about violence. Most participants characterized their time at school as a dominated by feelings of insecurity and vulnerability. Many had been bullied and felt let down by school staff who had been aware of the bullying, but failed to protect them. 'To be honest, the bullying was the worst. I've probably never experienced such pain ever'. (Jonna).

Some participants expressed disappointment in school staff who never asked them about their experiences at school or at home, but had instead blamed them for causing conflicts and defined them as the 'problem'. 'They did nothing because I quarrelled and fought. Yes, I quarrelled and fought just because no one was kind to me'. (Emmanuel)

Most participants never told teachers or other professionals about the abuse they experienced at home. Those who received support from the school health service said they were treated not as individuals, but according to the professionals' preconceived notions. Rather than explore the children's life situations, the councillors seemed to focus on other students' problems, try to reinterpret the participants' feelings, or gave irrelevant advice. 'I remember that she said a lot of things like "Yes I understand if you feel bad", and it felt like they were telling me what I should feel'. (Annelie)

Some participants knew that the school staff were aware of their life situation, which made them feel secure even if the staff never talked about it. Other later learnt that the school, without letting them know, had contacted the social services out of concern about their situation.

> When I was looking for all my records from the CAMHS, from all the places I stayed at, I actually found a report of concern from the time I was in fourth or fifth grade. I was very surprised. (Jonna)

Participants expressed disappointment and frustration in a continuing lack of support in their studies. Others, however, had positive experiences of teachers who offered them security, continuity and care by letting them skip triggering assignments, asking other students to show them extra consideration, supporting their studies or making sure that they had had breakfast.

> Then he [the teacher] would buy me a toast and a hot chocolate before school [and tell me] 'Try to sit down and eat a little now'. He was just there, he helped me. And so we had a lot of formative talks /…/ I talked to him about my performance anxiety and he has really been a reliable person for me. (Desirée)

Feeling different and alone. A reoccurring theme was feeling different from others because of having a turbulent family situation, receiving treatment or feeling inferior. Camilla said her self-image was negatively affected by the abuse she experienced, and that led her to withdraw from others. 'Back then I felt disgusting and I blamed myself for being raped. I remember feeling fat and stupid, as in not intelligent. /…/ I isolated myself very much'.

Several participants described having had a lonely, friendless childhood dominated by sadness. They explained the lack of friends in different ways, but many blamed themselves for having behaved strangely or aggressively or having caused chaos. One participant, Ida, said she never had a chance to make friends because she changed schools so frequently; another girl described how her anxiety for the family situation had hindered her from participating in social activities. 'During the years at CAMHS and up to [a certain time] I was just at home. I just sat at home, watched movies, and did nothing. I had no friends. I was just at home'. (Ida)

Some participants labelled their friends as 'bad' for giving them more stress than security. Many of their friends had social problems, suffered from mental health problems or abused drugs. One participant reported that from the age of 13 she had had a boyfriend who, during the 3 years they were a couple, repeatedly abused her physically and sexually.

Few participants told their friends about their family situation, the distress they felt and the treatment they received because they did not want to burden friends who had problems

of their own. Some said they had set their own needs aside, sometimes even lying, as a way to protect their friends.

> She never knew, because I said I was at the dentist when I was at the CAMHS, because I knew she was having a hard time and also went to the CAMHS a lot. So, another clear example of me standing back in order to protect others. (Desirée)

There were also participants who described their friendships as a source of refuge, saying they had always felt confident in friends who support them and offered comfort when they needed it.

> When I went to the CAMHS I had nightmares, uh, nightmares every day, every night. So yes, it was very difficult, so either my best friend or someone else had to FaceTime with me until I fell asleep because I was terrified of sleeping. (Lova)

Social services and the legal system

This theme reflects the participants' experiences of contact with social services, police and the judiciary. For some, these were reoccurring encounters throughout their childhood, sometimes whilst they were in treatment. Many described these experiences negatively, in terms of not feeling heard, helplessness and confusion, but a few participants had felt listened to and believed in for the first time during their experiences with social services and the legal system.

Powerlessness versus agency. When participants talked about dealing with social services, fear and powerlessness were recurrent and dominant feelings. Many described having been frightened and confused and subject to decisions made without their input or consent.

The importance of agency – the ability to participate in decisions – recurred in the participants' accounts, and some described their life situations having been changed dramatically without anyone consulting them. Several said they had objected to decisions without being listened to. For example Lova said that at the time she never understood why she had been separated from her mother and siblings. No one had taken the time to explain the situation to her, and the rare moments she got to meet her siblings were mostly painful as they never knew when they would meet again.

