Exposure to child physical abuse is associated with both short and long term consequences for children. All forms of violence towards a child is prohibited in Sweden by law, but still more than one in ten children report experiencing child physical abuse victimisation. Despite the knowledge of the possible harm there is a lack of specialised intervention offered to these children.

The overall aim of the thesis is to explore the experiences and possible consequences concerning reported health and the relations between a child who is victim of physical abuse and their parents, experiences among children disclosing the abuse, and the impact of an intervention designed to support these children in a Swedish context. This thesis includes four empirical studies with a mixed method design.

Results revealed a significant reduction of several symptoms associated with trauma after taking part in treatment. Furthermore, children’s narratives concerning the process of disclosure reveal the importance of trustworthy adults who act on the behalf of the child. Following the process of disclosure adults must further recognise children’s participatory rights and strive to earn their trust while offering adequate interventions targeting the physical abuse.
Putting words to child physical abuse

– Possible consequences, the process of disclosure, and effects of treatment. From children’s perspectives
PUTTING WORDS TO CHILD PHYSICAL ABUSE

– Possible consequences, the process of disclosure, and effects of treatment. From children’s perspectives

JOHANNA THULIN

LINNAEUS UNIVERSITY PRESS
Putting words to child physical abuse – Possible consequences, the process of disclosure, and effects of treatment. From children’s perspectives
Doctoral Dissertation, Department of Social Work, Linnaeus University, Växjö, 2019

Published by: Linnaeus University Press, 351 95 Växjö
Printed by: DanagårdLiTHO, 2019
Abstract

Aim: The overall aim of the thesis is to explore the experiences and possible consequences concerning reported health and relations between a parent perpetrator of physical child abuse and the children who are victims of the parental physical abuse, the children’s thoughts when disclosing the abuse, and the impact of an intervention designed to support these children in a Swedish context – Combined Parent Child Cognitive Behavioral Therapy (CPC-CBT).

Methods: This thesis has a mix-method design. Study I and IV used different self-assessment scales, and the outcomes were analysed using descriptive statistics, paired-samples t test, independent t test, ANOVA, Pearson correlations, and hierarchical linear regression. Study II and III consisted of interviews with 15 (Study II) and 20 (Study III) children, respectively. The interviews were transcribed verbatim and analysed using qualitative content analysis.

Results: The results suggest that experiencing child physical abuse affects the relationship between a parent and a child as well as the child's wellbeing in several ways. However, the results also suggest that participating in the CPC-CBT intervention could decrease parents’ use of violence and increase the child's wellbeing. In addition, the results suggest that trust and participation influence whether a child discloses abuse and contributes to the success of treatment.

Conclusion: The CPC-CBT could be seen as a successful turning point for the participating children, shifting from one trajectory (living in fear of violence) to another (living without fear). Furthermore, when children disclose to adults about their physical abuse, it is important that the adults recognise the children’s participatory rights and strive to earn their trust.

Keywords: child physical abuse, disclosure, participation, CPC-CBT, intervention
Mankind owes to the child the best that it has to give.

(UN, Declaration on the Rights of the Child)
‘Mankind owes to the child the best that it has to give’.

(UN, Declaration on the Rights of the Child)
Contents

Acknowledgments ............................................................................................. 5
Papers included in the thesis ............................................................................. 9
The individual contribution in the studies included in the thesis .................... 10
Abbreviations and definitions .......................................................................... 13
Introduction ..................................................................................................... 17
  The aim and research questions .................................................................. 19
Background ..................................................................................................... 21
  Raising awareness and towards a ban against physical abuse in Sweden ... 21
  The current Swedish legislation .................................................................. 30
  Child physical abuse as a parental strategy ................................................. 32
  Motivation to use violent discipline among parents .................................... 33
  Trends in parental use of corporal punishment in Sweden ......................... 34
  Possible consequences of physical abuse .................................................... 37
  Poly-victimization/traumatization ................................................................ 38
  The process of disclosing abuse .................................................................. 39
  The reporting on suspected physical abuse to child welfare services and the
  child care funnel ......................................................................................... 41
  The child within child welfare services ....................................................... 43
  The Convention on the Rights of the Child – with special focus on
  participation ............................................................................................... 46
Interventions for physically abused children ..................................................... 50
  Project Support ......................................................................................... 53
  Parent-Child Interaction Therapy (PCIT) .................................................. 54
  Multi Systemic Therapy for Child Abuse and Neglect (MST-CAN) .......... 55
  Combined Parent Child Cognitive Behavioral Therapy for families at risk
  for child physical abuse (CPC-CBT) ....................................................... 55
Theoretical perspectives and concepts ............................................................. 61
  A social ecological model for understanding risk factors and possible
  transitions for change ............................................................................... 62
  Life Course perspective ............................................................................ 66
  Sociology of Childhood ............................................................................. 68
  The Three Ps of the CRC .......................................................................... 72
Methods and materials ....................................................................................... 74
  Participants ............................................................................................... 76
  Gate-keepers ............................................................................................ 76
Ethical considerations ................................................................. 77
Legal framework and the key ethical question for this thesis ............ 77
Ethical aspects of the present research ........................................... 79
Methodological considerations ..................................................... 80
  Doing research on practice – the role of research and possible impact of researcher ................................................................. 82
Interviews with children ............................................................... 84
Study design of the outcome study ................................................ 84
Methodological discussion .......................................................... 86
  Unspoken signals ..................................................................... 88
  Addressing the child as an expert .............................................. 90
Results .......................................................................................... 92
  Summary of studies ................................................................. 92
  Study I ..................................................................................... 92
  Study II .................................................................................. 95
  Study III ............................................................................... 98
  Study IV ............................................................................... 100
Overall analysis from the theoretical perspectives ................................ 105
  Shifting trajectory? – Identifying possible turning points ............ 105
  Facilitating or hindering a new trajectory – following the 3 P of the CRC .......................................................... 108
  Trust and participation – core elements in a model for interpreting the results ........................................................................... 111
Discussion .................................................................................... 115
  Disclosing child physical abuse ................................................. 117
  Treatment .............................................................................. 119
    Putting words to child physical abuse ..................................... 121
  A loop of participation ............................................................ 122
  Voice and choice ..................................................................... 123
  What is the turning point? ....................................................... 125
  A century for children? ............................................................ 126
  Some further methodological considerations ............................. 129
    Cultural adaptations ............................................................ 131
  Main conclusions ...................................................................... 132
  Clinical implications ............................................................... 133
  Further research ...................................................................... 134
Populärvetenskaplig sammanfattning på svenska ............................ 135
References .................................................................................. 140
Acknowledgments

Having the opportunity to write this thesis has been the most enrichening experience in my career and I’m filled with gratitude for been given this possibility. It could not been made possible without the collaboration and support from several people. Support could come in many forms, and I have not space enough to thank all of you. But some special thanks goes to;

My first and warmest gratitude goes to my supervisors Cecilia Kjellgren and Doris Nilsson. Thanks for letting me on-board this important research project! Throughout the research project you have guided with tireless readings, thoughtful comments and pep-talk. Both of you have inspired and joined me in trying to enhance our field of practice by conducting relevant research.

Cecilia, my gratitude for you can’t be emphasised enough. From reading an article about a promising treatment to making a PhD position possible, you made this research happen. Never hesitating in challenging our own practice of child and family social work you have continued to be an advocate for children’s rights; you are my role model. Thanks for always being concrete and encouraging in your comments on my work and for letting me build on what you started. Thank you.
Doris you broaden my knowledge of trauma, symptoms and psychometrics. Your work with validating some of the assessment scales has grounded knowledge of the living conditions of vulnerable children in Sweden. You have always responded quick and being supportive in making the process move forward.

Torbjörn Forkby, thank you for generously reading and invaluable input in the final steps of the process.

Elisabet Näsman and Sofia Enell, thank you for your thorough reading and feedback during my midway and final seminars. Kerstin Arnesson, thanks for your valuable input in reading the final manuscript and encouraging support throughout the process.

Carl Göran Svedin, thank you for being a supportive working partner throughout the work with the thesis and valuable cooperation with the last article. You have been engaged in the work with CPC-CBT from the beginning and creative in thinking about how the thesis could go from a dream to reality.

To all of the children and their families across Sweden who have been brave enough to try to change a pattern and who accepted to participate in the studies, a warmest thank you for so generously sharing your thoughts, experiences and time with me; it has been such a privilege!

Bengt Söderström, Ylva Söderlind Göthner and Cecilia Sjölander at the Children’s Welfare Foundation (Stiftelsen Allmänna Barnhuset). My admiration for the work of the foundation has only increased during our collaboration. Having you as partners has been a tremendous privilege. The
perspective of the child is at your focus the entire time, and I’m deeply impressed by your patience, guidance and work effort in making the living conditions for children better. The work with implementing CPC-CBT in Sweden would not have been possible without you!

Anna Nelson, Ann-Christine Falk, Elisabet Kjellander, Emma Andersson and Linda Eriksson – you are pioneers, brave enough to lead the way in the field of social work and child and family therapy with abused children. To you and all the CPC-CBT therapists around Sweden, thanks for always welcoming me and supporting our research.

All my colleagues at the Linnaeus University. Especially thanks to Mikael Skillmark for always being supportive, for reading and commenting, but most of all for companionship. Emme-Li Vingare, for being a perfect team-member, Maria Nordstedt for endless conversations when traveling together, and all and former and present PhD students. My warmest thanks to Karin Pernebo for invaluable input and support, what a joy to have a fellow researcher with the same field of interest for continuing discussions!

Lotta Agevall Gross, Verner Denvall, Mikael and Cecilia, thanks for inviting me in your project and making the future looking bright. How fun to continuing doing research with you!

The work with the thesis started when I was employed at Högskolan Kristianstad. My gratitude goes to Stefan Hellmer for making the doctoral studies possible, to him and Fredrik Svensson, Gudmund Jannisa and Pia Rosander for continuing support and cheering.
Åsa Gustavsson, Gertrud Persson and Therese Åkergren, thank you for all your pep talks, interested questions and genuine concern even from before the thesis was a fact. The next round is on me!

To Olof Svensson, thanks for helping me keep alert by providing me with high quality chocolate throughout the writing process.

Arvid, Hedda, Saga and Theo – thank you for helping me with the cover. You are such stars!

All my relatives and friends, no named but no one forgotten, thanks for questions but also questions never asked, pep talks and dragging me out to the world “outside” from time to time, you are the best one could have and you all make me feel very rich.

To grandma, I’m sorry this is in English, but besides from that fact you have always supported me and telling me I could do this. I am blessed to have you.

Mum, Dad and Jenny, you are my roots, constantly giving me strength and courage. Thanks for always being at my ringside, being supportive and encouraging.

Emil, I might have “fallen behind” from time to time during this process, but you have continued to be my guiding lights. Thanks for thinking my work is important and encouraging me throughout the entire process.

Arvid and Hedda, how lucky I am to have the most thoughtful, kind, funny and completely lovely kids. I’m so proud of you, love you to the moon and back!
Papers included in the thesis


The individual contribution in the studies included in the thesis

**Study I**
Study design: Johanna Thulin, Doris Nilsson & Cecilia Kjellgren

Data collection: Johanna Thulin main part of the clinical sample, see manuscript for further details concerning the normative-sample

Analysis: Johanna Thulin

Writing the article: Johanna Thulin, Doris Nilsson & Cecilia Kjellgren

**Study II**
Study design: Johanna Thulin

Data collection: Johanna Thulin (14 interviews) and Cecilia Kjellgren (1 interview)

Analysis: Johanna Thulin & Cecilia Kjellgren

Writing the article: Johanna Thulin, Cecilia Kjellgren & Doris Nilsson

**Study III**
Study design: Johanna Thulin, Cecilia Kjellgren & Doris Nilsson
Data collection: Johanna Thulin (19 interviews) and Cecilia Kjellgren (1 interview)

Analysis: Johanna Thulin & Cecilia Kjellgren

Writing the article: Johanna Thulin, Cecilia Kjellgren & Doris Nilsson

**Study IV**

Study design: Johanna Thulin, Doris Nilsson, Carl Göran Svedin & Cecilia Kjellgren

Data collection: Johanna Thulin main part of the clinical sample, see manuscript for further details concerning the normative-sample

Analysis: Johanna Thulin (major responsibility), Doris Nilsson, Carl Göran Svedin & Cecilia Kjellgren

Writing the article: Johanna Thulin, Doris Nilsson, Carl Göran Svedin & Cecilia Kjellgren
Abbreviations and definitions

ACE Adverse Childhood Experiences
APQ Alabama Parenting Questionnaire
BDI Beck Depression Inventory
CPA Child Physical Abuse
CPC-CBT Combined Parent Child Cognitive Behavioral Therapy for families at risk for child physical abuse
CRC United Nations Convention on the Rights of the Child
IPV Intimate Partner Violence
LYLES Linköping Youth Life Experience Scale
PTE Potentially Traumatic Event
PTS Post-traumatic Stress
RCT Randomized Controlled Trial
SBU Statens Beredning för Medicinsk och Social Utvärdering (Swedish Agency for Health Technology Assessment and Assessment of Social Services)
SOC Sense of coherence
SSA Social Services Act
TAU Treatment-As-Usual
TF-CBT Trauma-Focused Cognitive Behavioral Therapy
TSCC Trauma Symptom Checklist for Children
TSCYC Trauma Symptom Checklist for Young Children
All individuals younger than 18 years are considered children in accordance with the UN convention and Swedish law. The terms child and childhood are used throughout the thesis. Even when childhood is used as a collective experience, it should not be seen as every childhood is the same. That is, every child and childhood is unique, with variations within as well as across families, villages, countries, cultures, conditions, and contexts.

Parent refers to the child’s caretaker. In reality, this could be a step-parent, adoptive parent, foster parent, or someone else taking a parental role.

Child abuse is a wide concept with several definitions. This thesis departs from the definition presented by the Commission Against Child Abuse: ‘Child abuse is when an adult exposes a child to physical or psychological violence, sexual abuse, or neglects to meet the child’s basic needs. Child refers to people under the age of 18’ (SOU 2001:72 p. 120, author’s translation). The definition used here is close to the definition presented by the World Health Organization (WHO): ‘Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power’ (WHO, 1999 p. 15). Both definitions list different types of abuse.

Although this thesis focuses on physical abuse, a child could be exposed to several kinds of abuse.
The WHO defines physical abuse as follows: ‘Physical abuse of a child is that which results in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be single or repeated incidents’ (WHO, 1999 p. 15). In Sweden, the Commission Against Child Abuse defines physical child abuse as follows: ‘[Child abuse occurs] when an adult causes a child injury, disease, pain or puts the child in a stage of powerlessness or a similar condition’ (SOU 2001:72 p. 121, author’s translation). The commission defines every form of corporal punishment as physical abuse.

UNICEF (2014) defines physical violence as including ‘all corporal punishment and all other forms of torture, cruel, inhuman or degrading treatment or punishment as well as physical bullying and hazing by adults or by other children. Corporal punishment is defined as any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light’ (UNICEF, 2014). UNICEF (2014) lists different forms of corporal punishment such as hitting, kicking, shaking, boxing ears, pulling hair, burning, slapping or spanking with or without objects. In this thesis, corporal punishment and physical abuse are interchangeable. That is, this thesis views all forms of corporal punishment as physical abuse.

Trauma is defined as an inescapably stressful event that overwhelms a person’s coping mechanisms (van der Kolk, 1996). Poly-traumatization is used to describe when an individual has been exposed to several potential traumatic events (Gustafsson, Nilsson & Svedin, 2009). The concept of poly-victimization (Finkelhor, 2008; Turner, Finkelhor, & Ormrod, 2010) is also present in relevant literature. Victimization refers to events caused by one or several persons with the aim of causing harm (Finkelhor, 2008). Victimization
excludes certain traumatic events such as the loss of a close relative or friend, disease, accidents, and war.

*Barnahus* (Children’s House) is the Nordic concept of a Children’s Advocacy Centre. A *Barnahus* is a facility for children exposed to violence and/or sexual abuse. Professionals cooperate under one roof to interview the child concerning the crime the child has been subjected to and to give the child multiple services in a child-friendly milieu.

Disclosure refers to the process of making previous secret information about maltreatment known to one or more recipients. Disclosure is a complex process involving several steps and judgements. A disclosure could be made verbally or non-verbally, as a well-thought out and planned decision or as a non-intentional verbal or non-verbal communicative act. In addition, a child could disclose in an informal network such as with family member, other relatives, or friends or in a formal network (also described as a professional recipient) such as with a teacher, a social welfare worker, or a police officer.
Introduction

Child physical abuse is a worldwide public health problem (Gilbert et al., 2009; Stoltenborgh et al., 2013). UNICEF estimates that over one billion children are victims of recurrent corporal punishment, indicating that six out of ten children worldwide are victims of physical abuse (UNICEF, 2014). In Sweden, this percentage is estimated to be considerably lower: 14% (Jernbro & Janson, 2017) to 15% (Annerbäck, Wingren, Svedin, & Gustafsson, 2010) of all teenagers in Sweden have reported at some time experiencing physical abuse at the hands of one or both parents.

The United Nations Convention on the Rights of the Child (CRC) states that every child has right of protection, provision, and participation. In the context of being a victim of child physical abuse, this concept implies protection from further abuse, sufficient support and interventions, and the child’s participation in decision making. To respond to the CRC, social workers at child welfare services as well as professionals in agencies meeting children must acknowledge children as agents with valuable information about what is in their best interest¹.

¹ The concept of the ‘best interest of the child’ (barnets bästa) will not be more deeply penetrated within this thesis. It is a core concept in the CRC and a concept incorporated within the Swedish Social Services Act as well as in the Parents’ Code. Furthermore, the Swedish government has decided that the Convention on the Rights of the Child should be law by 2020. However, there is criticism concerning the concept of what is best for the child, often concerning weak formulations and
This thesis departs from a Swedish context, where the child welfare service is responsible for investigating suspected child physical abuse and providing support and/or protection when necessary. All professionals working with children are obliged to report suspected abuse to child welfare services. However, some professionals working with children are reluctant to report suspected child maltreatment (Svensson, 2013: Svärd, 2016), leaving children unprotected by the welfare system. Furthermore, few children receive interventions aimed to prevent further abuse (Heimer, Näsman & Palme, 2017a; 2017b). Sweden was the first country in the world to ban corporal punishment (in 1979), but not until 2007 was an intervention introduced specifically targeting families where child abuse had occurred (Kjellgren, Nilsson & Thulin, 2017). To date, only a few methods have been tested in Sweden directed at child physical abuse (SBU, 2018). Of these methods, Combined Parent Child Cognitive Behavioral Therapy for families at risk for child physical abuse (CPC-CBT) is the only intervention developed that targets both the violent parenting and the abused child. Therefore, this thesis focuses on CPC-CBT. CPC-CBT was introduced in Sweden in 2007, and tested in a pilot study (Kjellgren, Svedin & Nilsson, 2013). The results indicated a decrease in parental use of physical abuse and decrease in children’s symptoms associated with trauma (Kjellgren et al., 2013). To test the efficacy of the intervention further, a larger research study was planned and is the foundation for this thesis. Specifically, this doctoral project focuses on children’s experiences with the intervention. To obtain background information about the consequences of the abuse concerning the effects of the parent-child dyad and the child’s sense of coherence (SOC), a study with a non-clinical group was designed, forming the first study of the thesis. To uncertainty, and consequently the outcomes for children (see Barnombudsmannen, 2005; Barnombudsmannen, 2011; Committee on the Rights of the Child, 2013).
better understand the thoughts and decisions of the children revealing the abuse, a second study was later formed to investigate the process of disclosing.

This thesis investigates whether the CPC-CBT intervention contributes to the end of a negative trajectory for abused children. The points of departure for this thesis are the findings in several previous studies: 14% of all children in Sweden report at some time being victims of child physical abuse (Jernbro & Janson, 2017); the presence of a large share of reported cases (57%) to child welfare services involve violence (Heimer et al., 2017a); possible harm in abused children (Annerbäck et al., 2012; Clarkson, 2014; Felitti et al. 1998; Gershoff, & Grogan-Kaylor, 2016; Grogan-Kaylor, Ma, & Graham-Bermann 2017; Moffitt, 2013; Nilsson, Nordås, Priebe, & Svedin, 2017; Norman, Byambaa, Butchart, & Scott, 2012); and child physical abuse results in long-lasting consequences (Felitti et al. 1998; Shonkoff et al., 2012). To improve the interventions provided by the child welfare services, the effectiveness of the interventions need to be evaluated from a child’s perspective. These points of departure form Study III and Study IV.

The aim and research questions
The overall aim of the thesis is to explore the experiences and possible consequences concerning reported health and the relations between a child who is victim of physical abuse and their parents, experiences among children disclosing the abuse, and the impact of an intervention designed to support these children in a Swedish context. The thesis is built on four studies, each with a specific research question:

1) What could the consequences of CPA on children’s experiences of their parents’ parenting strategies be and how do these strategies affect the children’s sense of coherence? (Study I)
2) How do physically-abused children experience and describe their process of disclosing abuse? (Study II)

3) How do physically abused children experience and describe participating in the CPC-CBT intervention? (Study III)

4) What impact do children report after participating in CPC-CBT with respect to decreasing parental physical abuse and increasing wellbeing? (Study IV)
Background

This chapter provides a context for the empirical studies within the thesis. First, the chapter provides a historical description of different landmarks regarding the prohibition of all forms of CPA in Sweden. Child abuse as a parenting strategy is explored and different risk factors are outlined from both a child and parental perspective, followed by possible consequences for victimized children. Next, the chapter focuses on the process of disclosing the abuse from a child’s perspective and the child’s experience with the interventions assigned by the child welfare service. Finally, the chapter briefly describes some interventions targeting child physical abuse with a special focus on CPC-CBT.

Raising awareness and towards a ban against physical abuse in Sweden

In 1979, Sweden became first country in the world to ban all forms of corporal punishment. In the language and Swedish legal framework of today, the concepts of corporal punishment and physical abuse are interchangeable. That is, all forms of corporal punishment are seen as physical abuse. However, this is not the case throughout the world, where corporal punishment could be accepted but physical abuse legally prohibited. This section presents a historical description concerning events leading to the Swedish ban. The description will focus on how the legal framework has changed from
supporting corporal punishment to prohibiting it. This is not an exhaustive exposition, but tries to shed light on some historical events leading to the new landmark concerning the rights of the child in Sweden. This section starts with the 20th century, a century named ‘the century of the child’ by Ellen Key (Key, 1900). Both the concepts of corporal punishment (aga) and physical abuse will be used to clarify how they became intertwined in a legal sense.

At the beginning of the 20th century, parents had the legal right to raise their children in any way they deemed suitable, including using corporal punishment as a parenting strategy. However, no one was allowed to physically hurt a child who was not part of their family; if an adult did so, they could be charged for a crime. Nonetheless, a legal custodian was free to judge what was a reasonable punishment or correction method, including the use of physical harm as a corrective measure. In addition, legal guardians such as school teachers had the same right to choose what constitutes a reasonable punishment, including corporal punishment. That is, the places where children spent most their time – at home and school – were the most unsafe places they could be (Bergenlöv, 2009).

In 1900, Ellen Key (author and pedagogue) denounced all forms of corporal punishment in schools as well as in homes in her book The Century of the Child (Key, 1900), ushering in a new set of values about the way adults should treat children. For Key, children should be free, accountable, and democratic citizens. Rather than seeing the child as the object of correction, Key saw the parents as requiring correction. For Key, corporal punishment was only used by parents who showed a lack of intelligence, patience, self-control, and dignity; that is, she saw corporal punishment as a disciplinary strategy that characterised deficient parenting (Key, 1900). According to Bergenlöv (2009), Key contributed to a new discourse concerning corporal punishment. With her
book, Key shed light on the inappropriateness of physically abusing children even under the guise of discipline.

In 1902, Sweden passed the first Child Protection Act (barnavårdslag). The law regulated the upbringing of maladjusted and neglected children (Prop., 1902). With support from the law, children could be separated from their parents if the child was considered vicious and maladapted. The act allowed school districts to implement child welfare committees (barnavårdsnämnder) that were in charge of looking after neglected and maladjusted children (Bergenlöv, 2009; Forkby, 2005). The child welfare committees consisted of members appointed by the local church, with the vicar as chair of the committee (Forkby, 2005). The law also stated that committees could warn maladapted children and use corporal punishment when necessary. The child welfare committees were charged with appointing the right person to perform the physical punishment (Bergenlöv, 2009).

According to Lundström (1993), the 1902 legislation was influenced by social control and protection, focusing on protecting society rather than children. The general view was that society should be protected against deviant, maladapted children so as to keep society safe for lawful citizens (Lundström, 1993). Over time, however, the Child Protection Act of 1902 was criticised. Partly, the rise in criticism of the 1902 law was the evolving belief that society should care for children who are victims of abuse and/or neglect and not only when the child was seen as problematic and a danger to society. Consequently, in the Child Protection Act of 1924, it became possible to separate children from their parents due to physical abuse and/or neglect (Bergenlöv, 2009; Lundström, 1993; SFS 1924:361). In addition, the Child Protection Act of 1924 extended the committee’s authority from 15 year olds to 18 year olds (Forkby, 2005; SFS 1924:361).
In the Child Protection Act of 1924 it became obliged to implement child welfare committees. According to Lundström (1993), the Child Protection Act of 1924 was an attempt to provide a rationale of effective child care that was uniform across the country. By gathering the different child protection missions within one organisation, the child welfare committee, there was a hope that judicious persons would be recruited to be members of the committees and that they would develop consistent and uniform child care. The proposition preceding the act specified which professions would take part in the committees – e.g., vicars, teachers, and medical doctors (Prop., 1924:150 § 3). It was believed that the different professions would provide a broader vision of the needs of the child: a vicar or priest would provide moral guidance, a teacher would provide child-rearing guidance, and a medical doctor would provide medical and child development guidance (Lundström, 1993).

Ohrlander (1992) describes how the child welfare committees obtained a normative role. They were assigned different tasks, such as to investigate, judge, control, interfere, and execute (p. 153). Ultimately, this broad responsibility was intended to secure good living conditions for all children. Ohrlander (1992) categorizes the missions for the child welfare committees into five domains: 1) securing proper conditions for a child, which could mean removing a child from parents’ custody; 2) inspecting institutions and homes for proper care of children, including the homes of un-married mothers, homes judged to be risk environments, homes of foster families, and homes for orphans; 3) establishing and keeping contact with people (e.g., priests and teachers) who could inform about suspected cases of abuse; 4) consulting and educating the public about good child-rearing and good home environments; and 5) spreading information about effective parenting by engaging people
considered well-established in child rearing such as child welfare committee agents, foster families, and supervisors (Ohrlander, 1992).

With an increased focus on the child in the early 20th century, harmful home environments received increased attention. Through placement in foster families or institutions, the child was supposedly guaranteed a good upbringing (Ohrlander, 1992). With the establishment of public social care, the responsibility for children was divided between parents, individuals, and the state (Andresen et al., 2011), where the state had the overall responsibility and right to intervene against the will of the parents and children.

Furthermore, with the new institutions, a pedagogical responsibility was achieved, considering not only the upbringing of the child but also good child-rearing practices. However, placement in institutions was also considered to have deterrent effects – i.e., a corrective effects (Ohrlander, 1992). The removal of the child from their parents could have been preceded by warnings. According to the Child Protection Act of 1924, corporal punishment and warnings were considered a first step for correcting maladjusted children (SFS 1924:361 § 22 chapter 3). In addition to being state-sanctioned, corporal punishment was also considered a mild punishment and necessary for child rearing (Ohrlander, 1992). However, the use of corporal punishment was banned in higher public schools in 1918 and in secondary schools in 1928 (SOU 2001:18). In addition, the view that residential care was the best option for children in need was gradually challenged; in 1960, a law was passed that favoured the use of foster families rather than residential care facilities (Andresen et al., 2011).

In the 1930s, the politician Alva Myrdal followed in the steps of Ellen Key. Myrdal thought that mothers and fathers needed education in order to provide
a good upbringing for their children and to share the responsibility of parenting. In 1931, she formed a study circle. Instead of talking about discipline and obedience, parents needed to develop an understanding of their child. The hierarchy between parents and children should even out, so the use of corporal punishment was unacceptable: ‘If we do not want to raise up for new dictatorships, this upbringing of personal obedience becomes unnecessary […]’ (Myrdal, 2002, p.119, author’s translation).

In 1945, a proposition was put forward in the Swedish Parliament concerning a total ban against corporal punishment in schools. It was argued that a ban against corporal punishment in secondary and upper secondary schools was appropriate but that the lack of a ban against corporal punishment in primary schools was illogical. The proposition was not passed, but it influenced public opinion and the School Commission called for an investigation. The investigation found that corporal punishment in schools should be banned. The proposal went onto referral, but faced resistance, especially from teachers. In 1947, the National Board of Education (Skolöverstyrelsen) appointed an internal investigation of school employees. However, the School Commission was not satisfied and presented a commission report concerning a more modern school. The concept of democracy was emphasised; that is, the commission found that children should be brought up to be democratic individuals. Freedom and independence were key words, so the use of corporal punishment was impossible. Furthermore, children’s exposure to harmful environments was brought forward, emphasizing treating and caring rather than repressing and correcting. In 1950, the investigation by the National Board of Education did not come to the same conclusion; this investigation advocated for a continued use of corporal punishment. The investigation was met with resistance, as only the public schools’ union
wanted to continue using corporal punishment. However, the public debate ceased (Bergenlöv, 2009).

In 1957, the defence of corporal punishment were removed from the Penal Code. During the 1950s medical doctors in Sweden were bringing attention to children with previously unexplained injuries. Per Selander (1957) wrote an article published in the *Swedish Journal of Medicine (Svensk Läkartidning)* about fractures and head traumas where he stated medical doctors should be attentive to possible child abuse. Since the abuse often re-occurs, Selander called for a focus on protecting the child. A few decades earlier, doctors in the US had started the same debate, initiated by paediatric radiologist Caffey who reported on bone fractures and head trauma, a focus picked up by Kempe and colleagues who named the condition of abused children the Battered Child Syndrome (Bergenlöv, 2009; National Board of Health and Welfare, 1969). The 1957 Penal Code’s removal of the defence of corporal punishment was followed by a 1958 ban on corporal punishment in all educational facilities (Bergenlöv, 2009). It would take another 20 years before the ban extended to children’s homes.

In 1960, paediatrics produced guidelines for assessing cases of Child Physical Abuse (CPA) and how to act when identifying an abused child. The Parliament appointed the National Medical Board (*Medicinalstyrelsen*) to investigate the number of cases of child physical abuse where hospital care was required (Pierre, 1975). By this time, the possible harmful effects of corporal punishment were known: ‘[. . .] physical abused children usually show severe physiological changes in form of depression, behavioural disturbances, and disturbances within the physiological life’ (National Board of Health and Welfare, 1969, p. 7, author’s translation). The investigation listed two categories of motives for the abuse: 1) abuse as a punishment with a
child-rearing motive and 2) abuse without a child-rearing motive. The committee stated awareness about some perpetrators of abuse, claiming the legal use of corporal punishment as an afterthought for ‘hiding such abuse that primarily aims of something entirely different than child-rearing’ (National Board of Health and Welfare, 1969, p. 8, author’s translation). Group 2 consists of cases of ‘murder, manslaughter and other malicious abuse’ (National Board of Health and Welfare, 1969, p. 8, author’s translation). The investigation covered 1957 through 1966 and included 119 children. The committee asked for all medical cases concerning suspected or confirmed physical abuse of children. Only 33 of 178 clinics or hospitals reported knowledge of such cases. A vast majority, 145 clinics or hospitals, indicated they did not have any abuse cases. The child welfare committees in Stockholm, Gothenburg, and Malmö did not report any cases due to lack of administration routines. The report, however, reveals improvements in the medical awareness of CPA. In 1957, only two children were identified as being physically abused (one death case), a number that increased to 35 children in 1966 (three death cases). The increase seemed to be caused by improved awareness and more frequent media reporting (National Board of Health and Welfare, 1969). The included children had received hospital care due to suspected abuse-related injuries. One-third of the cases were infants and two-thirds were below the age of three. In total, 15 children died. Of these 15 children, six came from homes that were labelled as ‘good homes’ with caring parents. For example, these children had been taken to their regular visits to child health care. These ‘new’ findings seemed remarkable (National Board of Health and Welfare, 1969).

With the publicity of some child abuse cases in 1970 and 1971, public opinion was changing about the efficacy and morality of using corporal punishment (SOU 2001:18). The author Gunnel Linde and journalist Berit Hedeby
arranged a public exhibition with photos of abused children, and in 1971 they formed the non-governmental organisation Children’s Rights in Society (Barnens Rätt i Samhället, BRIS).

The Swedish Parliament appointed the National Board of Health and Welfare and the Children’s Welfare Foundation to investigate the incidence of child abuse with a special focus on socio-economic factors of at-risk families. Children registered in child welfare services in 1969 and 1970 were included (National Board of Health and Welfare, 1975). The report revealed that only one-third of all child welfare committees reported knowledge of any cases of physical child abuse in that time frame. In addition, other professionals had a low frequency of reported cases. In total, the report concerned 777 children. Physical abuse was found in 30% of the cases. In 80% of these cases, child welfare had taken actions after the investigation. The intervention for half of these children was out-of-home placement (National Board of Health and Welfare, 1975).

In 1966, the previously approved parental use of corporal punishment was withdrawn from the Parents’ Code. Since then, corporal punishment is seen as physical abuse (Bergenlöv, 2009). However, corporal punishment was not explicitly banned in the Parents’ Code (Durrant & Olsen, 1997; SOU 1978:10). Furthermore, no ban was made concerning modest physical corrections, which led to difficulties judging what constitutes modest (Bergenlöv, 2009).

In 1978, the Minister of Justice appointed a new commission. This commission clearly stated the inappropriateness of using violence as a disciplinary strategy. The proposition that preceded the ban against corporal punishment was clearly stated and concluded all forms of corporal punishment
of children are violence (SOU 1978:10). Furthermore, the proposition stated
the need for parental education and stressed the importance of changing the
opinion of those in favour of using corporal punishment (SOU 1978:10). The
new ban was met with high approval and was supported by all political parties
and 98% of all Parliament members (Durrant, 1999). The change in the
Parents’ Code was put into force 1 July 1979. The new law became part of the
Parents’ Code, not the Criminal Code, as it was aimed at educating parents,
not punishing them. Since all forms of corporal punishment were to be
regarded as physical abuse, the Penal Code should be used when deciding a
penalty (SOU 1978:10). The ban was followed by an education leaflet that
was distributed to all families with a minor child. The leaflet was translated
into several languages. Furthermore, information was placed on milk cartons
to inform the entire family (Durrant & Olsen, 1997).

In 1982, another important step was taken when physical abuse in private
places, such as the homes of families, was subject to public prosecution. From
this point, anyone could report suspected abuse. In addition, in 1982, the new
comprehensive Social Services Act was implemented (SFS 1980:620). It
included legislation on child protection in a general framework for regulation
of the municipalities’ responsibilities for vulnerable groups. Healthcare, pre-
school, and school staff were now obliged to report suspected child abuse to
care services.

The current Swedish legislation

In 1979, Sweden became the first country in the world to prohibit all forms of
corporal punishment. As one of the first countries, Sweden also ratified the
UN Convention on the Right of the Child (CRC) in 1990. Relative to other
countries, Sweden has strong structural support for vulnerable children.
Sweden has taken legal actions that require welfare services to be provided to
physically-abused children using a family-centred approach (Gilbert, 2012). However, Leviner (2013) notes that prohibition against corporal punishment seems to work on an educational rather than judicial level. The act prohibits all forms of violence against children, but does not include any sanctions. In legal processes, the Criminal Code is applied. The Criminal Code in turn emphasises violence that causes lasting damage or pain, which could exclude, for example, boxing ears or pulling hair.

Since the ban, there has been a decrease in the number of children reporting being physically abused at home. When the ban was passed by Parliament, almost 50% of all children reported having been physically abused (Leviner, 2013), and 14% of all children in the latest national study report this victimization (Jernbro & Janson, 2017).

Since the ban was passed in Sweden, there has been a high rise in reports to the police concerning child physical abuse. During the first decade of the 21st century, reports to the police increased by 62% for children 7- to 14-years-old. For children younger than seven, the increase was 176%. The numbers not only refer to abuse committed by an adult, but also refer to violence between children (Leviner, 2013). The large increase in reports should not be interpreted as an increase in actual cases of CPA. Rather, the increase indicates an awareness and commitment among professionals and the public to report suspected CPA (cf. Janson, Jernbro, & Långberg, 2011). Other factors might explain the continuing increase in reports: the implementation of and collaboration with Barnahus (cf. Johansson, Stefansen, Bakketeig, & Kaldal, 2017) and recommendations concerning police reports (Child Welfare Services are required to report to the police all suspected cases of CPA; SOSFS 2014:6). Despite the rise in reported cases, Leviner notes the change in proportion of convictions has not changed since the law was passed and
argues that the judicial system seems to consider mitigating aspects and judge ‘milder’ forms of physical abuse as a social rather than a judicial problem (Leviner, 2013).

Child physical abuse as a parental strategy

Parents use different parenting styles. Parents’ attitudes about child rearing and goals for their child affect the emotional climate, which varies between parents, families, and cultures. The quality of the parent-child relationship has been found to be statistically correlated to the parent’s use of corporal punishment (Gershoff, 2002). Abused adolescents perceive their parents as having a less optimal parenting style and reported significantly more psychological distress such as anxiety and depression and lower global self-esteem than non-abused adolescents (Nilsson et al., 2017). Furthermore, parents with a responsive parenting style, including encouraging and showing appreciation, seem to foster children who are better at solving problems, better able to make decisions, and more confident than adolescents of parents with a demanding parenting style (Slicker, Picklesimer, Guzak, & Fuller, 2005). Parental use of corporal punishment has been found to precede poor developmental outcome for the child (Grogan-Kaylor et al., 2017).

As a parenting strategy, corporal punishment does not have any long lasting positive outcome for children (Gershoff, & Grogan-Kaylor, 2016). Some countries allow what is labelled ‘milder’ forms of corporal punishment such as spanking (e.g., hitting with an open hand). However, research supports the negative effects of all kinds of physical punishment (Gershoff, & Grogan-Kaylor, 2016). Furthermore, there is an increased risk that ‘milder’ forms of corporal punishment escalate to more severe forms (Gershoff, & Grogan-Kaylor, 2016).
Motivation to use violent discipline among parents

Swedish parents participating in an interview study mostly highlighted love and compassion as important factors in parenting (Jernbro, Svensson, Landberg, & Janson, 2018). Parenting is dynamic, for example changing as the child grows older. According to Swedish parents, several factors influence their parental strategies: 1) the parents’ social, physical, and mental abilities as well as their attitudes and personality, all factors related to the way the parents were raised; 2) the parents’ relationship with their child, partner, and other family members; 3) the parents’ work, economy, education, and parental support; and 4) the parents’ expectations and demands from family and society (Jernbro et al., 2018). Similarly, Annerbäck (2011) lists four factors that increase the likelihood parents will use corporal punishment: 1) propensity to use corporal punishment; 2) stressed social and financial situation; 3) lack of responsive network; and 4) child-related factors such as disabilities or young age.

Unlike Sweden, most countries view corporal punishment as an accepted parenting strategy. Parents who favour the use of corporal punishment as an effective parenting tool argue that corporal punishment is distinct from violence (Taylor, Hamvas & Paris, 2011a). According to Taylor et al., these parents argue that corporal punishment is a necessary strategy for teaching children right from wrong and is most often conducted out of love. Furthermore, these parents believe it not only keeps children safe from accidental harm but also gives children long-term lessons as well as a strategy to apply when other strategies are ineffective (Taylor et al., 2011a). Parents in favour of corporal punishment also argue that it is a way to get the child to obey and behave or that it is a way of teaching the child a ‘correct’ behaviour. The later implies using corporal punishment stops misbehaviour (Durrant, Rose-Krasnor & Broberg, 2003).
The opinion that corporal punishment is a normative behaviour and necessary for child-rearing increases the risk for this parental behaviour (Lansford et al., 2015). Parents who perceive corporal punishment as approved by professionals and family held more positive attitudes toward this disciplinary strategy (Taylor et al., 2011b). Likewise, adults who experienced corporal punishment as children and who considered this type of abuse as deserved reported higher approval of corporal punishment. Parents’ view of the abuse being deserved implies a view of children taking over the responsibility of the parental act (Durrant et al., 2017).

**Trends in parental use of corporal punishment in Sweden**

Parental use of and attitudes in favour of corporal punishment have decreased in Sweden over the past decades (Durrant, 1999; Janson et al., 2011; Jernbro et al., 2018). Sweden has a history of measuring both parental use of corporal punishment as well attitudes of parents towards corporal punishment. The Solna study, which included children born between 1954 and 1957, found that 95% of the mothers reported hitting their children at some point (SOU 2001:18), and around 30% of the parents reported hitting their one- to two-year old children daily (Janson et al., 2011). These parents also reported high frequencies of self-experienced physical abuse: 98% of the mothers and 88% of the fathers (SOU 2001:18). In 1980, before the Swedish ban of corporal punishment, a national survey of 1105 parents was conducted as part of the SUSA study (*Studier av Utgångsläget inför den Svenska Anti-aga lagen*). The SUSA study found that 51% of the parents reported using physical violence at some time during the previous year, and 40% reported using physical violence more than ten times the previous year (Edfeldt, 1985).
Due to the earlier described increase in police reports concerning physical abuse following the ban, the Ministry of Health and Social Affairs in 1998 appointed a committee to investigate the reasons for the increasing numbers and the frequency of child physical abuse and to improve the scope for preventing violence against children and the knowledge professionals have concerning corporal punishment (SOU 2001:72). To satisfy this responsibility, the committee in year 2000 used the same SUSA survey (1609 parents responded): 8% reported using corporal punishment at some time during the previous year, 16% of them reported using corporal punishment more than ten times during the previous year (SOU 2001:72).

In 2011, another national survey was conducted (1358 parents responded) (Janson et al., 2011): 92% reported negative attitudes towards corporal punishment and 3% reported that during the previous year they had physically hurt their children. Parents responded that instead of physical abuse they tried to discuss with their children and distract them depending on age of the child (Janson et al., 2011). In 2017, the survey was sent out yet again (1051 parents responded): 1.9% reported that during the previous year they had used physical violence towards their child (Jernbro et al., 2018).

Historically, changes in public opinion precede changes in law; however, in this case, the law (i.e., banning corporal punishment) preceded changes in public opinion and ultimately behaviour (Bergenlöv, 2009). That is, the Swedish Parliament used a legal framework to change opinions about corporal punishment. Countries that ban corporal punishment report less support of use of corporal punishment as a parenting strategy (Zolotor & Puzia, 2010). However, no ban is placed in a vacuum. Negative opinion about the use of corporal punishment often precedes legislation (Zolotor & Puzia, 2010). Although opinion in Sweden was already shifting towards more negative
attitudes against corporal punishment before the ban, studies have shown that
the ban influenced parental attitudes about corporal punishment. The
percentage of parents in favour of corporal punishment decreased in each
survey: 53%, 35%, 26%, and 11% for 1965, 1971, 1981, and 1984, respectively. Despite the efforts in changing the Penal Code in 1957, 50% of
the population was still in favour of using corporal punishment, a number that
was halved by 1981 (Durrant, 1999; Janson et al., 2011). Although there have
been some remarkable shifts in opinion about corporal punishment, since 1994
the opinion has been relatively stable, with a decrease from 11% (1994) to 7%
(2006) and 8% (2011) (Table 1). However, in 2017, only 0.3% of the parents
favoured using corporal punishment (Jernbro, et al., 2018). By 2017, it
appears that using violent disciplinary strategies had become taboo (Jernbro et
al., 2018). In a 2017 interview study, 95% of the parents stated that conflicts
with children should be solved through discussions and that violence was both
physically and psychologically harmful to children (Jernbro et al., 2018).

Table 1. Trends in parental attitudes in favour of using corporal punishment

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of parents in favour of using corporal punishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1965</td>
<td>53%</td>
</tr>
<tr>
<td>1968</td>
<td>35%</td>
</tr>
<tr>
<td>1971</td>
<td>26%</td>
</tr>
<tr>
<td>1981</td>
<td>11%</td>
</tr>
<tr>
<td>1994</td>
<td>7%</td>
</tr>
<tr>
<td>2006</td>
<td>8%</td>
</tr>
<tr>
<td>2011</td>
<td>0.3%</td>
</tr>
<tr>
<td>2017</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Note. a Numbers retrieved from Janson, Jernbro, & Långberg, 2011.
b Numbers retrieved from Jernbro, Svensson, Landberg, & Janson, 2018.
Possible consequences of physical abuse

Victimization of child physical abuse is correlated with both internalizing and externalising problems (Gershoff, & Grogan-Kaylor, 2016; Moffitt, 2013; Norman et al., 2012). Physically-abused children are at risk for decreased mental health (Annerbäck et al., 2012; Clarkson 2014; Felitti et al., 1998; Grogan-Kaylor et al., 2017; Nilsson et al., 2017) and decreased physical health (Felitti et al., 1998; Moffitt, 2013). Furthermore, the abuse could affect school performance (Huang, & Mossige, 2012; Maclean, Taylor, & O’Donnell, 2016) and increase risk-taking behaviours (Annerbäck et al., 2012) and aggressive behaviours (Howell, 2011).