> When we had to say goodbye, that was the worst. But, because the thing was that when we said goodbye, we did not know when we would see each other again, so that was the … that was the hardest.

Participants who had been given the space and time to recount events and incidents in their meetings with social services expressed that this had been important. For some it had been the first time they felt listened to and their opinions had been considered in decisions about their life situation. This group described their experiences of the social services more positively than those who felt ignored and powerless.

> It was the first time I had someone who just… 'this is'. So they really acted like this as soon as I said, like, 'But she beats me and she is being violent'. Then it was like, 'Get the boss, call them, now we do it like this, you will stay with your dad'. So, there was someone who understood that it really was serious. (Ida)

Fear and disappointment. Of the participants who had experienced contact with the police and/or legal system, a majority characterized the encounters in terms of fear and confusion. Some described how although the police had come to their homes multiple times, the situation remained the same. This lack of action led to their mistrust and fear of the police. 'The police came to us many, many times and we got a picture, maybe the wrong picture, I don't know if it is the wrong picture, but yes, we were scared of the police'. (Katrin)

Participants described interrogating police officers as dismissive and cold, and legal trials as stressful. They often reported not being listened to or being given incorrect information about their legal rights. Malkolm exemplifies their common feelings of powerless, confusion and disappointment when he describes being misinformed by his legal representative when the person accused of sexually abusing him was acquitted.

> Malkolm: I remember that I asked my lawyer, 'If I should appeal this, must I sit and talk about it again?' and she said yes, and then I decided that I would not appeal. And then a few years later I followed my brother in a trial against him.
>
> Interviewer: Against your brother?
>
> Malkolm: Mhm. And he did not have to say anything. They just watched a video recording from the previous trial as I remember it. And then I felt like, if I [knew I] did not have to talk about it, I could just as easily have appealed.

Although participants often felt mistrust in their meetings with officials, some described those contacts more positively. Those with positive experiences felt respected and listened to by the police or the legal counsellor. Ida described that although she had been disappointed when the report against her mother was dropped, she was also relieved because she had been believed.

> It felt really good when they wrote in this letter, 'We believe in Ida, she speaks the truth'. Mainly because I had been so overlooked, so many had diminished [my experience] and said that it was not so, so it felt really good and that it was from the police […], but yes. Then I also was very sad because it never led up to anything.

Discussion

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

One of the main findings is the participants' continued experiences of stressors such as psychological, physical and sexual violence. For some, the perpetrator was a family member or relative who made the home an unsafe place. Some described continued

conflicts with and between parents and many expressed concern about their parents' mental health, siblings' safety and friends' problems. Many had been bullied at school and others described stressful meetings with the justice system. These findings, which offer valuable insights into the complexity of the life situations of children exposed to family violence, strongly suggest the need to assess both environmental factors and psychiatric symptoms when designing interventions for these children and their families – especially as parents of children with mental health problems tend to seek biopsychological explanations rather than consider how the child might be affected by the family system (O'Reilly and Kiyimba, 2021).

The results of the present study support those of Weisz et al. (2015), who highlight the importance of exploring the life circumstances of children when developing and implementing treatment interventions for them. Aspects other than the child's psychiatric symptoms need to be mapped. The family relations, current and previous school situations, ongoing exposure to bullying or other abuse, and the exposure of parents and siblings to abuse all seem to be significant to the well-being of the child.

Although participants were recruited because they had experienced violence in their families previous to treatment, several described continuing exposure and insecurity during their care from CAMHS. Some were harassed by parents and others refused contact with parents who continued to be threatening. A study by Wongcharoenwatana et al. (2021) indicates that the risk of reoccurring CA is higher if the perpetrator is a parent. This was the case for some participants, although others had been violated by other family members. Perhaps most important, these findings indicate the danger of assuming that violence ceases once it has been discovered. Therapists working with children who have experienced family violence need to be aware that their clients continue to be at risk of ongoing and future exposure to adversities at home and elsewhere. Throughout treatment, both children and parents should repeatedly be offered opportunities to discuss their exposure to violence and other forms of abuse. Interventions to increase safety and safety planning should be a regular part of treatment.

Concerns for a parent's well-being was another main finding. Several participants said that they wished their parents and siblings could also receive treatment. This finding is supported by studies showing that when parents struggle with difficulties such as relationship problems, psychopathology, anger/hyper-reactivity, their children are at higher risk than others of experiencing IPV/CA (Dixon et al., 2007; Stith et al., 2008). Witnessing IPV also increases the risk of exposure to other forms of family violence such as neglect and emotional or sexual abuse (Hamby et al., 2010).