Physically-abused children have an increased risk of developing PTSD (Sugaya, et al., 2012). According to Hiller et al., PTSD symptoms that last more than six months are likely to persist if not treated (2016). However, most of the studies included in the meta-analysis conducted by Hiller and colleagues includes children who experienced accidents or non-interpersonal traumas, for example, hurricanes and car accidents (2016). It is possible that children’s parents helped them cope with their experiences. Children who experience interpersonal traumatic events (such as physical abuse) are more likely to develop PTSD than children who experience accidents or non-interpersonal traumas (Alisic et al., 2014), further arguing for the need of effective interventions. Alisic et al. argue that the higher presence of PTSD when experiencing interpersonal traumas could be due to the often more chronic condition (e.g., repeated abuse). Furthermore, when the perpetrator is a parent, there could be a lack of social and emotional support (Alisic et al., 2014). Physically-abused adolescents report psychological distress such as anxiety and depression and lower global self-esteem more than non-abused
adolescents, and they perceive their parent as having a less optimal parenting style (Nilsson et al., 2017).

Early stressful experiences such as child physical abuse affect the genetic predisposition. Being exposed to ongoing stressful events affects the developing brain, which could result in long-term health consequences (Shonkoff et al., 2012). What today are known as adult diseases could actually be explained by developmental disorders (Shonkoff et al., 2012). In the light of the emerging research concerning how the developing brain is affected by stressful events, such as child physical abuse, the impact of CPA must be understood in a life-long perspective. Being a victim of abuse could affect the child’s school performance (Huang & Mossige, 2012; Maclean et al., 2016), which further could affect future career possibilities. Taken together, the emerging research on child physical abuse from different perspectives indicates a possible life-long impact of abuse victimization.

**Poly-victimization/traumatization**

Children who have experienced multiple kinds of adverse childhood experiences or potentially traumatic events are particular vulnerable (Clarkson, 2014; Felitti et al., 1998; Jernbro & Janson, 2017). Experiences of potentially traumatic events are common during childhood (Turner, Finkelhor, & Ormrod, 2010), and a vast majority (84%) of Swedish teenagers report that they have experienced at least one potentially traumatic event (Aho, 2016). Experiencing different kinds of potentially traumatic events affects the child’s wellbeing more than being exposed to the same kind of event repeatedly (Turner et al., 2010). Furthermore, a recent Swedish study reveals that children who have been exposed to more severe abuse or repeated abuse are
more likely to also be exposed to other forms of maltreatment (Jernbro & Janson, 2017).

On average, children report experience three (Finkelhor, 2008) to four (Aho, 2016) potentially traumatic events. Finkelhor et al. (2009) found that the 10% reporting the highest levels of victimisation could be defined as poly victims. In a Swedish study, this meant that children were experiencing ten or more events (Aho, 2016). In addition to the physical harm, poly-victimisation could increase different kinds of trauma symptoms, such as anger, depression, and anxiety (Finkelhor, Ormrod, & Turner, 2007).

Victims of child physical abuse are likely to also experience neglect, sexual abuse, and being exposed to intimate partner violence (Jernbro & Janson, 2017; Sugaya et al., 2012) as well as being bullied in school (Jernbro & Janson, 2017). Some children experience so many potentially traumatic events that the victimisation should be seen as a continuing state rather than as single events. Children could be exposed both at home, in school, in the neighbourhood, and on the Internet, decreasing the possibility for a safe, nurturing place. These circumstances could lead to a brain on constant alert, resulting in diseases such as heart problems and dementia (Moffitt, 2013).

**The process of disclosing abuse**

Despite the fact that 14% (Jernbro & Janson, 2017) to 15% (Annerbäck et al., 2010) of children in Sweden report being physically abused by one or both caretakers at some point, few of these children receive the attention of child welfare services. One-third of all physically-abused children do not report the abuse to anyone, and around one-third disclose to one adult. Only 7% disclose
Disclosure is a process, not a single event (Alaggia, 2010; Foster & Hagedorn, 2014; Jensen et al., 2005). Children are more likely to disclose abuse from a perpetrator outside the family than abuse from a family member (Lorentzen et al., 2008; Lyon et al., 2010). Victims of physical child abuse sometimes have warm affection and concern for their perpetrators, protecting them by not disclosing the abuse (Lemaigre, Taylor, & Gittoes, 2017). Furthermore, shame, guilt, or fear of not being believed often prevents a child from disclosing (Foster & Hagedorn, 2014). Fear could prevent a disclosure, but a decision to disclose could also be made when the child has no hope for the abuse to end (Allnock & Miller, 2013; Linell, 2015). When experiencing the violence as unbearable, a disclosure is often perceived as the only way out (Linell, 2015).

It is important for adults to facilitate a disclosure. When the abuse is not detected, the child is at risk for further victimization and the possibility for support and interventions decreases (Foynes, Freyd, & DePrince, 2009). A disclosure could come when the child sees an opportunity to tell their story of abuse to a trusted adult. These kinds of unintentional disclosures could be facilitated when the topic is addressed in, for example, school (Allnock & Miller, 2013; Jensen et al., 2005). Furthermore, children suggest that schools should provide more information about child abuse and children’s legal rights (Jernbro, Eriksson, & Janson, 2010). In addition, children also stress the importance of adults being observant and willing to ask questions (Allnock & Miller, 2013; Lemaigre et al., 2017). School seems to be the most important arena where children can turn to adults for help. Children most often disclose their physical abuse to teachers, school nurses, and counsellors when
disclosing to professionals (Jobe & Gorin, 2013; Linell, 2015). When disclosing, children want adults to listen and to act on the information. Adults also need to provide support for the child and explicitly believe what they are told (Allnock & Miller, 2013; Jernbro et al., 2010).

The reporting on suspected physical abuse to child welfare services and the child care funnel

To ensure the protection of vulnerable children, several authorities need to cooperate. Child welfare services is responsible for providing support and/or protection but needs to be aware of which children are in need. In Sweden, all professionals who have contact with children in their work (such as child healthcare workers, school personnel, and childcare workers) are required to report any child abuse they suspect or know about (SFS 2001:453, chapter 14). However, the likelihood of reporting to child welfare services varies. Preschool teachers only report to child welfare services in 30% of cases where they suspect child abuse (Svensson, 2013). Among healthcare providers, 66% failed to report suspected child abuse (Borres & Hägg, 2007). A prevalence study revealed that no dentists reported suspected abuse within a six-year period (Kvist, Cocozza, Annerbäck, & Dahllöf, 2017). According to Cocozza (2007), only 2% of all reports of child physical abuse over one year came from child health centres. Lack of confidence in child welfare services was the most common reason for not reporting (Borres & Hägg, 2007). According to a recent thesis, nearly six out of ten hospital staff working with children have chosen not to report to child welfare services despite suspicions of child maltreatment (Svärd, 2016). An interview study with hospital staff revealed several reasons for not reporting suspected child abuse: their insecurity about judging what is considered abuse or maltreatment; their ambivalence regarding how to act; and their lack of confidence in the interventions child welfare services provide (Svärd, 2016). Fear could also be a barrier to
mandatory reporting. However, no reports were labelled fear for the safety of
the child or fear of worsening the relationship with the child, rather 25% of
nurses and nurse assistants reported fearing for their own safety and nearly
40% of physicians reported fear of worsening their relationship with the
parents as reasons for not reporting (Svärd, 2016).

The process from report to intervention has been described as a funnel
(Wiklund, 2006; Östberg, 2010). There is an on-going out-filtering process
from reports to investigation and later to possible intervention where the
reports mark the open top of the funnel and the narrow bottom mark the few
children receiving an intervention (Wiklund, 2006; Östberg, 2010). The
National Board of Health and Welfare reported a declining trend among local
authorities to start an investigation within the child welfare services (National
Board of Health and Welfare, 2012). Two Swedish doctoral theses reveal that
between 41% (Cocozza, 2007) and 70% (Östberg, 2010) of all reported cases
(on different forms of maltreatment) are filtered out before an investigation.
As of 2014, legislation was sharpened and requires child welfare services to
initiate an investigation of all cases of suspected child abuse (SOSFS, 2014:4).
The low inclination to file a report decreases the possibility for abused
children to receive help. A considerable proportion of the incoming reports are
filtered out before an investigation, further diminishing the possibility of the
children receiving adequate interventions. Of the reports not resulting in the
initiating of an investigation, 45% of these children were investigated for
being victims of child physical abuse within five years (Cocozza, Gustafsson
& Sydsjö, 2006). According to Cocozza (2007), only 16% of all reported files
during a year lead to an intervention. Studying the out-filtered reports revealed
that child welfare service in only 6% of the cases chose to talk to someone
outside the family (Cocozza et al., 2006). Taken together, there are reasons for
concerns that physical abused children are not receiving the support they need.
The child within child welfare services

In Sweden, professionals use different concepts to express concern for children. For example, physical abuse of children can be referred to as children at risk, vulnerable children, children in danger, or child maltreatment. This lack of clear terminology is compounded by the fact that the concepts are not legal definitions (Kaldal, 2010). Intimate Partner Violence (IPV) is translated into Swedish as Våld i nära relation (VNR), which could be back-translated to Violence in Close Relation. Both IPV and VNR refer to the violence within the partner relationship. However, since VNR uses the broader concept of close relation, some suggest this could include violence against the child. This thesis departs from a view that violence against the child must be highlighted as a specific form of violence (even though it often co-exists with IPV). The importance of using child physical abuse as a concept rests on seeing the child as a subject, a person in a special position. The child has not chosen to live in a specific relationship and has no possibility to act in the same way as an adult in a close relation. Children need to be positioned, not marginalised. Furthermore, general talk and writing about child welfare could focus on the family system more than on the child, meaning that the specific problems or phenomena such as child abuse could go unrecognised (Pösö, 2011). Child welfare interventions are often motivated by a holistic perspective of the child’s situation rather than pointing out any single problem, such as abuse (Pösö, 2011).

Child welfare services can be divided into two broad categories: child protection service and family service (Gilbert, 1997; Gilbert, Parton & Skivenes, 2011). Sweden and the other Nordic countries have adopted a family service system that focuses on the needs of the child and family (Križ & Skivenes, 2017). The Nordic countries have similar approaches to child
welfare in both their legislation and their organization of child welfare (Eydal & Kröger, 2011; Gilbert et al., 2011). Unlike many countries, the Nordic countries have made physical abuse and corporal punishment illegal (Johansson et al., 2017). The differences concerning the organisation of child welfare services is highlighted in this chapter due to the relevance for the thesis: the study of the US intervention (a child protection system) carried out in a Swedish context (a family service system). The family service perspective focuses on prevention and support and strives to achieve consent from parents (Pösö, Skivenes & Hestbæk, 2014). Interventions favour in-home solutions. Parents are seen as responsible for their children and child welfare services aims to compensate eventual shortcomings and help parents develop better parenting strategies (Pösö et al., 2014). However, by focusing on holistic interventions based on the consent of the parents, children could remain in a dysfunctional family setting. That is, using a family perspective could be applied on the expense of a child perspective (Pösö et al., 2014). Although children in the Nordic countries have a strong participatory right within society (Križ & Skivenes 2017), child welfare services still needs to be more child-centric in their decision-making (Pösö et al., 2014).

The two systems – the child protection system and the family service system – seem to be approaching each other, making the distinctions no longer adequate (Gilbert et al., 2011). A third system or approach has been suggested: a child-centred approach (Pösö, 2011) or a child-focused orientation (Gilbert et al., 2011). This new approach seems to value the practice of social work from a child perspective. Furthermore, this approach could inspire new methods for working with children (Pösö, 2011). In a child-focused orientation, the child is seen as an individual with needs that could contrast with the needs (or will) of the family. Gilbert et al. (2011) argues that a child-focused orientation could lead to de-familiarisation. For example, the
implementation of *Barnahus* is a way of making sure the child is heard and taken care of regardless of the cooperation of the child’s parents (Gilbert et al., 2011). Similarly, Swedish legislation has taken several steps to advance the right of the child (e.g., the right to be heard regardless of parents’ objections and the obligation to initiate an investigation when child abuse is suspected). However, the child’s legal rights to participate and be heard in the investigation process seem to be ignored when child welfare services decides about an initial investigation (Cocozza et al., 2006; Heimer et al., 2017a).

Talking with the family could be the only source of information, and the conflict of interest between children’s need of protection and parents’ reluctance to reveal information needs to be further problematized (cf. Cocozza et al., 2006). Furthermore, even when reports are made to child welfare services due to suspected child physical abuse, Heimer et al. are addressing the diminishing of violence in the investigation and how it often is not mentioned as a problem when discussing interventions (Heimer et al., 2017a). This could explain why children re-enter the system as the result of new child abuse reports (Jonson-Reid, Drake, Chung, & Way, 2003; Lindell & Svedin, 2006).

As the child welfare process progresses, children’s voices seem to weaken, whereas parents’ voices seem to strengthen (Heimer et al., 2017b). As the care and intervention planning phases approach, child welfare to a large extent frames interventions according to the parents’ rather than the child’s perspective (Heimer et al., 2017b). In addition, the lack of parental responsiveness is often reframed as the behavioural problems of the child during the process, resulting in interventions that are poorly matched to the needs of the child (and the family) (Heimer et al., 2017b).
Many physically-abused children found that child welfare services provided insufficient or unsatisfying help (Jernbro et al., 2010). A vast majority (74%) of children entering child welfare services are still in contact with child welfare services after four years (Lindell & Svedin, 2006). International (Jonson-Reid et al., 2003) as well as Swedish (Lindell & Svedin, 2006) research reveals that more than 40% of children referred to child welfare services due to child physical abuse are re-referred because of new reports of abuse within four years. Furthermore, child welfare services has on average known about child physical abuse the five years before applying for Care of Young Persons Act (CYPA) in order to protect the child (Linell, 2017). Obviously, the previous interventions required by the Social Services Act that these children received were inadequate. The children’s lack of participation in their child abuse investigations (Cocozza et al., 2006; Heimer et al., 2017a) and the number of re-referrals to child welfare services (Jonson-Reid et al., 2003; Lindell, & Svedin, 2006) support the children’s perception that interventions provided by child welfare services are ineffective, leaving the children vulnerable to further abuse and its consequences (Jernbro et al., 2010).

The Convention on the Rights of the Child – with special focus on participation

The Convention on the Rights of the Child (CRC) was adopted in November 1989 by the United Nations General Assembly. The CRC consists of 54 articles including social, economic, cultural, civil, and political rights of the child. Some articles with special relevance for this thesis will be given further consideration. In brief, the CRC opens by stating that everyone below the age of 18 should be considered a child (Article 1) and that the best interest of the child shall be of primary consideration in all actions concerning children.
(Article 3). Article 12 outlines the child’s legal rights to be heard and the obligations of governments to ensure these rights:

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law. (UN CRC, Article 12, 1989)

This article is incorporated within the Swedish Social Services Act 11 chapter 10 §. Article 12 concerns the right to be heard. It should be seen in accordance with Article 13, the right to freedom of expression. Doek (2009) argues that both articles, together with Article 15, the right to freedom of association, form the foundation for participation. Article 19 goes further by stating that governments should protect children from all forms of violence, physical as well and psychological, including all forms of exploitation, sexual abuse, neglect, exposure to accidents, and violent images:

States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. Such protective measures should, as appropriate, include effective procedures for the establishment of social
programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement. (UN CRC, Article 19 1989).

In a retrospective study 20 years after the ratification of the CRC, Doek (2009) argues that the CRC has been successful in putting children’s rights on the agenda throughout the world. The almost unanimous ratification was historical. By signing the CRC, member states accept that abuse (as defined in the CRC) is a violation of the child’s fundamental right of being protected from all forms of violence regardless of a society’s norms. However, the work towards a unanimous view of the inappropriateness of physical abuse together with the goal of ending poverty have been the major obstacles in realization the CRC (Doek, 2009). A special report was ordered by the General Assembly and presented in 2006. It suggested that all member states make all forms of violence against children illegal by 2009. Although Doek (2009) reports improvements in the number of countries that have made all forms of child abuse illegal, the results have not been what was expected. However, the work towards a world-wide ban of all forms of child abuse continues. In Agenda 2030 (adopted by all member states in 2015), the member states of the United Nations are encouraged to work to end all forms of violence against children, including working towards both prevention and a ban of corporal punishment (Violence Against Children, 2019).

In summary, the UN Convention on the Right of the Child declares three kinds of rights for the child: protection, provision, and participation. The children have the right to protection and care, to provision of service and to participate in decision making when it concerns them. In the General comment on the
CRC, the UN Committee on the Rights of the Child (2009) refer to the 12th paragraph with respect to the right to participation. As the Committee points out, although the term participation does not appear in the 12th paragraph, the term is the cornerstone of the CRC. Participation is to be seen as ‘ongoing processes, which include information-sharing and dialogue between children and adults based on mutual respect’ (2009, p. 5). The Committee further emphasises the need for information-sharing and that children should be able to understand how decisions are made and to what extent their voices have been recognized (UN Committee, 2009). The General Committee has criticised Sweden for not living up to its obligations. In their latest observation, the General Committee criticises Sweden for insufficiently implementing the CRC’s recommendations, especially concerning investigations by child welfare services (Committee on the Rights of the Child, 2015).

Children’s participation in decision meetings concerning their case can make professionals more aware of the needs and wishes of the child. By setting mutual outcome goals, the different aspects of interventions could be discussed. This discussion could increase the child’s motivation to work towards the goal (Bell, 2011). However, whether a child participates in decision making is often determined by an adult. According to Bell (2011), organisational settings are required for participation. In addition, adults need to use familiar words to make sure that the child understands what the adults are saying.

Two Swedish theses concerning child welfare services’ approach to children experiencing domestic violence found that children are not invited to participate in the investigation process (Dahlkild Öhman, 2011; Sundhall, 2012). If heard, their statements are not considered to the same extent as the
adults (Sundhall, 2012; see also Leviner, 2011). The consequence of this oversight is likely to be that the investigation about the child tends to be based on an adult perspective. A study of court verdicts reveals that a child agreeing with a professional’s opinion is considered a competent child, but a child disagreeing with a professional’s opinion is considered incompetent (Röbäck & Höjer, 2009). Furthermore, children could describe a lack of information, not knowing how their given information was to be handled, and what would appear in the investigation document (Eriksson & Näsman, 2012).

In terms of protection and participation, child welfare services seems organized towards a perspective of protection, which may not be compatible with child participation. Although children’s rights have increased, especially in the field of legislation, the adult perspective has precedence in most outcomes (see Leviner, 2011; Sundhall, 2012). People are largely judged by their age: the older one is, the more mature one is viewed. This view categorises people as children or adults. Children are to be socialized to become competent adults, but are not always invited in processes that affect them and are as a consequence cut out from the possibility to express their views and experiences, leaving the process of socialisation a bit effete. However, participation can in fact enhance the provided interventions from child welfare services and improve the outcome for the child (Vis et al., 2011). There is no reason not to give vulnerable children participatory rights within child welfare in order to protect them. As Heimer and Palme state, participation is essential for whether the child will receive protection and provision (2016, p. 449).

**Interventions for physically abused children**
In the investigation preceding the ban against corporal punishment, the committee stressed the importance of educating parents about the new ban and
the harmful effects of using violence directed at children (SOU 1978:10). As described earlier, a campaign was launched, including information on milk cartons and the distribution of an information leaflet (Durrant & Olsen, 1997). However, no specific intervention was offered to families in need. Compared to methods targeting CPA, more methods have been developed and implemented that support children exposed to intimate partner violence. In Sweden, interventions like Trappan (Källström Cater, 2008), Bajen (Almqvist, Georgsson, Grip, & Broberg, 2012), and Kids Club (Källström Cater & Grip, 2014) have been evaluated. The results show that participants appreciate these interventions, but for several children the trauma symptoms remained at follow-up.

Few studies have evaluated the impact of interventions targeting victims of child physical abuse. In a recent review concerning treatment of trauma exposure, only three studies were identified that concerned victims of physical abuse (Dorsey et al., 2017). Furthermore, the current literature is insufficient when it comes to evaluating how children experience interventions from social welfare services (Pösö et al., 2014; SBU, 2018) and child psychiatric clinics (Biering, 2010; Pernebo, 2018).

Children receiving different interventions from mental health services highlight the relationship with the therapist as an important factor for treatment outcome. Trust-building and confidentiality are described as essential components of any professional interventions (Davies, & Wright, 2008; Dittman & Jensen, 2014; Freake, Barley & Kent, 2007). Children want adults to listen to them and try to understand them (Day, Carey, & Surgenor, 2006). Furthermore, children want to be given information and to be involved in decisions concerning their treatment (Biering, 2010; Davies & Wright, 2008; Freake et al., 2007). They often find that a lack of information
concerning the content and purpose of their therapy makes it difficult to prepare for treatment (Day et al., 2006).

Children describe the trauma narrative as one of the most helpful components in treatment (Dittman & Jensen, 2014). Verbalizing the problem provided a sense of relief (Day et al., 2006). Sharing their story with their parents in a safe environment could help the children understand their parents’ ability to deal with their emotions. This is important for maintaining the child-parent relationship and the healing of the child, since the parents provide support for their child when treatment is completed (Dittman & Jensen, 2014). However, not all children are comfortable with talking, so non-verbal interactions such as drawing or playing are important (Davies & Wright, 2008).

The research on children’s experiences with treatment is even more rare concerning younger children (Biering, 2010; Pernebo, 2018). However, Pernebo and Almqvist (2016) have interviewed children aged 4 to 6 years who were exposed to intimate partner violence on their experiences with group treatment. These children highlight joy, feeling safe, building relationships with the group members, talking about the violence, and competence as important aspects of counselling (Pernebo & Almqvist, 2016).

As previously noted, little has been done concerning developing treatment interventions for physically-abused children in Sweden (SOU 2001:72). The following section will give a brief introduction to some internationally developed and tested interventions, included in the SBU review of treatment interventions targeting abuse and neglect (SBU, 2018). The studies included in the review were mostly conducted outside Sweden. The section begins by describing two interventions that focus on parents of young children: Project Support and Parent-Child Interaction Therapy (PCIT). The next two
interventions have an extent age-span and include the child in a more direct way: Multi Systemic Therapy for Child Abuse and Neglect (MST-CAN) and Combined Parent Child Cognitive Behavioral Therapy for families at risk for child physical abuse (CPC-CBT). CPC-CBT is the only intervention that teaches violent parents non-violent parenting strategies while helping their children recover from their experiences without explicitly focusing on the child’s behaviour. Project Support, PCIT, and MST-CAN were originally developed to help parents handle children with behavioural problems. Using an integrated approach, CPC-CBT focuses on the parents’ aggressive behaviours and the consequences for the child. As CPC-CBT is the focus of this thesis, a more detailed description is provided.

**Project Support**

Project Support, a parental intervention, was originally developed to support mothers who were victims of interpersonal partner violence handling their children with conduct problems. Project Support teaches the parent child management skills focusing on reducing harsh parenting with the support of a therapist (Jouriles et al., 2010). Project Support takes it cues from social learning theory with emphasis on reinforcement and ignorance. In the family’s home, therapist demonstrates and instructs the parents in different parenting skills. Although a manual-based program, the intervention emphasises flexibility as a means to meeting the needs of each family (Jouriles et al., 2010). The intervention targets parents with children aged 3 to 9 (National Board of Health and Welfare, 2018).

According to the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU, 2018), families who participated in Project Support had fewer abuse referrals to child welfare services than families receiving treatment-as-usual (TAU). Parent’s experiencing IPV reported less externalising behaviour by their children after completing Project
Support compared to TAU; however, there were no significant differences concerning the child’s internalising behavioural problems and no differences were reported concerning the mental well-being of the parents (SBU, 2018).

The intervention is implemented in Sweden and there is ongoing research on the outcomes. A pilot study reveals promising results within a Swedish context (Draxler, Hjärthag, & Almqvist, 2018).

**Parent-Child Interaction Therapy (PCIT)**

PCIT, developed for children up to the age of twelve, addresses the interaction between parents and children. PCIT aims at changing dysfunctional patterns in the parent-child dyad by coaching parents in their interaction with their child. The intervention was originally developed for children with emotional and behavioural disorders.

PCIT is an evidence-based intervention that borrows from attachment theory (i.e., teaching the importance of parental responsiveness and a strong and secure attachment), developmental theory, and social learning theory (i.e., teaching limit setting and consistency within a responsive relationship). PCIT has been reported to be successful in an international context concerning reducing children’s externalising behaviours and increasing the positive relationship between child and parent (SBU, 2018), and reducing parental stress (Kennedy et al., 2016). Parents completing PCIT have fewer abuse referrals to child welfare services (Kennedy et al., 2016; SBU, 2018), but no significant differences have been reported regarding parents’ inclination to use violence after treatment (SBU, 2018). Furthermore, compared to TAU, no significant differences have been reported concerning children’s internal behaviour (SBU, 2018). Moreover, PCIT is rarely used in Sweden, so it is difficult to properly assess its effectiveness in a Swedish context.
Multi Systemic Therapy for Child Abuse and Neglect (MST-CAN)

MST-CAN is an evidence-based intervention for families with children ages 6-17. Families come to the attention of child welfare services for suspected physical abuse and/or neglect. MST-CAN includes the entire family in in-home interventions aimed at keeping the child with the family. MST-CAN includes a minimum of three sessions per week, typically lasting six to nine months. Treatment includes components from cognitive behavioural therapy (handling anger and processing trauma), reinforcement-based therapy (addressing adult substance misuse), family therapy (communication and problem solving), as well as safety planning and addressing parental responsibility over the child’s wellbeing (www.mstcan.com).

A randomised control study revealed that MST-CAN reduced youth mental health symptoms, parental psychiatric distress, and parenting behaviour associated with maltreatment (reducing neglect, psychological aggression, and reports of assault). Although the intervention reduced abuse re-referrals, the difference was not statistically significant compared to a control group (receiving Enhanced Outpatient Treatment, EOT) (Swenson et al., 2010). However, in Sweden, MST-CAN is rarely used.

Combined Parent Child Cognitive Behavioral Therapy for families at risk for child physical abuse (CPC-CBT)

The intervention is developed by Runyon and colleagues at the CARES Institute (Child Abuse Research Education and Service). Combined Parent Child Cognitive Behavioral Therapy for families at risk for child physical abuse addresses physical violence and its consequences for children by focusing on parenting strategies (Runyon, Deblinger, Ryan, & Thakkar-Kolar, 2004). CPC-CBT is intended to help parents end and replace corporal punishment with positive parenting strategies and to help children recover
from their experiences of being victims of abuse. The intervention addresses the whole family, including the violent parent (Runyon & Deblinger, 2014).

Although mainly based on cognitive-behavioural theory, CPC-CBT also relies on systemic theory, trauma theory, developmental theory, and motivational theory/interviewing. The intervention includes components that previous research has proven effective for treating physically-abused children and their parents such as positive reinforcement and behavioural contracting (Runyon et al., 2004). As in trauma-focused cognitive behavioural therapy (TF-CBT), careful and gradual exposure of the trauma is a significant part of the CPC-CBT intervention (Runyon & Deblinger, 2014).

In Sweden, child welfare services makes risk-assessments concerning the safety of the child and assess whether CPC-CBT could be an appropriate intervention for the family. Risk-assessments are conducted repeatedly. In addition, parents sign a non-violence contract before treatment and therapists address the safety of the child weekly with both parents and children. Therapists inform both parents and children about their professional obligation to report any suspected abuse.

Treatment could be provided to a single family or a group of families. Children and parents meet with separate therapists before a joint meeting at the end of every session. The length of the joint sessions increases as the child feels safer with the parent. CPC-CBT is an outpatient treatment with weekly meetings and follows a structured treatment manual with specific themes addressed each week (Runyon & Deblinger, 2014). The treatment includes four phases, often continuing for 16 weeks: 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.

**Children’s treatment**
The CPC-CBT treatment aims to help children process their experiences of abuse. During treatment, they are gradually exposed to abuse-related material in order to increase the child’s comfort level dealing with personal experiences. In the initial phase, Engagement and Psychoeducation, children will learn about violence and its possible consequences. The aim is to help the children better understand their own reactions and to acknowledge these reactions.

During the second phase, the Effective Coping Skills phase, children learn to identify, regulate, and appropriately express their emotions. With support from their therapists, they learn productive coping strategies for dealing with feelings of anxiety and stress in order to reduce their level of anxiety. The strategies also prepare them for being able to share their abusive experiences in their trauma narrative (a later part of therapy). CPC-CBT focuses on helping children access, understand, and express their feelings. Some children have difficulties recognizing and regulating their feelings. Based on cognitive behavioural therapy, the intervention aims to help children understand the connection between the children’s thoughts, feelings, and behaviours. Many abused children blame themselves for the abuse. That is, they believe that the violence happened because of their behaviour. Therefore, CPC-CBT repeatedly addresses those thoughts and beliefs to ensure that the children learn that they were not responsible for their abuse. This belief will also be clarified together with the parents, and parents will be encouraged to take responsibility for the abuse (see the Parent’s treatment section). Different activities such as drawing, games, roleplaying, and tools can be used as part of the therapy, depending on the child’s age and maturity.
In treatment, the child’s safety is the first priority, so it is integrated into every phase of the treatment. In the Family Safety Planning phase, the family members develop and implement a safety plan. This plan includes using skills learned to enhance the safety of all family members. The treatment begins by giving the child space and time to describe the specific occasion that resulted in the report to the child welfare services or to the police. Since the episode could be experienced as very scary, the children may need to repeatedly talk it through. The therapist helps the children explain what they experienced and how their parents behaved. An important part of treatment is to repeatedly confirm that the children did not do anything to deserve the abuse.

In the final phase of therapy, the Abuse Clarification phase, the children develop a trauma narrative. Before starting the work to support the child to create the narrative, the therapist makes sure that the child feel safe with their parents and that the abuse has stopped. The therapist encourages and helps the children talk about a specific experience of abuse. Some children prefer drawing, playing, using dolls, or using character cards to help form their narrative. The narrative is eventually shared with the parents. The children and therapists rehearse reading the narrative until the children feel ready to share it. The parents eventually respond to the narrative (see parents’ treatment).

**Parents’ treatment**
Many parents referred to treatment were physically-abused when they were children. During the Engagement and Psychoeducation phase, they are encouraged to discuss and process their physical abuse. These processes could lead to a better understanding on how their parenting style is perceived and increase their empathy for their children’s experiences. In this phase, parents are encouraged to examine how children can be affected by a violent environment. During the Psychoeducation phase, they learn about child
development and needs of children as well as possible consequences of child abuse. CPC-CBT educates parents about alternative non-violent parenting strategies, including teaching them how to be an active listener. Active listening will also prepare them for listening to their child’s narrative during the Abuse Clarification phase. Parents also learn the importance of expressing appreciation for their children, confirming and praising them. In the Effective Coping Skills phase, they learn how to understand and express their feelings. It is common that parents need help regulating their emotions, so anger management is an important part of treatment. Like their children, parents are taught how thoughts, feelings, and behaviours interact. At the end of treatment, parents receive their children’s narratives about the abuse and read it together with their therapist. During the Abuse Clarification phase, parents prepare a responding letter. Therapists support the parents writing an abuse clarification, where parents take responsibility for their abusive behaviour and relieve their child from blame. In this letter, the parents also express what they learned in treatment and how they think they can parent their child in a more positive way. In their letter, the parents also respond to any fears, misconceptions, or concerns their children expressed in their narrative. Therapists make sure that both the children and parents are prepared before they share their narratives.

Joint sessions
Every treatment session ends with a joint session where children and parents communicate what they have learned. In these sessions, parents practice parenting strategies, and both parents and children practice being more positive with each other. These sessions often result in the parents and children confirming one another and giving (and receiving) praise. During the third phase, children and parents create a security plan together. This helps the family know how to act if any member in the family fears that a future stressful situation could escalate to abuse. The plan states what everyone
should do and how to act to minimize the risk for abusive behaviour. The joint sessions provide opportunities to practice the security plan.

In a review concerning psychosocial treatments for child and adolescent trauma exposure, including studies applying different quantitative methodology, interventions were grouped by overall treatment family (Dorsey et al., 2017). CPC-CBT was included in ‘Group CBT with Parent Involvement’ and labelled ‘Probably efficacious’, level 2 of the five levels (level 1 = Well-Established Treatments; level 2 = Probably Efficacious Treatment; level 3 = Possibly Efficacious Treatment; level 4 = Experimental Treatment; and level 5 = Questionable Efficacy). The group ‘Individual CBT with Parent Involvement’ met the highest criteria and was labelled as well established. Furthermore, Dorsey et al. (2017) conclude that the well-established interventions all included similar components, such as psychoeducation, emotion-regulation, imaginal exposure, in vivo exposure, cognitive processing, and/or problem solving. The same components are evident also in CPC-CBT treatment (Runyon et al., 2004; Runyon & Deblinger, 2014).

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) uses a six-level rating system to assess the value of interventions: level 1 = Well-Supported by Research Evidence; level 2 = Supported by Research Evidence; level 3 = Promising Research Evidence; level 4 = Evidence Fails to Demonstrate Effect; level 5 = Concerning Practice; and level 6 = Not able to be Rated) (California Evidence-Based Clearinghouse for Child Welfare, 2019). The CEBC rates CPC-CBT at 3: Promising Research Evidence with High Relevance for the Child Welfare System. In Sweden, the Children’s Welfare Foundation is responsible for educating therapist in CPC-CBT. By March 2019, 192 therapists have been trained in the method and additionally 25 therapists are currently in CPC-CBT training.
Theoretical perspectives and concepts

The overall aim of the thesis is to explore the experiences and possible consequences concerning reported health and the relations between physically-abused children and their parents. This thesis includes an investigation of the children’s thoughts when disclosing their abuse and the impact of an intervention designed to support victims of child physical abuse in a Swedish context. As this is a broad aim, the thesis uses concepts from different theoretical perspectives to process and understand the results. The Social Ecological Model is used to understand risk factors for CPA and how different systems interact in order to change a trajectory. Concepts from the Life Course perspective is used to further describe how the intervention could be a turning point leading to a new trajectory. The Life Course perspective bears similarities with the Sociology of Childhood in that both theoretical perspectives anchor childhood in a historical setting. The concepts of agency and participation, central in the Sociology of Childhood, are also used throughout the thesis as methodological standpoints. They are also important concepts within the theory of the three Ps of the CRC (i.e., participation, protection, and provision) as put forward by Heimer et al. (2017b), and these will be discussed further from a child welfare perspective.
A social ecological model for understanding risk factors and possible transitions for change

This section outlines a theoretical model developed by Bronfenbrenner (1977; 1979) and later Belsky (1980; 1993), the social ecological model, and aims to provide a theoretical basis for understanding risk factors associated with physical abuse. The ecological approach highlights the interaction between the child and the different systems (Bronfenbrenner, 1979; Belsky, 1980).

Children live in different systems with a variety of family constellations. Every family is part of a society, with legislations and norms. A family is not a closed system; it interacts and takes (and gives) input from the surrounding society. Likewise, Farineau (2015) stresses the importance of professionals in child welfare to consider both the child and the different systems surrounding the child when choosing an intervention. The child and the family are not passive subjects going in and out of child welfare interventions; they enter, interact, and influence the system (Farineau, 2015). Previous research (Annerbäck, 2011; Belsky, 1980; Garbarino, 1977; Jernbro, 2015) about child physical abuse has been inspired by Bronfenbrenner’s ecological framework (1977), which describes the interactions between individual, family, and surrounding society. Bronfenbrenner defines ecology of human development as ‘the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded’ (Bronfenbrenner, 1979 p. 21). In a later development of his work, Bronfenbrenner added time as an important factor (Bronfenbrenner & Evans, 2000). Time refers to not only the time in life (such as different developmental stages) but also the historical time in which an individual lives. Bronfenbrenner’s later model, the PPCT model, states that an
outcome depends on the process, characteristics of the person, the context, length, and frequency of the time interval (Bronfenbrenner & Evans, 2000, p. 119).

Inspired by Bronfenbrenner’s work, Belsky (1980; 1993) adapted the model to focus on child maltreatment. As in Bronfenbrenner’s model, Belsky developed a model with four interacting levels or systems, but to some extent conceptualizing different factors. Bronfenbrenner’s model starts with the microsystem: the interaction between the child and its closest environment such as the family or school. According to Bronfenbrenner, the mesosystem includes the interaction between different systems such as the school that reports suspected child physical abuse to child welfare services or the family as a system interacting with child welfare services when entering interventions. The exosystem concerns factors outside the everyday life of the child that still affect the child such as how school is organised or factors affecting the parents’ work. Finally, the macrosystem concerns the norms and laws within society.

The Belsky’s model begins with an earlier starting point than Bronfenbrenner’s model. More specifically, Belsky’s model conceptualizes child maltreatment as a: ‘social-psychological phenomenon that is multiply determined by forces at work in the individual (ontogenic development) and the family (the micro-system), as well as in the community (the exosystem) and the culture (the macrosystem) in which both the individual and the family are embedded’ (Belsky, 1980 p. 320). Belsky (1980) emphasises the interactions between factors at different levels, and each level could include both supporting as well as risk factors.
Whereas Bronfenbrenner’s model (1977) begins with the child and his or her close relations, Belsky’s model (1980) begins with ontogenic development, the parents, and the parent’s experiences. How the parents are raised influences their parenting strategies and therefore affects the child. Parents who themselves are victims of child physical abuse are more inclined to use corporal punishment as a parenting strategy (Thornberry & Henry, 2013). Furthermore, if the parent misuses drugs and/or alcohol or suffers from depression, the risk for physical abuse increases (Garbarino, 1977).

The microsystem concerns the actual family and all its interactions. All relations within a family affect each other. Parenting strategies affect how the child feels and acts (Graham & Weems, 2015; Nilsson et al., 2017). Children who do not feel supported by their parents are at greater risk for developing an aggressive behaviour (Howell, 2011). In families where intimate partner violence occurs, the risk for child physical abuse is increased (Janson et al., 2011). There could also be risk factors associated with the child (Belsky, 1980). Children with different cognitive, intellectual, or somatic disabilities are at higher risk for victimisation (Janson et al., 2011; Kimura & Yamazaki, 2016; Svensson, Bornehag, & Janson, 2011). It can be more demanding to raise a child with disabilities, and these parents describe experiencing a lack of support from professionals (Svensson, 2013).

In the exosystem, the social structures that surround the family are in focus. Belsky (1980) highlights two main factors that affect the family: the labour market and the neighbourhood. In particular, the lack of work could be stressful. Unemployment could put an economic pressure on the family, feelings of insufficiency, and lack of structure and daily routines. Unemployment also could involve children and parents spending more time together, which could result in more tensions.
A close friend or a supporting environment could be a facilitating factor. Families in which CPA occurs are often more isolated and lack a healthy support system (Garbarino, 1977). Different factors in the exosystem work by adding pressure on the family, which increases the stress level (Belsky, 1980). It is in this level that child welfare services operates and could offer interventions.

Although child physical abuse is evident in all socio-economic groups, studies have repeatedly shown an increased risk for CPA for immigrant children, children raised by single mothers, and children raised in socio-economic disadvantaged neighbourhoods (Gilbert et al., 2009; Svensson et al., 2011). However, authorities are more likely to pay attention to children from these groups. It has been reported that it takes fewer visible signs of abuse (e.g., bruises) for a parent born outside Sweden than a native Swede to be reported to the police (BRÅ, 2011).

Lastly, the macrosystem refers to the legislation and the social norms within the society. As described earlier, attitudes towards child abuse in Sweden have changed since the ban of corporal punishment in 1979, and fewer children today report abuse victimization than before the ban (Jernbro & Janson, 2017). The reported numbers in Sweden are also considerably lower than in countries without such a ban (cf. UNICEF, 2014).

In both Bronfenbrenner’s and Belsky’s models, there is no firm line between the different systems. That is, there is a constant flow between the different systems and they interact and affect each other. Bronfenbrenner’s and Belsky’s models, although similar, differ in the chosen point of departure. That is, Belsky’s model is developed with child maltreatment as the focus. As such, this thesis uses Belsky’s model and concepts.
Life Course perspective

The Life Course perspective is a framework for understanding human development and takes into consideration both structural settings such as historic time and societal factor as well as individual agency (Elder, 1998). Originally, the theory was developed from a birth to death perspective, but in later research the utility for explaining more limited time periods has been highlighted (White & Wu, 2014).

Three important concepts within the theory, and with relevance for this thesis, are trajectory, transition, and turning point. A trajectory is a path in life, a certain pattern. The Life Course perspective considers different trajectories, for example, education and work. Every trajectory in turn includes several transitions (Elder, 1998). A transition is a passage from one period in life to another, often focusing on location (Enz & Talarico, 2016). A transition could be starting school or a new job. Depending on the trajectory, individuals attach different meaning to the transitions. However, transitions are likely to consider changes within external circumstances, not individual changes (Enz & Talarico, 2016). The individual could experience a transition as it happened (e.g., moving to a new city), but the transition could also have impact long after it originally happen. Starting university studies (a transition) could lead to a specific job (another transition) and later another work opportunity. Both favourable and adverse events could have this cumulating effect. The theoretical concept of trajectory has been used for example to understand the development of criminal behaviour among youth (Piquero, Jennings, & Barnes, 2012) or life paths among children experiencing intimate partner violence (Etherington & Baker, 2016). Interventions from social welfare services often aim to change a trajectory. Timing is important when social welfare is involved in a family (Elder, 1998; Enell, 2014). Timing, in turn,
demands a present, trustworthy, and available social welfare worker who has a
dialogue with children about their needs and wishes (Enell, 2014).

Elder (1998) stresses how historical context influences trajectories. Society’s
views of family and the importance of education have changed over time and
affect people’s behaviours. Another important factor is relationships, what
Elder (1998) calls linked lives. What happens to one family member and how
it is handled influences the other family members. As Elder (1998) stress the
historical context, timing and linked lives, individuals do hold control over
their life path through human agency. Human agency is understood as the
result of an individual’s earlier experiences, a view also present in
Bronfenbrenner’s (1977) and Belsky’s (1980) works as both stress the
importance of linked lives. In his later work, Bronfenbrenner extended his
model to include time as an important variable (Bronfenbrenner & Evans,
2000), bringing the theories even closer.

A turning point includes two elements. The word ‘turn’ indicates a change and
the word ‘point’ refers to a specific time (Enz & Talarico, 2016). A turning
point could be a special occasion or a process that affects an individual’s
identity (Wingens & Reiter, 2011). Whereas transitions tend to focus on
changes in external circumstances, turning points include some form of
personal change (Enz & Talarico, 2016). There will be a before and an after
marked by the turning point (White & Wu, 2014). A turning point could be
life changing and could affect a trajectory and the entire life course (e.g.,
Elder, 1998). Sometimes the occasion is well planned such as when a couple
tries to get pregnant and sometimes the occasion in un-intentional such as
when a couple unexpectedly gets pregnant. Turning points often represent
specific events. Likewise, a transition could not be considered a turning point.
unless a personal change is attached to the situational change (Enz & Talarico, 2016).

Interventions planned by social welfare services aim to change the individual’s path of actions and motivation, and a successful intervention could be a turning point (White & Wu, 2014). Which events and situations that actually will realise a turning point can only be judged retrospectively (Enz & Talarico, 2016; Wingens & Reiter, 2011).

Sociology of Childhood
As a theoretical framework, the Sociology of Childhood bears similarities to the Life Course perspective. Although the content and meaning of childhood can change, childhood remains a structural form (Qvortrup, 2011). The position of the child within the family and the society also changes with time. Both the Sociology of Childhood and Life Course perspective requires contextualising childhood. To elaborate on this, I will return to a historical description, but this time with a focus on the concepts of child and childhood.