At school, many participants reported being bullied and not receiving the support they needed. Some described the bullying as their worst ever experience and remained disappointed no one at school had protected them. Studies indicate that children who experience violence in the family are at increased risk of being exposed to violence outside the family (Hultmann et al., 2020), of being victims of bullying at school (Mohapatra et al., 2010), and of bullying peers themselves (Chesworth et al., 2019). A meta-analysis shows that all forms of violence in childhood, most particularly bullying, can negatively affect educational outcomes (Fry et al., 2018).

Few participants in the present study talked to friends or professionals at school about their home situation, and many described being lonely. A safe school situation with

professionals who knew what they were going through might have been a protective factor, and ways to increase cooperation between CAMHS and schools is a potential area of future research. Some school-based interventions intended for trauma-related symptoms have shown positive effects (Rolfsnes and Idsoe, 2011), but also that those effects can be impaired by other factors, such as poverty-related stress and PTSD in the parent (Ros et al., 2019). This points once again to the importance of not seeing the child as an isolated unity.

Several participants experienced their contact with the judiciary as confusing and stressful. A study by Jouriles et al. (2020) showed that children who had experienced police involvement in IPV incidents suffered higher levels of anxiety symptoms, a finding supported by other studies suggesting that children tend to experience police involvement as confusing and unhelpful (Øverlien and Aas, 2016; Swanston et al., 2014). Research is lacking in children's experiences of contact with the police and courts when the perpetrator is a parent, and the extent to which their experiences of the judiciary affect their well-being and the efficacy of treatment has yet to be investigated.

Clinical implications

The actual experiences of children are a vital source of information in the design of clinical guidelines regarding interventions for them. Various aspects other than psychiatric symptoms should be considered in planning and evaluating treatment interventions. Many participants reported that they still were subjected to violence in their family, at school or elsewhere whilst they were in contact with CAMHS. This illustrates the importance of therapists not assuming child is automatically secure by virtue of the violence having been discovered. The chance of family violence actually ceasing once recognized by CAMHS and/or social services is an area for future research, as are effective ways of preventing more violence. The results show the vital importance of continuously addressing issues around safety and safety planning when working with children that experience family violence.

This study shows that children exist in a context in which their well-being is affected by the well-being and actions of other family members and close friends. Worries about parents or siblings suffering from physical or psychiatric illness and problems with friends or at school are likely to increase the burden on the child in treatment. Eventually, a child who is treated in isolation from their social context risks receiving ineffective interventions that do not help them with challenges in the important, but unacknowledged, parts of their life situation. Children who have experienced family violence would likely benefit from increased collaboration, not only among the various actors with a direct effect on their situation, but also among those providing interventions to their parents and siblings. The complexity of a child's life and the different areas that overlap and interact need to be recognized. One approach to complex situations is to work in multi-disciplinary teams (Herbert and Bromfield, 2019), but how best to practise and implement this approach in this specific group needs further study.

Therapeutic work with children subjected to violence that focuses solely on one aspect – violence in the family OR the parental role OR bullying OR experiences of contact with

the judiciary – risks missing how these aspects interacts and affects the child's life and well-being.

Strengths and limitations

The first author (MO) who conducted the majority of the interviews and the analysis was one of the therapists offering care and therapy in the treatment study that the present study is based upon. This thorough pre-understanding of therapeutic work with children and families affected by violence entails an obvious risk to the ability to maintain objectivity and prevent preconceptions from influencing the result. To counteract these risks, consistent efforts were made to remain aware of them through self-reflection, meticulous supervision, careful parallel coding and discussions with the other authors. At the same time, this pre-understanding may have enabled a deeper comprehension of the participants' experiences of the CAMHS and life situations, a perspective often lacking in evaluations of interventions for children who have been subjected to violence. Another limitation of the study is that the interviews were conducted several years after the participants received care at the CAMHS and their memories may have been clouded. On the other hand, this may have allowed the participants to confront feelings and disclose information that they had previously felt necessary to keep secret. It is also possible that their ability to reflect upon their previous situation had increased in step with their increased maturity.

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Ethical approve statement

The study was approved by the Regional Ethics Review Board, University of Gothenburg (approval no. 806-16).

Data availability statement

The data that support the findings of this study are available on request from the corresponding author, [MO]. The data are not publicly available due to ethical restrictions e.g. their containing information that could compromise the privacy of research participants.

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