As pointed out earlier, the ban of corporal punishment required considering the child as an agent and the rights of the child. Introducing the ban ultimately marked a shift from parents’ rights to choose what they considered appropriate child-rearing strategies to the right of the child not being abused. Ellen Key named the 20th century ‘the century of the child’ (1900), and children gained more rights during this time period. During the 20th century, several new laws were implemented to improve the well-being and living conditions for children. For example, extended childcare, building programs, school reforms, health care reforms, and child allowance were put into action. Laws are one way to contextualise and construct childhood (Andresen et al., 2011). The introduction of the Child Welfare Acts in 1902 and 1924 marked a new
viewpoint, where parents no longer had the ultimate right to care for their children (Prop., 1902:2; SFS 1924:361). The introduction of child welfare committees in 1902 and the obligation to introduce them following the Act of 1924 aimed to secure the living conditions for every child (Ohrlander, 1992). In the commission report preceding the Child Welfare Act of 1924, children were described as a precious property requiring careful care (Ohrlander, 1992, p. 189). Through the child welfare committees, the state took over some of the parental responsibilities. What was considered good parenting and child-rearing became more out-spoken, and staff at the child welfare committees aimed at educating parents in parenting (Ohrlander, 1992).

The content and meaning of childhood varies between cultures as well as between families living on the same street. Childhood is inter-connected with several concepts, maybe most commonly with family, parents, school, and relations. A child is a member of a family, often with no possibility to choose the same for themselves. The status of the child within the family changed in Sweden in the beginning of the 20th century. Children were to a higher degree now seen as individuals, not only members in the family unit. With an increased focus in the needs and rights of children, a potential harmful home environment received new attention. The child became a concern and project for society (Ohrlander, 1992). The Act of 1924 (SFS 1924:361) was celebrated as a declaration of rights for children. It was regarded in itself as evidence that Sweden had lived up to ‘the century of the child’ (Ohrlander, 1992). Bear in mind that the same law gave legal rights for corporal punishment. Between 1917 and 1924, several laws were put in place to increase the living conditions and support for children, for example, regulations concerning school and labour. When parents were no longer automatically perceived as the best people to raise their children, a growing interest in professionals was formed. Myrdal argued for the need for professionals involved in child care and
agitated for introducing pre-schools (Myrdal, 2002). With more women working outside the home and a new way of viewing the needs of the child, public day care was extended (see also Myrdal, 2002). In time, the focus of day care shifted, and it became organised within the domain of the school system, from previously being a part of the social welfare system (Andresen et al., 2011). Today, a vast majority (84%) of Swedish children age 1-5 attend preschool (SCB, 2017).

The Life Course perspective conceptualized different stages in life, most obviously childhood and adulthood (Honig, 2011), where the Sociology of Childhood emphasises the unique structures of childhood. The development of the school system significantly demarcated the difference between childhood and adulthood as schools became the way to teach children relevant knowledge for becoming adults (see also Hendrick, 2011). The 20th century’s increase in compulsory school increased the length of childhood (Andresen et al., 2011).

The introduction of a compulsory school\(^2\) contributed to a new form of childhood. School reforms in the early 20\(^{th}\) century took the needs of the family into consideration, allowing children to leave school for the harvest. During the second half of the 20\(^{th}\) century, schools became a significant part of the everyday life of children and thereby childhood (Andresen et al., 2011). Today, from first grade, children are required to attend school. This means that children, with increased age, spend a considerable time outside the family, with increased possibilities to form their own relations. By providing an environment for all children in a given society, normative expectations could

\(^2\) By 1842, the *Folkskolestadgan* stated that every district in Sweden should have a school and that children from the age of nine were obliged to attend school (Prop., 1842).
be formed and addressed within the school system. Society increased its power in forming (socializing) children (Woodhead, 2011).

The Sociology of Childhood problematized the view of seeing children as *becoming* rather than *being* (Halldén, 2007, Kampmann, 2000, James & Prout, 1997). The child is to be seen as an agent with participatory rights, not just a becoming adult. Gallacher and Gallagher (2008), however, argue that dichotomisation between being and becoming may not be so relevant since all individuals are moving along a continuum between these positions. Children and adults are not always competent. They are affected by enabling and obstructive structures around them. In this way, both children and adults are becoming throughout life. To become an adult is not the finish line, instead new episodes create new actions in a continuing development. Nonetheless, dichotomisation has shed light on a structure that often prevents children from exercising their rights. Eriksson and Wycichowska (2010) highlight how child welfare service tends to treat children out of a perspective of becoming rather than seeing them as agents. Adults seem to think they know what is in the best interest of children, sometimes without even considering what children have to say. These adult attitudes could be done with intention of protecting children from making consequential decisions, but some of the rights of the child could be ignored. Kampmann (2000) believes a child perspective could be established by asking children about their situation and their beliefs. Like James and Prout (1997), Andersson and Rasmusson (2006) distinguish between a child perspective and a child’s perspective: the researcher must see children as active agents contributing to their context of living, not merely shaped by adults.

The concepts of agency and participation are linked within the Sociology of Childhood as children should be seen as agents, individuals interacting with
the surrounding society. Like adults, they interact and participate in the community. Society has different expectations of children and tries to socialize them into different norms and values, but children are not passive recipients as they interact and contribute actively to the ongoing change within the community (e.g., James, 2011). Agency refers to children as active participants who by themselves influence the lives of others. They form their own relationships and develop skills on their own (James, 2011). Children are doing childhood (Halldén, 2007). However, to be an agent and have the right to exercise agency is not always the same, which I will try to problematize further in the Three Ps of the CRC section.

The Three Ps of the CRC

The United Nations Convention on the Rights of the Child is not in itself a theory, but rests on three theoretical concepts: participation, protection, and provision. These three areas of rights are not the opposite of each other, rather together they build the framework of children as bearers of rights. That is, participatory rights are not in opposition to either the right of protection or the right of provision. Nonetheless, earlier research has examined the gap between participation and protection, where children are viewed as vulnerable requiring protection rather than agents with participatory rights (Bijleveld, Dedding, & Bunders-Aelen, 2015; Vis et al., 2011).

In a study using the CRC as a theoretical framework, Heimer et al. (2017b) found that children in contact with child welfare services to a great extent are not part of defining the problem. In the absence of children’s participation, parents stand out as the primary source of information. As a consequence, shortcomings in parenting were downplayed. This situation could explain the poorly matched interventions found in the study (Heimer et al., 2017b). The theoretical framework put forward by Heimer et al. argues that increased
participation increases the chance of well-matched interventions. This is, the child has to be invited to be part of defining the problem. As with the three Ps in the CRC, participation is crucial for ensuring provision and protection.

The approach to the sociology of childhood in this thesis is twofold; it is both a theoretical frame where the concepts child, agency, and participation are addressed and is used to apply the concepts as methodological standpoints in the conducted research process. The concepts of agency and participation are used as guidelines throughout the process at different levels. The research departs from a viewpoint where children should be understood as agents with the right to make decisions, for example, about participating in research. The outcome of the different studies within this thesis aims to provide support for treating children as agents by acknowledging their competence whether by child welfare services or the research community. The empirical material in this thesis consists of children’s voices, reports, and/or perceptions. Children’s impressions of a certain event could differ from their parents (as it could differ from their siblings and friends). Previous research states that parents are likely to play down the effects of physical abuse and how exposed the child has been (Svensson, 2013; Litrownik et al., 2003). Furthermore, parents tend to value their parenting strategies more positively than their children do (Graham & Weems, 2015; Kjellgren et al., 2013). Taken together, the results illustrate the importance of clinical workers as well as researchers carefully listening to children, respecting their agency.
Methods and materials

This thesis has a mix-method design. The research questions have been answered using different methodological approaches. Even if the study designs of the included studies bring forward the voice of the child to different extent, they all depart from the view that children are reliable agents. The exclusion of parental participation is not to be seen as disinterest or denial of the important knowledge parents can bring to the subject matter. That is, the aim here is to highlight children’s voices, their perspectives and their experiences.

The overall aim of the thesis is to explore the experiences and possible consequences concerning reported health and the relations between a child who is victim of physical abuse and their parents, experiences among children disclosing the abuse, and the impact of an intervention designed to support these children in a Swedish context. A naturalistic study design explored the outcome from 14 treatment settings. Table 2 illustrates the study design for the included studies. The number of the study (I-IV) is the same as the number of the article, for example, Study I is Article I.
<table>
<thead>
<tr>
<th>Study I</th>
<th></th>
<th></th>
<th>Data source</th>
<th>Data analysis</th>
<th>Overall research question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>71</td>
<td>38 (53.5)</td>
<td>10.22 (2.33)</td>
<td>Self-reported questionnaire</td>
<td>Independent t-test was used to analyse the differences between the two groups. Pearson correlation was used to investigate relationships between CSOC and parental strategies. Hierarchical linear regression analysis was performed in order to explore the contribution of physical abuse on sense of coherence.</td>
</tr>
<tr>
<td>non-clinical</td>
<td>164</td>
<td>87 (53)</td>
<td>11.5 (0.83)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study II</th>
<th></th>
<th></th>
<th></th>
<th>Qualitative content analysis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>15</td>
<td>3 (20)</td>
<td>11.6 (2.22)</td>
<td>Individual interviews</td>
<td></td>
</tr>
<tr>
<td>Study III</td>
<td></td>
<td></td>
<td></td>
<td>Qualitative content analysis</td>
<td>How do physically abused children experience and describe their process of disclosing abuse?</td>
</tr>
<tr>
<td>Clinical</td>
<td>20</td>
<td>6 (30)</td>
<td>11.9 (2.45)</td>
<td>Individual interviews</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study IV</th>
<th></th>
<th></th>
<th>Data source</th>
<th>Data analysis</th>
<th>Overall research question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>42</td>
<td>16 (38)</td>
<td>8.86 (1.78)</td>
<td>Self-reported questionnaire</td>
<td>Repeated measures analysis of variance (ANOVA) were used to calculate for differences between the clinical and non-clinical group over time and to determine whether differences was due to group assignment. Within-group ANOVA was used to assess differences within the clinical group before treatment, post-treatment and at six month follow-up. Possible mean differences concerning children's reports of parental use of corporal punishment were calculated with Paired Samples t-test between pre-treatment, post-treatment, and follow-up measures. To confirm and further test these results, repeated measures ANOVA within group was calculated.</td>
</tr>
<tr>
<td>non-clinical</td>
<td>213</td>
<td>120 (53)</td>
<td>11.92 (0.92)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Participants
A more detailed presentation of the participants is provided under the summary of each study. Except from the children in the non-clinical groups in Study I and Study IV, children were recruited from different out-patient treatment units offering CPC-CBT, mainly within child welfare services, Barnahus, and child psychiatric clinics across Sweden. There were only a few inclusion criteria for the participating children: the treatment units were instructed to ask all families eligible for treatment and the abused child had to be six years old or older.

All the children had experienced physical abuse by one or both caretakers. The abuse was confirmed (at least to some extent) by both children and parents. Table 2 gives an overview of the included children. All 15 children in Study II were included in the group of 20 children in Study III, and 18 of the children in Study III were included in Study IV. Due to administrative errors, two children had to be removed from the analysis in Study IV (see flow chart in article IV for a full description of attrition). Children in the clinical group in Study I were included as participants in Study IV.

Gate-keepers
When aiming to interview children several, gate keepers had to be passed. Depending on the organisation in the municipalities, Barnahus coordinators, child welfare workers, directors at different levels, as well as treatment staff were required to cooperate before family’s could be invited to participate. Since most of the children participating in this study were younger than 15, the question of participation first had to be addressed to their parents. There are advantages when individuals close to the child judge the appropriateness of participation, but the shortcomings could not be overlooked. The researcher
depends of other people’s willingness to hand out information about the study. Furthermore, there is a risk that different professionals make their own selection of families, which in turn affects the selection and thereby the trustworthiness of the results. In this study, all families under the same time table should have been asked to participate; however this was the case is difficult to control for.

**Ethical considerations**
The study was approved by the Regional Ethical Review Board of Linköping, Sweden (Dnr 2008/206-08) with supplementary decision in 2013 (Dnr: 2013/189-32) and 2014 (Dnr: 2014/347-32).

**Legal framework and the key ethical question for this thesis**
Different legal frameworks can be applied to research. The law concerning ethics in research (The Act 2003:460 concerning the Ethical Review of Research Involving Humans) regulates ethical demands in research. Paragraph 8 states that human rights should always be considered by the ethical board. The UN Convention of the Rights of the Child states the human rights of the child. According to article 12, children have a right to express their views in matters affecting them (UN CRC, 1989). The right to participate in decisions concerning them is stated as a human right. Likewise, The Charter of Fundamental Rights of the European Union (2012) stresses the fundamental right of freedom of expression (paragraph 11). Furthermore, the EU stipulates that children rights are human rights (EU, n.d.). However, children in Sweden have the right to decide for themselves about participation in research at the age of 15 although a child of any age could deny participation (The Act 2003:460).
It is not without problems that the child’s opportunity to participate rests on their parents’ consent. There could be an obvious risk of conflict of interests as parents may want to keep the details of the abuse a family secret and the child may want to reveal the details of the abuse. The Norwegian decision lowering the age for when children are allowed to give consent to the age twelve gives opportunities for more children to participate in research (Dyb et al., 2016). Child physical abuse is an important topic to explore further in order to obtain better understanding of children’s needs. It is argued that it is not ethical to let abusive parents decide whether or not children are allowed to participate in research (Dyb et al., 2016).

The previously mentioned tension between protection and participation is visible also in the ethical discourse. In research concerning children, and particularly vulnerable children, the ethical debate could to some extent be considered divided into two sides: one view emphasises the child’s vulnerable position and exposure and one view emphasises the child’s competence and agency. However, the two sides do not have to be in conflict. With ethical awareness, a child can be seen as both vulnerable and competent (Cater & Øverlien, 2014; Hydén, 2011, Källström & Andersson Bruck, 2017). Hydén (2011) argues that the position of the child could be understood from a position of both agency and victim. In her research concerning children experiencing IPV, she introduced the concept of ‘participant witness’ where participant refers to the child’s agency and witness refers to the vulnerable position of the child, with structures sometimes preventing the child from acting. According to Hydén (2011), in a situation of violence these positions interact side-by-side. Øverlien (2012) follow these thoughts and describes how children find ways to act and interfere with the situation. Children are competent even if the structures around them and adult actions could be restrictive.
In a context of research, it is important to stress that a consideration of children as agents does not in any way reduce the responsibility of the researcher (Källström & Andersson Bruck, 2017). The researcher has the responsibility to follow ethical guidelines and during the entire process protect the best interests of the child. By doing this, research has an opportunity both to strengthen the child and the field of knowledge. Leira (2002) argues that children need their experiences validated as violence is often a sensitive topic to talk about and in many cases a taboo, leaving abused children alone with their experiences. This is of course an aim for treatment to address, but the validation can in similar ways take part within a research setting (Eriksson & Näsman, 2008; 2012; 2015). Eriksson and Näsman (2008; 2012; 2015) argue that a research process that invites children to participate as experts can be combined with care for the child. Furthermore, by validating their experiences, the third P in the UN Convention on the Right of the Child could be addressed. For example, Eriksson and Näsman (2008; 2012; 2015) argue that provision could be the result of providing the child with an opportunity to participate in research where their experiences are validated.

**Ethical aspects of the present research**

Talking to children about possible traumatic events demands careful considerations. In some families, physical abuse had been a family secret. Some children might find the subject sensitive to talk about, and it could provoke feelings of anxiety and guilt. Therefore, in the present research, it was considered important for the child to hear their parents’ consent before being interviewed. Children could be reluctant to talk about problems within the family without their parents’ permission (Lobatto, 2002). Before starting the interview, parents and children were informed about the study, its purpose, and how data was to be handled and used. Information was given both orally and in writing. All children were informed that their participation was
voluntary and they at any time could terminate their participation. Children were interviewed individually without their parents present in the room. A consent is not something the child (and parent) provides once. It should continually be negotiated throughout the research process, and it is the responsibility of the researcher to give the children opportunities to terminate their participation. In the interview setting, the interviewer was observant to any sign of discomfort displayed by the child. In some cases, this included taking breaks and in one case finishing the interview earlier than planned. All interviews were conducted within the settings where the child received treatment. Former therapists were available to the child during the research interview. No child expressed discomfort or wanted to talk to a therapist after the interview.

Previous research concerning children and trauma have not found evidence that children might be harmed by participating in research (Aho, 2016; Kassam-Adams & Newman, 2005; Jensen, 2012; Näsman, 2012; Priebe, Bäckström, & Ainsaar, 2010; Zajac et al., 2011). Furthermore, children who responded that some questions could be stressful still appreciated participating and stated that they would have done it again (Newman, Risch & Kassam-Adams, 2006). Earlier research discusses that participation could strengthen the child, and children could express that they wanted to participate in order to increase their knowledge about a certain topic as well as to help other children (Cater & Øverlien, 2014; Källström Cater & Överlien, 2015; Jensen, 2012; Näsman, 2012).

**Methodological considerations**

This research, apart from non-abused control groups, engaged a clinical sample of families from 14 treatment units. It is a strength that data have been
collected from different settings. The municipalities differ not only in size, but also in organisational and political governance. However, the strength of multiple settings could also be a weakness. A vast majority of the data collection was carried out by me, although some data were collected by other members of the research team. In some cases, other employees at the treatment facility assisted in data collection. Although information was provided on the procedure for those involved in the data collection, more individuals collecting data could result in differences in the oral information provided to the families. All forms are the same, and the same written information was handed out to all respondents before and during the data collection. Every self-assessment scale has instructions, including what timetable the person should consider. However, there was no way to be sure that all respondents read this information on every self-assessment scale. One scale asks for information about the previous month and another asks for the two last weeks. There is a possibility that some research administrators did not emphasize this timing enough. Therefore, some respondents could have filled in the form as if the special occasion being considered happened at any point in their lives rather than, for example, occurring during the previous two weeks. This inconsistency will of course affect the results. There are lessons learned, and a future data collecting design and procedures could be more rigorous. However, doing research in a real world setting is demanding albeit equally important. Despite several limitations, one could argue that it is of great importance that child welfare workers and therapists across Sweden have been engaged in this research project. The results mirror the difficulties doing research on practice, but as long as research focuses on practice, this will also be a strength according to the trustworthiness of the results.
**Doing research on practice – the role of research and possible impact of researcher**

The researcher inevitably affects research in several ways. By choosing a specific topic of interest, respondents, methods for gathering data, as well as interpreting the data, the researcher influences the results of the research (Malterud, 2001, p. 484). Physically abused children were not a new topic for me when I started as a PhD student. I had previously worked with children placed in foster care, where abuse and neglect were common reasons for placement. My experience with clinical social work and abused children in foster care helped me approach children without being tense and uncomfortable in the research interviews, which I believe was crucial to eliciting responses from children. My preconceptions grew throughout conducting the studies in this thesis and reading the literature. In writing the interview guide, I made an effort to create open questions that placed the children at ease expressing their conceptions and emotions. The interview guide was discussed with my supervisors to limit the risk for biases. Similarly, during the interviews, I tried to be cognisant of my preconceptions so these preconceptions did not influence my interactions with the children. For example, I asked follow-up questions, provided confirming remarks, and asked questions to clarify answers.

Another concern is how research affects practice at the time it is in being performed. It could be a goal for research to influence future practice, but at the very moment of the research, research should minimize its influence on practice. The research process followed the practice of CPC-CBT by asking questions before the intervention, at the end of the intervention, and six-months after the intervention. Families were asked about participation in research at the same time they were informed about the intervention, making practice and research intertwined. How this affect each other is hard to state.
However, similar results were obtained in a pilot study conducted in Sweden (Kjellgren et al., 2013) and research in the U.S. (Runyon, Deblinger, & Schroeder, 2009; Runyon, Deblinger, & Steer, 2010). In the research setting, researchers explained their role and the focus of the research and noted they were not involved in execution of the intervention or other decision-making concerning the family. However, answering questionnaires could be seen as a form of intervention.

Both children and parents were addressed as experts, which could have an empowering effect. Before each interview, the child was told (as well as their parents) how the interview was to be handled and that their information would be handled confidential. However, they were informed about the obligation of the researcher to report if any previously unknown information about abuse were disclosed. This obligation could have silenced some children or make them adjust their narratives. In one case, a child reported in the post-treatment interview about abuse from a parent not participating in treatment. This child thought that since his first disclosure was so well received and resulted in a better relationship with the first parent, he wanted the same for the other parent. Together with the child, I made up a plan where he was informed that I would pass the information to his social worker. A researcher should try to be neutral as far as possible, realizing it is impossible to be completely neutral (cf. Malterud, 2001). The child who disclosed the unreported abuse to me had decided to tell all the adults he identified as having a potential to help him. From the perspective of seeing children as agents, it was important to respect the strategy this child wanted to employ. Furthermore, apart from my legal obligation to report this newly disclosed abuse, ignoring the child’s request would have violated my personal ethical guidelines.
Interviews with children

Study II and Study III are based on interviews with children who had completed the CPC-CBT intervention. The main focus of the interviews was to explore children’s experiences with the CPC-CBT intervention. However, after a few interviews, I realized that children brought up different aspects of disclosing the abuse. As I started to read more literature on the topic of disclosing abuse and listened to the conducted interviews, a new sub-focus emerged for the remaining interviews. The interview guide was the same, but I explored with a new interest the questions that addressed the family milieu before entering treatment, the process of disclosure, and the transition to treatment. After conducting the 20 interviews and transcribed them verbatim, the transcriptions were read several times. All participating children described their experiences with CPC-CBT, and their narratives resulted in Article III. But 15 of the participating children also described the process of disclosing physical abuse. Their narratives resulted in Article II. In total, 20 children were interviewed, so the 15 children in Article II are part of the sample in Article III.

The interviews lasted on average 30 minutes. Children could have a dip in concentration when interviews last longer than 20-30 minutes (Lange & Mierendorff, 2011), which was evident in some of the conducted interviews.

Study design of the outcome study

The original aim in Study IV was to compare the outcome for CPC-CBT with the outcome for treatment-as-usual (TAU) offered by child welfare services. Municipalities that offered CPC-CBT were not involved in recruiting control families as there could be a risk that other interventions delivered by the unit were influenced by CPC-CBT. Efforts were made to establish contact with child welfare services that did not provide CPC-CBT. Contact was established...
with child welfare workers at different organisational levels and several visits at local child welfare units took place. After two years, we had not succeeded in recruiting any control families. A new strategy emerged and we tried to recruit families within the CPC-CBT municipalities. Two masters students employed in child welfare services were asked to help, but they were also unsuccessful recruiting control families. After four years, we were able to recruit only two control families. The inclusion criteria was simple: a child between the age of six and 18 who had revealed child physical abuse from one or both parents and who remained living at home (or where the child was re-unified with parents after a short out-of-home placement). These families seemed to have vanished. We can only speculate about the reasons. According to a recent study, child welfare workers tend to downplay parental violence in investigations and intervention plans (Heimer et al., 2017a). This could be one reason for social workers not identifying the families where physical abuse had occurred. Furthermore, Heimer et al. found that when social workers offer interventions, the violence was rarely mentioned (Heimer et al., 2017a) so it was not targeted by the intervention. Consequently, CPC-CBT as well as other interventions targeting the abuse would rarely come in question. Other reasons could be the gate keeping in order to ‘protect vulnerable’ children and families from research, lack of time, as well as feelings of uncertainty of the professional if the outcome of the work was going to be examined or evaluated.

In the absence of a clinical group receiving treatment-as-usual, a study design with a normative comparison group was developed (cf. Comer & Kendall, 2013; Kendall, Marrs-Garcia, Nath, & Sheldrick, 1999). Comparing data with a normative sample is one way to establish the efficacy of treatment outcome (Comer & Kendall, 2013; Kendall et al., 1999). The normative value is used as an indication of whether the treatment has been successful. The methodology
is conducted in two steps. Departing from the normative values, the pre-
treatment reports from children are compared to post-treatment reports and
follow-up reports. If the reported change falls below the cut-off point for a
normative sample, the results indicate that the children are to be considered
recovered, not only improved (Westbrook & Kirk, 2007). The procedure has
been found useful in previous studies (Westbrook & Kirk, 2007). Kendall et
al. (1999) argue that a study design with a normative group provides clinical
significance for reported results.

Methodological discussion

Study III investigates children’s perceptions of the CPC-CBT intervention.
The study design was retrospective, with interviews taking place after
treatment was completed. This approach could affect the outcome. When
children described the most important components of the treatment, most of
them highlighted writing their trauma narrative and receiving the letter of
clarification from their parents. This is the last part of treatment and could
therefore be the easiest to remember, indicating a recency bias. Children’s
perception of treatment is a neglected issue (e.g., Pösö et al., 2014), so future
research could address this issue using repeated interviews following the
process of treatment in order to further explore how children value different
components in treatment.

At the end of the interviews, the children were asked if they had any advice
for children who experience CPA. Some children said they would tell others to
ask for CPC-CBT. When asked about their motivation, some children could
describe the intervention in more detail and depth than they did in the
beginning of the interview when they were asked about their experiences with
the treatment. Furthermore, children could express what they thought children
experiencing CPA need and how adults around them should act. It seems that some children thought it was easier to talk about their experiences in third person. The children were also asked about their experiences of the interview. All children expressed that they felt good about the interview and some expressed hope that their answer could contribute to other children’s wellbeing.

Parents were asked whether they or any family member had received any other intervention than CPC-CBT during the study period. For the 62 included children, 49 parents responded to this question: 43 stated that the family had only received CPC-CBT. Examples of interventions concerning the remaining six children could be an investigation followed by diagnosis from Child Psychiatric Clinic (e.g., ADHD) with following support and/or prescribed medication, or parents receiving support from counsellors or probation officers. However, it is important to bear in mind that other life circumstances could have affected the responses. Some parents reported separation as a consequence of the abuse, and there were some stories of illness and death of family members before the start of the intervention. It is not possible to control for the extent these circumstances affected the responses.

As stated, the research’s point of departure is an understanding that children are agents with civil rights, such as participatory rights. However, this perspective was not strictly attended to during the actual information gathering process. The process could have invited children in a much more in-depth way. For example, the adult perspective of ethics and well-being of the child had precedence when deciding where to meet the child. The units where children had received treatment were chosen because the children’s former therapists worked in these units. A care perspective was established before letting the child participate in any other decisions. From a perspective of
children as agents a lot could have been done differently. For example, children could have been given the opportunity to choose where to meet such as at home or in a cafe, how to meet such as on the Internet, and how to complete self-assessment scales such as on a tablet or a computer.

The age of the children was between 6 and 18 years old. Some of the self-assessment scales were developed and validated for children from the age of six. In the interview study, children were between nine and 18 years old. The lower age limit in the interview study was chosen out of an understanding of children reaching the age of nine to be able to understand what it means to consent to participate in research and how the interviews should be handled and used. However, earlier research (Evang & Øverlien, 2015; Pernebo, 2018) has highlighted the competence of even younger children considering participation in research. In a retrospective perspective, the interview study could have included children from the same age as the effectiveness study – i.e., from age six.

**Unspoken signals**

Previous research stresses the competence of children participating in research and giving important and rich information (Lobatto, 2002). Children are capable of regulating their participation with different strategies (Evang & Øverlien, 2015; Lobatto, 2002; Källström & Andersson Bruck, 2017). Sometimes this could be expressed directly as with the child revealing ongoing abuse (described earlier in the section ‘Doing research on practice’). In other cases, the strategies could more accurately be described as unspoken signals. The term unspoken signals should here be understood as the way children regulate their participation in a more indirect way. For example, children could start talking about other things or respond with ‘I don’t know’. The researcher holds responsibility of the wellbeing of the respondent in the interview setting, so the researcher must be attentive to both verbal and non-
verbal signs, offering breaks when the need arises and making sure that the
needs of the researcher never take precedence over the wellbeing of the child.
Departing from a viewpoint of children as agents could therefore be
contradictory to the needs of a researcher. I will illustrate this with an excerpt
from an interview with a nine-year-old child. In the excerpts (I) denotes the
interviewer and (R) the respondent. The child had received two cinema-tickets
before the interview started as this was one term of the study. The excerpt
illustrates that this took focus from the interview, and it would have been
wiser to hand over the tickets (i.e., the compensation) at the end of the
interview. However, I wanted to make sure the child did not think he or she
had to deserve the tickets during the interview, so they were handed out in
advance. The excerpt illustrates some of the unspoken signals some children
used in order to regulate their participation.

(I) Can you remember why you started the treatment?
(R) No.
(I) In some cases, I do not know what happened in your family, with you
and your mum, but often children and their parents come to CPC-
CBT because the parent had been violent in some way. Maybe beaten,
pushed, nipped, or so. Made something like . . .
(R) Can you watch any movie with these? [Holding up the cinema-
tickets]
(I) Absolutely.
(R) Can one just go there saying ‘I want to watch this movie’?
(I) Mm, you make a reservation . . .
(R) Are we done now so we can go watch it now?
(I) I have some more questions.
(R) Okay.
(I) Mm. Can you put up with some more questions?
The boy starts this section by signalling that he is not interested in the questions any longer. We had returned to the phase before treatment and maybe he thought he had already talked enough about this. At first, he gives a short answer (‘No’) to my question. Then he tries to talk about something that was him more important, the value of the gift he had received: ‘Can you watch any movie with these?’ After some clarification about the process of transferring the tickets to a cinema experience, he was more direct in his wishes: ‘Are we done now so we can go watch it now?’. When I respond that I have some more questions he settles with this (‘Okay’). However, as I interpret his signs, both verbal (‘are we done now . . .’) and his body language and the strategy of starting to talk about something different than answering the question, I chose to ask an unplanned question: ‘Can you put up with some more questions?’. When the question is asked and the answer is no (with an emphasized ‘nooo’), I knew it was time to finish the interview even though as a researcher I wanted to gather more information.

**Addressing the child as an expert**

Seeing a child as an agent could also be to support them in the interview setting, making them feel they are the expert with the valuable information. The following excerpt is from an interview with a nine-year-old child. We are talking about the change within the family:

(I) Is there something you have learned here [in treatment] that have contributed?

(R) Ask my mum and dad.

(I) But I’m asking you, I think it is important to hear the answers from children.
(R) But I hardly know anything!
(I) You, you are the expert. Do you know, you are one of the experts of CPC-CBT in Sweden?
(R) Why?
(I) There are not many children who have tried it, so those of you who have tried [CPC-CBT], it is only you who have who can answer my questions.
[Short pause]
(R) What did you want to know?

Recognizing the child as an expert made her change her focus. Before, she was looking down and seemed insecure of what to say. She withdrew within her hoodie. When calling her an expert, she pulled back the hood and looked directly at my eyes, asking ‘what did you want to know?’. Thereafter, she contributed to the interview with what seemed to be more confidence. Here, the word ‘expert’ is used to mark the child’s special experiences. There is no right or wrong in the what they say or how they say it, so an experience should not be judged against other experiences. These children have an experience in this specific situation that I want to listen to.
Results

This chapter will provide a summary of each study included in the thesis. Three articles have been published in international journals, and the fourth is accepted for publication.

Summary of studies

Study I

‘Youth Reports of Parental Strategies and Sense of Coherence: Are experiences of being victim of physical abuse reflected?’. Published in the journal YOUNG

Study I investigates the impact of experiencing physical abuse with respect to how children report their parents’ parental strategies and how their sense of coherence (SOC) was affected. The study has three objectives: to compare physically-abused children’s reports of parenting strategies with a non-clinical group; to explore whether there were any differences between reporting SOC according to the presence of physical abuse; and investigate the impact of physical abuse on SOC.

Two groups of children were enrolled in the study: 71 physically-abused children referred to child welfare (clinical group) completing the first data
collection also included in Study IV and 164 children (non-clinical group) in a school-based comparison sample (not reporting being physically abused) (Table 3).

Table 3. Gender distribution across the sample in Study I

<table>
<thead>
<tr>
<th>Gender</th>
<th>Clinical group (n=71)</th>
<th>Non-clinical group (n=164)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Female</td>
<td>33 (46.5)</td>
<td>77 (47.0)</td>
</tr>
<tr>
<td>Male</td>
<td>38 (53.5)</td>
<td>87 (53.0)</td>
</tr>
</tbody>
</table>

There were several differences in how the children from the two groups reported their parents’ parental strategies. Abused children reported less parental involvement and fewer positive interactions than non-abused children. Compared to the non-clinical group, children in the clinical group reported that their parents did not play a large role in their everyday lives. In the non-clinical group, children reported higher frequency of parents spending time with them and praising and acknowledging them. Furthermore, physically-abused adolescents were also more likely to report that their parents’ parenting style was inconsistent, a behaviour that could cause insecurity with respect to how to act to please their parents.

The result suggests that being physically-abused negatively affects the emotional relationship between the child and the parent. Furthermore, physically-abused children reported significantly lower SOC than non-abused children. The SOC measures children’s ability to cope with life stressors. A high level of SOC can be seen as a general protective factor and is grounded in childhood and adolescence (Antonovsky, 1987).

In our second hypothesis, we stated that children in the clinical group would report lower SOC and that SOC would be positively correlated withParental Involvement and Positive Parenting and negatively correlated with Poor
Monitoring and Inconsistent Discipline. Children in the clinical group reported significantly lower levels of SOC than children in the non-clinical group. Regarding the hypothesis concerning correlations with parental strategies, the condition for the non-abused children was confirmed; however, for the physically-abused children, only the subscale positive parenting correlated with SOC. It could be that parents’ emotional engagement and compassion for the child could serve as a buffer for the child, even when experiencing physical abuse. Parental positive attitudes towards the child could enhance the child’s possibility to develop sense of comprehensibility, manageability, and meaningfulness.

Lastly, the results reveal that physical abuse uniquely contributed to SOC, even when controlling for other parental strategies. Parental use of physical abuse explained 50% of the variance in SOC and every increase in reported physical abuse indicated a substantial decrease in reported SOC. Interestingly, the impact of positive parenting was once more revealed; every increase in reported positive parenting by the abused children increased their SOC. It could be that different positive parental strategies to some extent balance the effect of physical abuse and support the child’s SOC.

Taken together, the results indicate that being physically abused by a caregiver could affect both the relationship with the caregiver as well as the child’s SOC (i.e., the child’s capability to cope with life stressors). However, the possible positive balance to some extent of experiencing a positive interaction with parents is important for child welfare services to acknowledge when deciding which interventions to offer: teaching parents both non-violent parenting and the importance of positive interactions with their child.
Study II

‘Children’s disclosure of physical abuse – the process of disclosing and the responses from social welfare workers’. Published in the journal Child Care in Practice.

As stated earlier, child physical abuse could have long-term consequences. Children abused by a caretaker are at special risk. It could be both that the abuse starts earlier in life and that there is an increased risk that the abuse will last longer (Kisiel et al., 2014). These children could also lack a responsive adult for support. Children abused by a caretaker are at greater risk of developing more harmful trauma symptoms as well as experiencing additional trauma compared to children who have experienced potential traumatizing events perpetrated by someone outside the family (Edwards et al., 2012; Kisiel et al., 2014; Tang & Freyd, 2012).

This study highlights the specific concerns of these children and explores how they experienced the process of disclosing the abuse. As the sample was part of the ongoing CPC-CBT study and children had received an intervention, the process of disclosure was followed until children had received treatment. Therefore, the study follows the process of disclosure and the responses by social welfare services from a child perspective. The study included 15 children (age 9-16) from 15 families. The mean age was 11.6 years old (SD = 2.22). Twelve (80%) were girls and three (20%) were boys. The children had received interventions from ten different child welfare services.

Table 4. Theme and categories in Study II

<table>
<thead>
<tr>
<th>Theme</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>The process of disclosure</td>
<td>Something became even worse</td>
</tr>
<tr>
<td></td>
<td>Unintentional disclosure</td>
</tr>
<tr>
<td></td>
<td>To select the receiver</td>
</tr>
<tr>
<td></td>
<td>To lose control</td>
</tr>
</tbody>
</table>
Disclosing abuse was described as a process requiring several decisions. The disclosure could be both intentional, where children described an escalation of violence, or a special episode experienced as specifically dangerous, making them think they had to disclose. It was a tough decision to disclose, but the fear of the possible consequences of not disclosing became even worse. Children had to choose a trustworthy recipient, but then had to wait for the recipient to act further. The child welfare services acted on the referral, but rarely informed the child about what actions were to be taken. Children could be taken to the police station or a Barnahus for a formal disclosure. For some of them, their parents were not informed until weeks had passed, leaving the child in agony over what will happen when their parents were informed.

Other children described a more unintentional disclosure. This could be facilitated by the subject being brought up in school, or a teacher or someone else asking the child a direct question, indicating the importance of providing opportunities for disclosure. The importance of school was twofold. First, staff at school were the most significant adult children choose when disclosing. Second, school is also an arena to teach about the rights of the child and addressing that violence is not the fault of the child, a matter several children thought was useful to be told about. Children stated the importance of both trustworthy adults and time to build relationships, which applies to both school staff and child welfare services. Furthermore, children wanted the recipient of the disclosure to act on the information. The recipient should stand by the child, be their advocate, and not question the veracity of their stories. If the adults did not satisfy these needs, the children could feel betrayed. The theory of betrayal trauma (Foynes et al., 2009; Freyd, 1994) stresses the importance of the relationship between the child and the perpetrator considering the impact of the abuse. The theory highlights that the relationship will influence how the abuse will affect the child. In the study, the concept of
betrayal is expanded to the process of disclosing. If the recipient fails to act as
the child expects, it is possible that the child will feel betrayed once more.

The narratives reveal how some of the children after the disclosure lost control
over how their narrative of abuse was handled. Child welfare workers were
acting, but not informing or involving the child of further actions. It is
important to bear in mind the specific conditions under which these children
live – they live with their perpetrators. They fear how the perpetrator will react
to their disclosure. Children are sometimes overwhelmed by feelings of
powerlessness, guilt, and fear. It is important that child welfare adopts routines
that secure the child’s wellbeing during this process.

All children in the study were eventually offered treatment targeting the abuse.
However, they were most often not consulted about treatment options and
most of the children were not even informed about what kind of treatment they
were to be given. It was up to their parents to select what kind of information
the child should receive concerning their future contact with child welfare
services, resulting in some parents blaming the child. The result indicates that
there is a time lapse where children after their disclosure are removed from
their position as participants. These children had proven their courage and
determination by trying to change a dysfunctional (and dangerous) pattern
within their families. It seems crucial that these children should be recognized
and allowed to participate in decisions concerning their own and their family’s
future. Child welfare services need to develop routines that make sure the
child is informed and consulted and that the practice of child welfare is child-
friendly.
Study III

‘Children's experiences with an intervention aimed to prevent further physical abuse’. Published in the journal Child and Family Social Work

There is a scientific gap in research concerning children’s experiences with interventions offered by child welfare services (Pösö et al., 2014; SBU, 2018). Study III attempts to close this gap. The study explores how children experience participating in the CPC-CBT intervention. Semi-structured interviews with 20 children were conducted. Interviews were transcribed verbatim and analysed with qualitative content analysis. Two themes with three categories each emerged (Table 5). The participating children were between 9 and 17 years old (mean age: 11.9 years; SD = 2.45) at the time for the interview. They had all experienced physical abuse by one or both caretakers.

Table 5. Children’s experiences of taking part of CPC-CBT treatment and themes and categories in Study III

<table>
<thead>
<tr>
<th>Theme</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiences of treatment</td>
<td>Overall impression of treatment</td>
</tr>
<tr>
<td></td>
<td>We were asked to write a letter</td>
</tr>
<tr>
<td></td>
<td>To receive a letter</td>
</tr>
<tr>
<td>Transformation in life</td>
<td>Family life today and in the past</td>
</tr>
<tr>
<td></td>
<td>Achieved life skills</td>
</tr>
<tr>
<td></td>
<td>Strategies for the future</td>
</tr>
</tbody>
</table>

Children had a positive overall impression of the treatment. All the children described a decrease in the violence perpetrated by their parents, and they felt assured that the violence would not re-occur. They described how the treatment had helped them come closer to their parents. Some children stated that they did not think they could have remained living with their parents if the family had not received help and their parents had changed their behaviour. Children appreciated how the violence was addressed with their parents. The
trauma narrative and their parents’ letter of clarification were highlighted. For some children, this was the first time they heard their parents express their feelings. When parents wrote and read their letters of clarification, they took responsibility for the abuse, relieving the child of blame. Children talked about the importance of being assured that the violence was not their fault.

Furthermore, children described several transformations within their lives. The children and their parents had become much calmer. According to the children, they and their parents had gained strategies for calming down and dealing with anger and frustration. The children described how they could talk to their parents in a new way, not fearing their parents’ reaction. The family members spent more time together, and children described their parents as more engaged and present in their everyday life. Likewise, children described how the family members reminded each other of what they had learned in treatment and sometimes they rehearsed different strategies they learned in treatment.

The children appreciated the structure of the treatment and described the intervention as child-friendly, where they were invited to set the agenda for the counselling. To have a therapist of their own made them feel secure as they had time to build trust in their relationship with their therapist. They also highlighted professional confidentiality. The emphasis of the professional confidentiality should be seen in the light of information and participation. The therapist of the child was talking to the parent’s therapist in order to prepare the joint sessions and all the therapists had mandatory reporting to child welfare services. But children were informed about this and all actions were taken only after consulting with the child. The children’s narratives demonstrate the importance of recognizing children as agents with a right to participate in decisions concerning them in order to improve their wellbeing.
Taken together, the children’s descriptions concerning the end of parental violence, a deeper closeness among family members, and warmer relations indicate that completing CPC-CBT had been a successful turning point.

**Study IV**

*Outcomes of CPC-CBT in Sweden concerning psycho-social wellbeing and parenting practice: Children’s perspectives*. Published in the journal of Research on Social Work Practice

This study explores the usefulness of CPC-CBT within a Swedish context and examines whether the positive results from previous studies in the US and Sweden could be confirmed within a larger Swedish sample with a representative comparison sample. Furthermore, this study explores whether effects of treatment would last six months after completing treatment.

**Participants**

**Clinical group**

In total, 80 children were contacted about participation in the study; 75 children agreed to participate, all receiving treatment in one of 14 treatment units. During treatment, 12 children dropped out and one family could not be reached (Figure 1). The 13 children who left treatment formed an intend-to-treat group. There were no significant differences between the intend-to-treat group and the final group receiving treatment ($n = 62$) considering exposure to CPA or trauma symptoms before treatment.

Between the post-intervention and the six-month follow-up, 14 children from 12 families dropped out. The most common reason was that the family could not be reached ($n = 8$). In some families, there were indications that the family was abroad or that the family had moved. Parents declined further
participation for six children, most often with the motivation that they did not want to remind their child about the previous conditions within the family.

Figure 1. Flowchart of participants

In total, 62 children participated in the post-treatment data collection and 48 children in the follow-up measure data collection. The 62 included children were between 6 and 16 years of age, mean age 9.62 (SD 2.61).
Non-clinical group
Effects of treatment were compared using a non-clinical group of children. These children were part of a larger representative sample, including children and adolescents, 10–17 years of age, living in a mid-size city in Sweden. The sample was originally used in a study validating the TSCC scale (Trauma Symptom Checklist for Children) in a Swedish context to provide norm values. The day for the study 807 children and adolescents were available in school and a total of 728 children and adolescents from this group responded on the TSCC. The dropouts were due to illness on the day of the research (n = 49) and incomplete questionnaires (n = 30). In order to match the clinical group, this study used a sub-sample of children between 10 and 16 years of age, mean age 13.07 (SD 1.59), resulting in 702 children.

Table 2. Gender of children included in analysis

<table>
<thead>
<tr>
<th>Gender</th>
<th>Clinical group (n=62)</th>
<th>Non-clinical group (n=702)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Female</td>
<td>33 (53)</td>
<td>349 (50)</td>
</tr>
<tr>
<td>Male</td>
<td>29 (47)</td>
<td>353 (50)</td>
</tr>
</tbody>
</table>

Results
The result can be summarised in three main findings. First, differences between groups were revealed before entering treatment with children experiencing CPA reporting significant higher levels of symptoms associated with trauma compared to the normative sample. After the clinical group had received treatment, no significant differences were reported between groups concerning the subscales depression, anger, dissociation, and the total TSCC scale. The positive finding remained at the six-month follow-up, with an additional reduction on subscale anxiety, indicating a non-significant difference across groups. Second, CPC-CBT seems to be effective concerning the main goal of treatment: reducing parental use of physical violence. Children participating in the intervention reported a significant decrease in
CPA victimisation (measured with the subscale corporal punishment) after completing treatment, with a remaining effect six months later. Third, together with decreased exposure of violence, children reported an improved wellbeing on all measured symptoms associated with trauma after completing treatment, with the exception of subscale anxiety. The positive findings remained at six-month follow up, together with subscale anxiety, indicating a lasting effect on all measured symptoms associated with trauma.

Taken together, the fourth study presents promising results for families who completed the CPC-CBT intervention. The results indicate that the intervention is successful in helping parents end destructive parenting by teaching alternative, non-violent parental strategies. Furthermore, children reported an increased wellbeing with maintained effects over a six month period. That is, children reported less anxiety, depression, anger, PTS, and dissociation six month after completing treatment. The results are in line with previous research on the CPC-CBT intervention (Kjellgren et al., 2013; Runyon et al., 2009; Runyon et al., 2010), supporting the efficacy of the intervention in different cultural contexts.

The study design with a normative comparison group provides valuable information on the significant change following treatment (Kendall et al., 1999). Kendall and colleagues argue that by comparing the outcomes of treatment with norm values, the outcome could indicate the effectiveness of treatment. If the reported change is in line with reports from the normative group, the result indicate that the treatment has provided sufficient help for recovery (Westbrook, & Kirk, 2007).

The significant differences between abused children and children in the non-clinical group before treatment indicates severe effects of being physically
abused concerning symptoms associated with trauma. The change in symptom load on depression, anger, dissociation, and the total TSCC scale after completing treatment as well as at the six-month follow-up (together with reported anxiety) compared with normative values supports the efficacy of treatment in helping children overcome some of the burdens of experiencing child physical abuse.
Overall analysis from the theoretical perspectives

In this section, I return to the theoretical concepts earlier described and further explore them in relation to the results from the studies.

Shifting trajectory? – Identifying possible turning points

The concepts of turning points, trajectories, and transitions are contextualized in different ways in the four studies included in the thesis. The first study examines the experiences of parental strategies and SOC among physically-abused children as well as among non-abused children. The result shows several differences for abused children compared to non-abused children. Together, the results signal a trajectory where abused children receive less support from their parents than non-abused children, including less engagement in their everyday lives and less positive interactions. The discrepancies in perceived parenting, with less positive parental strategies reported by the abused children, together with decreased SOC indicate life processes following ongoing problematic trajectories.

Study II focuses on the process of disclosing physical abuse. The decision to disclose marks an important potential turning point for changing the negative
trajectory associated with child physical abuse. Children most often make well-thought decisions before disclosing. They seek support and they decide to disclose often after an escalation of violence or a special episode experienced as especially severe. Some children express fear for disclosing, but they also fear remaining at home under the same conditions. Other children describe a more un-intentional disclosure. For example, some children noted that the topic had been brought up in school, providing them with an opportunity to talk about the abuse. Timing is an important aspect when aiming to change a trajectory (Enell, 2014). Children have to feel ready for disclosing, and parents have to be motivated to accept interventions aimed to support a change (another possible turning point).

Without a recipient who will act on the behalf of the child, the disclosure will not lead to a successful turning-point. Some children describe how they had to disclose multiple times and turn to different adults to make a change happen. These children need competent adults who can act on the disclosures and provide them with suitable interventions. Similarly, the children described trust as an important part of the success of their CPC-CBT intervention. They needed time to build a relationship with their therapist in order to open up about their feelings. It is also important that the intervention match their needs. Here, children describe the importance of addressing the violence in treatment. It could be the first time they hear another adult talking to their parents about the inappropriateness of using physical violence.

Entering and completing the treatment is the most obvious turning point in the empirical material. A turning point indicates a change relative to a specific time (Enz & Talarico, 2016). The individual could recognize a before the event, or process, and an after (White & Wu, 2014). A turning point impacts an individual’s identity (Wingens & Reiter, 2011) and leads to personal
change (Enz & Talarico, 2016). Furthermore, a turning point could affect a trajectory or the entire life course (e.g., Elder, 1998).

When children described their parents becoming calmer, non-violent, supportive, and engaged, they described their everyday life with new characteristics, indicating a new trajectory. Even if the empirical material did not consist of any information from their parents, it is important to acknowledge them in the process. Their motivation for entering and completing treatment is worth further investigation.

The last study focused on the quantitative effects of the CPC-CBT intervention. The result pointed to positive findings, with a decrease in violence and improved wellbeing in the children. The results remained positive at the six-month follow-up. The children reported increased wellbeing after the intervention and were to a large extent at the same level as children from a representative sample, indicating that the treatment had been successful. Previous research has revealed a high likelihood of re-referrals to child welfare services due to continuing abuse, indicating a problematic ongoing trajectory (cf. Jonson-Reid et al., 2003; Lindell & Svedin, 2006). The reported decrease in parental use of physical violence could indicate the intervention being helpful in changing this life path. Moreover, the reported decrease in physical abuse together with the result from the interview study where children describe how both they and their parents have gained strategies for handling their anger and frustration in a non-violent way suggest that the child is able to break a possible intergenerational path of violence. Being a victim of abuse increases the risk for engaging in that kind of parenting when the children eventually start a family of their own (Thornberry & Henry, 2013).
The actual time within treatment could also be seen as a transition. A transition could be described as a passage from one period in life to another, often focusing on location (Enz & Talarico, 2016). Transitions often include changes in the external circumstances (Enz & Talarico, 2016). It is a change that could be experienced when it happens, in this case the family deciding to try the intervention. Memories are partly attached to the location (going to the town where treatment is offered). But the impact could remain long after the intervention takes place. Children describe how they and their family members rehearse or remind each other about different strategies they were taught in treatment in order to make the change remain. Furthermore, children describe a family climate before treatment as characterised by fear and violence (former trajectory). After treatment, children in the interview study express feeling more secure, not fearing the violence to reoccur and experiencing a new climate within the family (new trajectory). These results could indicate a transition from one type of life (living in fear) to another (living without fear).

Facilitating or hindering a new trajectory – following the 3 P of the CRC

The overall results point at the treatment as a successful turning point. Several turning points could have worked together to facilitate the change of the trajectory. Some of them are beyond the scope of this thesis, however, some information is given of what could participated to the outcome.

The interviews with the children after treatment reveled the importance of trust. Trust is needed throughout the process, from disclosure to assessment to interventions. Children stressed the importance of the recipient of their disclosures listening to them, being kind, and being patient (cf. Allnock & Miller, 2013; Jernbro et al., 2010).
The children highlight several effective components. Trust is one, but children also highlight the importance of addressing the violence and process the trauma. It is important to address the violence and process of trauma with the parents as well. This result is supported by Dittman and Jensen (2014), who not only describe addressing the violence and process of trauma with children as helpful for the trauma recovery but also discuss its positive effects on the parents. Sharing the trauma narrative with the parents helps the child feel comfortable with the parents’ ability to deal with their emotions. They will also create a mutual understanding of what has happened and how it has affected the child. Children express relief after verbalizing the trauma (cf. Day et al., 2006), even if it could be painful at the beginning of the process. It was also important to address cognitive distortions. At the beginning of treatment, some children described how they, despite the knowledge of the ban against physical abuse, thought the violence was their fault. They wanted repeated assurances that the violence was not their fault.

In the process following a child’s disclosure of physical abuse, it seems that adults miss the opportunity to involve the child. This is even clearer after child welfare services become involved. In all the cases in the interview study, the children received an intervention aimed at ending the abuse. However, the children were rarely consulted and most often not even informed about what kind of intervention they were to receive.

Previous research has revealed shortcomings in child welfare services. Despite the legal framework stressing the importance of involving the children, social workers tend to focus on meetings with the parents, and the parents end up formulating the problem (Heimer et al., 2017b). Children and youth tend to be defined on the basis of their problems (Enell, 2015; Heimer et al., 2017b). Without the possibility of being involved, children are losing their position as
agents, and they have few possibilities to make sense of the investigation process. Both Enell (2015) and Heimer et al. (2017b) stress the importance of the investigation process and the following intervention to form a logical entirety that children can make sense of. It is important that children within this process not only are seen as problem carriers but also as rights holders (Heimer et al., 2017b) who possess strengths and are entitled to social benefits (Enell, 2015).

Using the CRC as theoretical framework (cf. Heimer et al., 2017b), the CPC-CBT intervention meets the three Ps criteria: protection, provision, and participation.

1) Children entering the intervention are (supposed to be) protected, even if they continue to live with their (former) abusive parent. In weekly meetings, the therapists build a relationship with the child and address whether the violence has ended in the family. The therapist is obliged to report to child welfare services if the child reports ongoing violence. Of course, children could withhold information from their therapists, but the result from the interview study (Study III) and the outcome study (Study IV) reveal a decrease in violence.

2) Children are provided with treatment targeting the reason for being reported to child welfare services. In contrast to earlier research (Heimer et al., 2017b), child welfare offers a treatment corresponding to the violence within the family. Children in the interview study describe the importance of addressing the violence. It could be the first time they heard an adult talk to their parents about the inappropriateness of using physical abuse and that the violence was not the fault of the child.
3) Children are seen as active *participants* within the CPC-CBT intervention, and they describe the treatment as child-friendly, as they were invited to be part of setting the agenda for the counselling (Study III). The intervention’s point of departure is their telling of an abusive event, and it is their parents who must adjust to their narrative, not the other way around. By having a therapist of their own and receiving help preparing for their joint sessions with their parents, the children gain trust in their therapist and the intervention. If they feel insecure, they receive help from their therapist when addressing certain topics.

In the theory section I argue, with support from Heimer et al. (2017b), that participation is crucial for both satisfying provision and protection. However, children in Study II describe a lack of participation in the decision process leading to the CPC-CBT intervention. The positive outcome described in Study III could be explained by the fact that child welfare workers acknowledged the original report of child physical abuse given by the child and let that narrative influence the decision process. The violence was not down-played as in Heimer et al.’s study (2017b). Children were listened to, even if the information given to the child was limited. When in treatment, the children regained their rights as participants and were listened to and consulted.

**Trust and participation – core elements in a model for interpreting the results**

Interpreting the voices of children, the outcome of treatment depends on trust and participation, which are the foundations of the model presented below.
Both trust and participation are crucial for enabling the different phases. Without trust in a recipient, the disclosure would not happen. Although participation seems to be missing to a great extent in the time following the disclosure, it is returned, and emphasised, when describing the intervention. Trust in the therapist and the professional confidentiality makes therapy a protected zone for development. Feeling safe and acknowledged for their disclosure and hope for a better family climate, children are listened to and invited to construct a new narrative about the abuse. They emphasise the importance of repeatedly being assured that the violence was not their fault. Children could have a lot of explanatory models for describing why the abuse took place, but when talking it through with their parents and therapists a new construction is created, one that exonerates them of blame for the abuse. This continues in the explanatory work phase, where both children and parents write about the abuse. Children write their trauma narrative and parents
respond by writing a letter of clarification. This is shared during the joint sessions. In this process, parents take responsibility for the violence, relieving the child from blame. Therapists judge if the family is ready for this phase; if the child does not feel secure and safe, the therapists will not expose the children to this phase. Children described it being hard at first to finish writing the trauma narrative since it evokes painful memories, but all the children who stated that also emphasised the importance of doing it since it felt better after they completed their narrative. It is, however, a vulnerable part of treatment, and this is not possible without the child trusting the therapist and feeling in control over the course of events. In the reorganisation phase, the family could relate in a new way. Children express feeling closer, doing more things together (‘now it is nice to come home’), and parents being friendlier. The violence ended and children described feeling assured that it will not re-occur. The stabilisation within the family is also supported by the reports of the children’s wellbeing, with decreased symptoms associated with trauma after completing treatment and at the six-month follow-up.

How can we understand CPC-CBT to be a successful treatment using Belsky’s ecological model? At ontogenic development, Belsky argued for the influence of both early experiences in the parents’ lives as well as lack of adequate knowledge in child rearing. In the model below, the phases narrative (re-) construction and explanatory work includes psycho-education about child development and consequences of abuse. Children in the interview study concerning the intervention describe parents calming down and spending more time with them after treatment. Some of the parents had been abused themselves\(^3\) and throughout treatment they could deal with their previous experiences.

A lot of processes take place at the micro-level. The child makes several judgements that affect the family system, and the family system responds in ways that affect the individual child. At the micro-level, both children and the family system have made efforts to change the dysfunctional pattern within the family. Children disclosed the abuse, but both children and parents had accepted the intervention and worked together with the therapists to improve the relationship and change their behaviour. At the exosystem level, different systems worked together. Most of the disclosures took place in school. The school reported the abuse to child welfare services, another function in the exosystem. Without the interaction between the school system (their reporting) and the child welfare services, the child’s situation may not be noticed and no interventions would be offered. Likewise, it is important that child welfare services acknowledge the reason for the reporting (the physical abuse) and address this with the family. The family in turn accepted the proposed intervention and later worked together with child welfare services during the intervention. Both the microsystem and exosystem include factors that act and interact to make the change happen. The quality of these interactions determines the possibilities for both participation and trust. Lastly, the macro-system is the norms and legislations within the society. Sweden is considered to have high structural support for vulnerable children (Gilbert, 2012). It could be argued that the ban against child physical abuse has been a protective factor for children; however, the lack of offered interventions could be seen as a neglect of structural support.

---

Discussion

More than one out of ten children in Sweden experience physical abuse perpetrated by one or both caretakers (Annerbäck et al., 2010; Jernbro & Janson, 2017). Drawing on the possible long-term consequences of child physical abuse, considering both mental health problems (Annerbäck et al., 2012; Clarkson, 2014; Felitti et al., 1998; Grogan-Kaylor et al., 2017; Nilsson et al., 2017) as well as physical health problems (Felitti et al., 1998; Jernbro & Janson, 2017; Moffitt, 2013), the need of intervention is clear. The overall aim of the thesis was to explore the experiences and possible consequences concerning reported health and the relations between a child who is victim of physical abuse and their parents, experiences among children disclosing the abuse, and the impact of an intervention designed to support these children in a Swedish context. This thesis focuses on the CPC-CBT intervention since it is an intervention aimed at both decreasing parental use of violence towards the child and helping the child recover from their experiences.

Traditionally, child welfare services has dislocated treatment of children to child psychiatric clinics. The results and experiences from implementing CPC-CBT within different social service organisations highlights the possibilities for child welfare services to provide efficient treatment. Child welfare services aims to help families change their destructive trajectories. While an investigation in itself could be a process of change, providing adequate
treatments further strengthens child welfare as an arena for change. By extending the treatment programs previously solely provided by child psychiatry to social work, more children will have access to efficient treatment.

This thesis outlines some of the negative consequences following child physical abuse (Study I). There are several differences in how children being victims of physical abuse and non-abused children report their interactions with their parents and parental strategies. Abused children report a significantly lower SOC and victimization of physical abuse explains 50% of the variance in SOC. Results from Study I reveal the importance of providing interventions for families where physical abuse occurs as well as the importance for interventions to enhance the positive interactions between parents and children. Symptoms associated with trauma and the persistence of PTSD could decrease in the first six months post-trauma, but after six months it is unlikely that children will improve their wellbeing without adequate treatment (Hiller et al., 2016). However, as Hiller et al. note, most studies in their review consist of non-intentional trauma exposure or non-interpersonal traumas such as car accidents (Hiller et al., 2016). In these cases, a responsive parent could be present, helping the child cope with their experience. When the trauma is inter-personal and a family member is the perpetrator, this protective shield could be lacking (Alisic et al., 2014). Physically-abused adolescents perceived their parents as having a less optimal parenting style and reported significantly more psychological distress such as anxiety and depression and lower global self-esteem than non-abused adolescents (Nilsson et al., 2017). Furthermore, interpersonal traumas are more likely to generate PTSD than non-interpersonal traumas (Alisic et al., 2014). Since the abuse often re-occurs (Jonson-Reid et al., 2003; Lindell & Svedin, 2006), it is likely that it has persisted more than the six month stipulated by Hiller and
colleagues to be a limit where self-healing could occur (Hiller et al., 2016). Together with other known possible consequences from suffering child physical abuse, the needs for interventions are clear. The fact that the violence is perpetrated by those who are supposed to protect and care for the child is an aggravating circumstance. However, when identified, child welfare services could offer interventions aiming at healing the relationship between parent and child. Previous research has stated the possibility for interventions to improve the parent-child relationship (Sternberg, et al., 2005), a finding supported in Study III.

**Disclosing child physical abuse**

As presented in the model in Figure 2, children must be able to disclose the abuse before interventions can be provided. Children in Study II describe disclosure as a process with several tough decisions. The analyses in the study categorised the disclosure as intentional or non-intentional. A further analysis could broaden this categorisation. The category intentional could be divided in planned and un-planned. Some children made up their mind that they had to disclose in order to make a change happen as the result of a specific episode experienced as crossing a line or an especially severe abusive act by a parent. The child could make up their mind that next day in school they will turn to a trusted teacher or the school nurse and tell. This could be described as an intentional planned disclosure. Other children describe how they wanted to tell someone about their situation, but they were not sure about the timing. The disclosure was facilitated when they saw an opportunity and a responsive adult. This sub-category could be labelled as intentional un-planned disclosure. The un-intentional disclosure could in turn be divided into un-intentional by force or trigged. For example, some of the children were surprised by a direct question from a teacher asking them about how things are going with their mother. These children had not planned to disclose but choose
to do so when confronted with a direct question. Other children describe a topic being unexpectedly addressed in school triggering them to make a personal comment that leads to a disclosure. The intentional disclosure is to some extent cognitive thought of by the child. They have reflected over the possibility to disclose and thought of a suitable recipient. The unintentional disclosure is more situational, where others act in a way that triggers disclosure.

Although the path to disclosure often differs, there are some common characteristics when children describe the recipient of the disclosure. First, a professional has to be responsive. In addition, according to the children, it is important that the recipient is kind, trustworthy, takes time to listen, and implicitly and explicitly accepts the veracity of their story. These characteristics seem to lay the ground for the disclosure, intentional or unintentional.

Results from Study II highlight school as an important arena for abused children as schools often provide a safe environment, and the possibility of long-term relationships with teachers promotes the establishment of relationships with trustworthy adults. School could also be an arena where children are thought about the rights of the child and that the abuse never is the fault of the child.

It is possible that the different ways of disclosing affects the child’s further acting and reflecting in the process. The disclosure is in a way an ongoing process where the child often has to disclose to several adults. All disclosures in this study were reported to child welfare services. The initial telling of the child then shifted form and became a story that the child had to relate to. Children in Study II describe different feelings after the disclosure. Some
children were afraid of what would happen, some were exposed to pressure from family members and members of the extended family, and some had feelings of guilt and shame, but there were also some children who felt a sense of relief. Future research could further examine the relationship between forms of disclosure and children’s feelings and wellbeing.

TREATMENT

Children’s experiences of the CPC-CBT intervention were explored in Study III and Study IV using different methodologies. In the interview study, children described a positive impression of the treatment. All of the participating children described a decrease in parental violence, a result supported in Study IV. They further stated (Study III) that they felt assured that the violence would not re-occur. According to the children, the treatment had helped them come closer to their parents. Some children expressed that they did not think they would have been able to remain living with their parents if the family had not received help and the parent had not changed their behaviour. Separating children and parents is sometimes necessary, but it is also associated with further problems and life experiences for the child (Vinnerljung & Sallnäs, 2008).

Children stated that it was important that therapists addressed the violence with their parents and that they were their advocates. They needed to (repeatedly) be assured that the violence was not their fault. Children in Study III describe cognitive distortions where they blamed themselves for their parents’ actions. Durrant et al. (2017) argue that by thinking of the abuse as deserved, the blame of the violence is shifted from the perpetrator (the parent) to the recipient (the child). As pointed out by Durrant et al., in no other act of violence is the word punishment used (Durrant et al., 2017). Furthermore, children described several transformations within their lives. Both parents and
children gained strategies for calming down and managing anger and frustration. According to the children, both children and their parents had become much calmer. It was easier to talk and interact with their parents, and the children described not fearing the reaction of their parents. Parents were more engaged and spent more time with their children after treatment.

Study IV supports the results from Study III: there was a decrease in parental violence after treatment and present six-months later. The same trends in decrease in parental physical abuse have been reported in previous studies evaluating CPC-CBT in both Sweden (Kjellgren et al., 2013) and the US (Runyon et al., 2009; Runyon et al., 2010), supporting the usefulness of the intervention in different contexts.

Children reported a decrease in all symptoms associated with trauma after finishing the intervention, with the exception of subscale anxiety. As with parental violence, the results remained at the six-month follow-up, together with subscale anxiety. That is, children report less anxiety, depression, anger, PTS, and dissociation six month after completing treatment. Compared to a non-clinical group, physically-abused children reported significantly higher levels of symptoms associated with trauma before entering treatment. No such significant differences were reported after treatment concerning depression, anger, dissociation, or on the total TSCC scale with the same positive result at the six-month follow-up (together with subscale anxiety). This result indicates both the severe effects of physical abuse victimization and the efficacy of the CPC-CBT intervention.

Taken together, Study IV presents promising results for families who completed the CPC-CBT intervention. The results indicate that the intervention has been successful in helping parents end their abusive behaviour, and hopefully thereby ending a dysfunctional trajectory for the
children. Furthermore, the positive results following this study reveals that effects obtained in treatment could last six month after completing treatment. Children’s reports indicate that parents could uphold their gained non-violent parental strategies even when there is no longer support from therapists. Children also describe a better relationship with their parents after the violence has ended, a finding also present in earlier studies (Stemberg et al., 2005). In summarise, the treatment seems to have been a successful turning-point shifting from one trajectory (living in fear) to another (living without fear).

**Putting words to child physical abuse**
Parental views about raising children and attitudes toward corporal punishment/CPA have been investigated in Sweden since 1980 with the same questionnaire. This history provides unique information about shifts in parental attitudes in Sweden. In 2017, there was significant drop in the number of parents favouring violence as a disciplinary strategy. Although the numbers are positive, they could be explained by the taboo surrounding CPA (Jernbro et al., 2018). This taboo could make both parents and children reluctant to talk about the abuse, which in turn could be an obstacle for searching and/or accepting help. Therefore, it is important that interventions address this sensitive topic in preventive interventions as well as in treatment. In Study III, the children participating highlighted addressing abuse as a significant part of the intervention. The intervention was the first time they heard someone talking to their parents about the inappropriateness of using physical violence.

Previous research has revealed insufficient result for actions taken by child welfare services after referrals of child physical abuse. Children have often remained in their parents’ custody (Lindell & Svedin, 2006) with a substantial number of re-referrals (Jonson-Reid et al., 2003; Heimer et al., 2017a; Lindell & Svedin, 2006). The interventions offered by child welfare services rarely
addressed the reason for referral – i.e., parental use of violence (Heimer et al., 2017a). Children in Study III described appreciating how the treatment focuses on the cause of referral – i.e., the parental use of violence. The promising results from Study IV support parents’ ability to gain and maintain non-violent parental strategies over a six-month period, indicating a decreased likelihood of re-referrals to child welfare services.

A loop of participation

When summarizing the impressions after meeting the participating children and living with their stories over time, the lack of human rights concerning participation within this group is striking. According to the children’s narratives, confirmed by previous research, they depend on adults giving them their rights. Although these children are living their experiences, adults seem to have preference of interpretation of the same. Coming to the disclosure phase, children choose a recipient, but how this person chooses to act is beyond the control of the child. Some children take several risks in the disclosure phase. They could also feel that they have to disclose to more than one person to make a change happen. We can only speculate how many children give up during this process. When the adult (most often a teacher) contacts child welfare services, the children once more are depending on adults to decide whether their story merits investigation. Child welfare workers are likely to listen to the parents and let the parents decide the interventions (Heimer et al., 2017b), a fact confirmed by the children in this thesis. Only a few of them were informed about the suggested intervention, and even fewer were asked about what kind of treatment they would prefer.

The children seem to be in a loop of participation. Most of them choose to disclose the abuse to a trusted recipient. In this process, they are active agents seeking change. However, they seem to lose their agency and control over
how their disclosure is handled. It is an un-even level of power throughout the experience-disclosure-treatment chain. The recipient of the disclosure and later child welfare services are taking actions, but they are not informing or involving the child. The children describe re-gaining their right as participants once they begin treatment (Study III). Their telling about the abuse is the starting point for their treatment, and they are informed and consulted about every step in treatment. Children describe being part of setting the agenda for the treatment, which seems to facilitate treatment as a successful turning point. Trust and participation are also essential parts of the model presented in Figure 2.

Several of the children emphasised the importance of trust and the professional confidentiality. The professional confidentiality should in light of treatment be seen as children being recognized as participants, informed and consulted about different aspects of treatment. The children’s therapists are obliged to report any ongoing or new abuse and they talk to the parent’s therapists during the treatment. But the child is always informed and consulted about every step, making it easier to build a trustworthy relationship.

**Voice and choice**

This thesis focuses on children’s experiences. The choice to highlight the experiences of children is not an ignorance of the difficulties put on their parents or the child welfare services but rather intends to give voice to a group with limited possibilities to be heard. As pointed out by Heimer et al. (2017a), child welfare workers rationalise decisions from the point of view of legislation. However, it is time to discuss if the current legislation is actually helping these children or if its comprehensive frame distorts the understanding of potentially contradictory goals, making it harder for a practice governed with the best interest of the child in mind. When establishing consent, child welfare workers turn to the parents, rarely the children (Cocozza et al., 2006;
Heimer et al., 2017a). In this case, the abusive parent is given the power to decide however they want to participate in an intervention, giving marginalised attention to the needs and wishes of the child. To what extent does child welfare services address the responsibility of the violence? Results from Study III highlight the importance for children to hear that the violence was not their fault. Child welfare services has a complex mission, and one of the most important parts of its mission is to function as a last resort for some children. The results from this thesis indicate that child welfare services could make improvements in this area.

Child welfare workers are sometimes balancing care and participation (Bijleveld et al., 2015; Vis, Strandbu, Holtan, & Thomas, 2011). But sometimes neither care nor participation is attained, especially when the violence is inaccurately described – i.e., the child’s situation is not fully described. By not letting the child participate, a more nuanced picture is lost, which decreases the possibility of providing protection (two of the three Ps of the CRC). The children studied in the thesis were in many ways ignored by the adults charged to protect them – i.e., their parents and child welfare services. Moreover, these children are living with their perpetrators, sometimes with no possibilities to escape the violence. Child physical abuse is a limited field of research, despite its occurrence both among the child population and within reports to child welfare services. By including children as active agents in at least some parts of the research, this thesis hopes to broaden the base of knowledge concerning the thoughts and experiences of physically-abused children.

In future work, the tension between protection and participation should be examined further, from both a child and a social worker perspective. Drawing on the results from this thesis, future research should focus on how child
welfare services could implement child-friendly routines during their application, investigation, and intervention phases. The century of the child has come and gone, but child physical abuse and child welfare services persist. With child-friendly routines where the child is invited to be part in setting the agenda for the whole application-investigation-intervention chain, society could be ready to allow for both participation and protection with regards to physically-abused children. The results from this thesis emphasise the importance of inviting children to frame the problem, of listening to them, and of giving them time to build trustworthy relations with social workers (including time to talk solely with a social worker as well as together with their parents) to provide for a successful transition to a trajectory without violence.

**What is the turning point?**
The concepts of turning points, trajectory, and transition have guided the analysis. The results from Study I concerning children’s reports of parental strategies and their own SOC together with children’s telling in Study II about an everyday life filled with violence, brawling, screaming, and fear indicate an ongoing problematic trajectory. Their telling in Study III concerning the change within their families after treatment supported with their reports of improved wellbeing in Study IV could be seen as a shift to a more secure trajectory. Treatment could in this light be seen as both a transition (the path leading to the new trajectory) and a turning point facilitating the transition. However, there could have been several turning points, both in treatment and concerning other factors. Disclosing abuse could be a turning point, together with a responsive adult listening and reporting the abuse. Coming to child welfare services, the decision to offer CPC-CBT, and a family’s acceptance of the intervention could be another turning point. In treatment, children highlight the importance of trust, the structure of the treatment, addressing of
the violence, and the writing and receiving of the letters. It is not possible and has not been the aim of the thesis to point at any specific part being the turning point. The turning point(s) is likely to be constituted by a chain of decisions and actions, taken by both the child and different adults around the child. However, the results indicate that the decisions and actions together facilitate a new trajectory for the children.

A century for children?
More than 100 years have passed since Ellen Key named the 20th century ‘the century of the child’. The century came and passed. In the light of a child-friendly society, how far have we come? In the 1970s, Pierre (1975) discussed the deficits within the child welfare committees in Sweden. Despite alarms from health care concerning risks of physical abuse, children were reunited with their parents, often with continuing hospitalisation as a consequence as the abuse tended to be repeated. With inadequate responses, this seems to be the case 30 (Lindell & Svedin, 2006) and 40 (Heimer et al., 2017) years later. Furthermore, Pierre was concerned that it was impossible to obtain any statistics from the child welfare committees concerning the reasons for reports. It was not possible to gather information about how many cases of suspected physical abuse the committees were aware of (Pierre, 1975). This is still a concern today, 40 years later. An investigation concerning the three largest cities in Sweden – Stockholm, Gothenburg, and Malmö – in the mid 1970s revealed that the child welfare committees in the two largest cities questioned the incidence of physical abuse. Pierre suggested that every service should assign one employee that works part-time with physically-abused children. This was assumed to increase the competence within every service and speed up the processes. In a retrospective perspective, Pierre’s suggestion about assigning one staff member working part time with abused children was
commendable, but must have been far less than the need. Even those who dared to see the problem could not grasp the size of the problem.

The un-willingness to see physical abuse, its bare existence and consequences, is not a problem restricted to the 1960s and 1970s (see Pierre, 1975). The mandatory reporting to child welfare services concerning suspected child abuse and/or maltreatment was sharpened in the Social Services Act of 1982. Despite these efforts, several studies have revealed how different professionals still downplay their obligation of reporting. According to Svensson (2013), preschool teachers report only 30% of children who they suspect are victims of abuse. Similar numbers are found in studies concerning healthcare providers (Borres & Hägg, 2007; Svärd, 2016). Kvist et al.’s study found that no dentists had report a suspected case of abuse within a six year period (Kvist et al., 2017). Different reasons have been given for the relatively low figures. Lack of confidence in child welfare services is one (Borres & Hägg, 2007; Svärd, 2016). Fear is also a reported reason by nurses, nurse assistants, and physicians, but not fear of what would happen to the child or how the relation to the child will be affected, rather they fear for the safety of the presumed (mandated) reporter and concerns of the relation with the parents (Svärd, 2016).

The child welfare services seem to still have problems facing the issues of parental use of violence towards their children. The investigation carried out by Heimer et al. (2017a) reveals a high prevalence (57%) of violence in cases reported to child welfare services. However, the outspoken strategy by the child welfare workers was to seek consent from the parents, and as a consequence the violence was rarely mentioned in investigations and intervention plans. The reasons and consequences for this outspoken strategy demands further research. This strategy together with the fact that no
intervention had been developed within a Swedish context in order to help these children and families must be considered questionable. The knowledge of the harmful effects of child physical abuse have been well known since the 1960s, laying the ground for the ban of corporal punishment (Bergenlöv, 2009; Pierre, 1975; SOU 2001:18). Despite the efforts put in information campaigns informing about the ban and the harmful effects of corporal punishment/CPA, it is remarkable that no specialized help has been developed and provided. At its best, it shows a high trust in people’s ability to adopt new knowledge, and accordingly change misbehaviour.

What can we learn from history? The increased awareness in the 1960s led to new investigations and committees with the aim to further explore the subject of CPA. The investigation in 1969 concluded that child welfare committees should implement a registry of causes of reports (National Board of Health and Welfare, 1969). This was followed by Pierre’s 1975 recommendations (Pierre, 1975). The 1969 committee wanted more knowledge of different professionals working with children. They asked for compulsory education about CPA for medical doctors, nurses, and social workers (National Board of Health and Welfare, 1969). These are examples of improvements that are still incomplete.

In 1966, the allowance of using corporal punishment was withdrawn from the Parents’ Code. Since then, corporal punishment was seen as physical abuse (Bergenlöv, 2009). It was argued that it was an unclear line regarding what was considered modest physical corrections (Bergenlöv, 2009), and prosecutions concerning physical abuse were refused in court (SOU 1978:10). The ban was put in action in 1979 by a new regulation introduced in the Parents’ Code. What was and is considered physical abuse is still today up to the Criminal Code. The Criminal Code emphasises violence causing lasting
damage or pain, which could exclude pulling a child’s hair or pushing them. Leviner (2013) is pointing at how the prohibition against corporal punishment has worked on an educating level more than a judicial level. The increases in reported cases of CPA to the police have not led to any notable increases in proportions of convictions (Leviner, 2013), making the question relevant: What has really changed?

Some further methodological considerations

One of the research questions for this thesis is the effectiveness of the CPC-CBT intervention. A broader focus could have been the effects of interventions given by child welfare services in families where child physical abuse had occurred. However, because CPC-CBT has been the only specialized intervention provided in Sweden for these families targeting both child and parent, it is not possible to compare the results with other treatments. The results presented in the thesis are positive, but in order to state to what extent, they need to be compared to children receiving other interventions. It is not possible to state that the positive effect reported by the children is caused by the intervention. That kind of causal relationship needs a randomized trail including control groups. Nevertheless, the components of the CPC-CBT could be compared with components of other programs found to be promising.

According to Kramer and Lan Holtz’s (2011), meta-analysis concerning the efficacy of early interventions for children experiencing a potentially traumatic event should these interventions include psycho-education, individual coping-skills and trauma exposure. The well-established Trauma Focused Cognitive Behavioural Therapy (TF-CBT), originally developed for children experiencing sexual abuse, lists their components in the terms of PRACTICE: Psychoeducation, Relaxation, Affective Modulation, Cognitive Coping, Trauma Narrative and Processing of the Trauma, In-vivo exposure, Conjoint session, and Enhancing Safety Skills (Silverman et al., 2008). CPC-
CBT shares these components (Runyon, & Deblinger, 2014), supporting the efficacy of the CPC-CBT intervention. Further the treatment aims for parents to take responsibility for their previous violent actions. This could have significantly contributed to decreasing the child’s symptom load. Further research could extend the knowledge base concerning how children experience different components included in the intervention.

Most children in this study highlight writing their trauma narratives and receiving the parents’ letters of clarification. However, these results could be due to recency bias as these were the last activities of the intervention. However, the result supports previous research stressing the importance of being exposed to and processing the trauma in treatment (Cohen et al., 2010; Dittman & Jensen, 2014).

No information about re-referrals was gathered in the study, and the follow-up time has been limited. But even if violence re-occurs, children know that there is help, and hopefully they will carry with them the previous experience of being listened to and believed when seeking for support.

The children’s perspective was chosen as the overall perspective for the thesis; however, the CPC-CBT treatment is an integrated treatment for children and their parents. CPC-CBT is not solely a child intervention. Without the participation of the parents, CPC-CBT could not work. The positive results for children identified in the studies of this thesis are related to and affected by similar positive results for parents in treatment, results not presented in this thesis. In treatment, children and parents interact and support each other in

---

achievements that result in favourable treatment outcomes of the whole family. Parents’ motivation for entering and completing treatment is crucial for the positive outcome for children.

The experiences of the clinical group indicate short comings as well as good practice. In a general perspective, 14 in 100 children in Sweden self-report being physical abused. A minority of these report their abuse experiences to professionals. A smaller minority of these are acknowledged by child welfare services and are referred to specialized treatment such as CPC-CBT. In this context, children participating in the studies included in this thesis could be considered a privileged group, not representative of the majority of children experiencing CPA in Sweden. This further underlines the need for improved ways to identify and meet the treatment needs of this population.

**Cultural adaptations**

During the ten years of implementation of the CPC-CBT, the intervention has undergone some cultural adaptions under the supervision of the programme developer, which could mean some of the parenting strategies were excluded for not being relevant in Sweden. The usefulness of the intervention has been reported in both US and Sweden (Kjellgren et al., 2013; Runyon et al., 2009; Runyon et al., 2010). In Sweden, the results have been equally positive regardless of the origin of the family (parents born in Sweden or outside Europe) (Thulin & Kjellgren, 2017). However, it is important that there will be continued research on the intervention and its usefulness concerning different subgroups according to, for example, ethnicity or degrees of trauma.
Main conclusions
The main conclusions from the included studies are summarized below.

- There are several differences in how abused children and non-abused children report their parents’ parental strategies. Physically-abused children report significantly less parental involvement and fewer positive interactions than non-abused children.

- Physical abuse has a unique negative impact on sense of coherence and abused children report significantly less sense of coherence than non-abused children.

- Disclosing abuse from a caretaker is a sensitive process requiring the abused children to make many difficult decisions. Trust in adults is an important factor both when a physically-abused child chooses a recipient to disclose to and when a physical-abused child participates in the intervention. Adults who these children trust with their stories need to be their advocates, acting on the behalf of the child without questioning the veracity of their stories.

- CPC-CBT is an effective treatment for physically abused children concerning decreasing the risk of further abuse and increasing the child’s wellbeing (decreased symptoms associated with trauma). The results mirror the intervention given by 14 treatment facilities, indicating the intervention is applicable to different settings. Furthermore, it highlights the possibility for child welfare services to provide adequate interventions targeting a substantial reason for entering child welfare services.
Children highlight the importance of a treatment including them and their parents and that the therapists address the physical abuse. The trauma processing is sometimes initially difficult since it evokes painful memories, but children emphasise it to be one of the most valuable parts of treatment. Likewise, to receive a letter from their parents where parents take responsibility for the abuse and open up about their thoughts and feelings are described as helpful and healing.

Clinical implications

The results from the thesis suggest the following implications for improving the clinical work.

- Professionals must stand by the child when receiving a disclosure of physical abuse and act further as the child’s advocate.

- Schools should provide more education and discussions about the rights of the child to be open to more disclosures.

- Child welfare services must adopt child-friendly routines during the entire investigation phase, ensuring that the children have sufficient information and are included in decisions concerning them and their family.

- When suspected abuse is reported to child welfare services, the abuse must be addressed with both children and parents (both separately and together) and adequate interventions targeting the abuse must be offered.
- Treatment focusing on physical violence should be made available for children across the country.

**Further research**

Further research is needed in different aspects of child physical abuse. Below are some suggestions raised by this thesis:

- Future studies should explore what factors facilitate disclosure and how both the school system and child welfare services could be more child-friendly in this concern.

- Future studies should explore physically-abused children’s experiences of how child welfare workers include them in the investigation process and decisions concerning eventual interventions, with a special focus on how children make sense of the process.

- Future research should compare CPC-CBT with treatment-as-usual.
Populärvetenskaplig sammanfattning på svenska


Syftet med avhandlingen har varit att undersöka vilka möjliga konsekvenser barnmissandel för med sig avseende hälsa och hur misshandlade barn beskriver relationen till sina föräldrar. Avhandlingen syftar vidare till att undersöka våldsutsatta barns tankar kring avslöjandet av våldet och att studera utfallet av behandlingsinterventionen KIBB i en svensk kontext.

misshandel oftast fortsatt kvar hemma även efter att misshandeln kommit till socialtjänstens kännedom. Vidare visar både svensk och internationell forskning att 40 % av barn som aktualiserats vid socialtjänsten på grund av misstänkt våld hade åter aktualiserats genom förnyade anmälningar rörande nytt våld inom fyra år (Jonson-Reid et al., 2003; Lindell & Svedin, 2006). Sifforna indikerar att socialtjänsten inte förmått erbjuda adekvata insatser för barn och deras familjer. Trots den utbredda förekomsten av barnmisshandel har det saknats beprövade insatser att erbjuda barn och deras föräldrar i syfte att minska risken för ytterligare övergrepp samt att öka barnets välmående. Vidare har det saknats studier som lyfter barns erfarenheter av att delta i en intervention som uppmärksammar fysisk barnmisshandel från såväl socialtjänst som barnpsykiatri.

Avhandlingen inkluderar fyra empiriska studier med olika metodologiska tillvägagångssätt. Delstudie I undersöker vilka konsekvenser barnmisshandel kan få med avseende på hur barn skattar föräldrarnas uppfostringsmetoder samt hur känsla av sammanhang (KASAM) påverkas. I delstudien har en grupp våldsutsatta barn och en grupp barn som skattat att de inte varit utsatta besvarat formulär som mäter föräldrstrategier och känsla av sammanhang. Resultatet visar att det fanns flera skillnader mellan hur grupperna barn skattade sina föräldrars uppfostringsstrategier och känsla av sammanhang. Resultatet visar att det fanns flera skillnader mellan hur grupperna barn skattade sina föräldrars uppfostringsstrategier, där barn som varit utsatta för fysisk misshandel skattade mindre närvarande och engagerade föräldrar. Barn som varit utsatta för fysisk misshandel skattade en signifikant lägre känsla av sammanhang och våldet visade sig också ha en unik påverkan på KASAM.

Avhandlingens andra delstudie syftade till att undersöka hur barn utsatta för misshandel upplevde avslöjandet av sin våldsutsatthet. I studien ingick femton barn mellan 9-16 år. Barnen beskrev avslöjandet som en process med flera övervägande. Det var vanligt att de valde att avslöja för någon personal i
skolan, så som lärare eller skolkurator. Barnen beskrev att det var viktigt att ha förtroende för den person de valde att berätta för.


Utfallsmåtten jämfördes även med skatningar gjorda av 702 skolungdomar, en representativ jämförelsegrupp. Resultatet visade att de våldsutsatta barnen hade signifikant högre symptom till följd av trauma än jämförelsegruppen.
innan behandling avseende samtliga undersökta symtom. Efter behandling förelåg inte längre någon skillnad avseende barns skattningar av nivåer av depression, ilska och dissociation. Den positiva effekten kvarstod vid uppföljningen efter sex månader, tillsammans med reducering även för symptom på delskalan ångest.

Sammanfattningsvis visar studierna på en rad möjliga konsekvenser av att ha varit utsatt för fysisk barnmisshandel som bland annat sämre känsla av sammanhang och sämre hälsa avseende bland annat ångest, depression, ilska och dissociation. Resultatet visar också att barn fattar olika beslut i samband med att våldet avslöjas. Personal i skolan lyfts fram som särskilt viktiga i avslöjandeprocessen. Skolan har en särskild funktion i att såväl erbjuda tillitsfulla varaktiga relationer som möjliggör att barn vågar berätta om sin utsatthet, men också som en arena där barns rättigheter kan adresseras, i syfte att möjliggöra samtal om våld och utsatthet. Barn tycks efter avslöjandet förlora kontrollen över hur deras berättelse hanteras och vuxna agerar på olika sätt utan att informera barnet om vad som kommer att hända. Det kan föranleda en stressfylld och orolig tid för barnet innan det så småningom erbjuds en intervention. Liksom vid avslöjandet beskrivs tillit vara en viktig komponent i behandling och möjligheten att skapa förtroendefulla relationer där barnet känner att deras ord tillmäts betydelse. Väl i behandling uppskattar barnen strukturen på den samma, där de får tid att etablera en tillitsfull relation till sin behandlare och där våldet är tydligt adresserat. Behandlingen tycks bli en lyckad vändpunkt där barnen beskriver, och effektstudien ger stöd för, att våldet i familjerna minskat och barnen förbättrat sitt mående.

får del av den interventionen påverkar det deras livssituation och hälsa på ett avgörande sätt. Avhandlingens delstudier illustrerar värdet av att inkludera barn i forskning och belyser deras förmåga att bidra med värdefull information avseende sin livssituation.
References


Källström Cater, Å. & Överlien, C. (2015). Etiska dilemma i forskning. [Ethical dilemmas in research.] In M. Eriksson, Å. Källström Cater, & E. Näsmann (Eds.), *Barns*
röster om våld – Att lyssna, tolka och förstå. [Children’s voices about violence – to listen, interpret and understand.] Malmö: Gleerups.


Leviner, P. (2011). Rättsliga dilemm i socialtjänstens barnskyddsarbete. [Legal dilemmas in the social services child protection work.] Stockholm: Jure förlag AB.


SBU. (2018). Öppenvårdsinsatser för familjer där barn utsätts för våld och försummelse. En systematisk översikt och utvärdering inklusive ekonomiska och etiska aspekter. [Primary care interventions provided to families where children have been subjected to abuse and neglect. A systematic review and assessment including economic and ethical aspects.] Stockholm: Statens beredning för medicinsk och social utvärdering (SBU).


SFS 1924:361. 1924 års barnavårdslagen. [Child Protection Act of 1924.]

SFS 1980:620. Socialtjänstlagen. [Social Services Act.]

SFS 2001:453. Socialtjänstlagen. [Social Services Act.]


### Electronic sources


Prop. 1842. *Kongl. Maj:ts Nådiga Studga angående Folkundervisningen i Riket: gifwen Stockholms slott den 18 juni 1842.* [His majesty’s merciful proposition to the parliament regarding people’s education in the country.]

Prop. 1924:150. *Förrslag till lag om samhällets barnvård.* [Proposal for a law on community child welfare.]

SCB (2017). De flesta barn går i förskola oavsett bakgrund. [Most children attend preschool regardless of background.]
http://www.scb.se/sv_/Hitta-statistik/Artiklar/De-flesta-barn-i-forskoala--oavsett-bakgrund/. Hämtad den 1 augusti 2017

The Act 2003:460 *concerning the Ethical Review of Research Involving Humans.*
http://www.epn.se/media/75686/the_ethical_review_act.pdf. Retrieved 2017-12-19


www.mstcan.com Retrieved 2018-08-30

Violene against children (2019).
https://violenceagainstchildren.un.org/content/overarching-priorities Retrieved 2019-03-07